



Medicaid Information Technology System

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

Recipient Plans Participant Guide

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Table of Contents

Course Overview.....	1
Overview.....	1
Objective(s).....	2
Agenda.....	2
Introduction to Recipient Plans.....	4
Overview.....	4
Benefit Plans and MITS.....	4
Types of Plans.....	4
Benefit Classification.....	6
Assignment Plans.....	7
Check Your Understanding.....	8
Summary.....	9
Maintaining Recipient Plans.....	10
What.....	10
Who.....	10
When.....	10
Relevance.....	10
Requirements.....	10
How to.....	10
Success.....	12
Practice #1.....	12
Practice #2.....	12
Summary.....	13
Benefit Dependent and Excluded Plan Data.....	14
Overview.....	14
Dependent Plan Data.....	14
Excluded Plan Data.....	15
Check Your Understanding.....	16
Summary.....	16
Maintaining Dependent and Excluded Plan Data.....	17
What.....	17
Who.....	17
When.....	17
Relevance.....	17
How To.....	17
Success.....	18
Practice.....	18
Summary.....	18
Introduction to Rules.....	19
Overview.....	19
Rules as Policy.....	19
Rule Directives.....	19
Types of Rules.....	20
Tree Structure.....	21
Rule Summary.....	22
Rule Categories.....	23

Check Your Understanding	24
Summary	25
Searching for Rules	26
What	26
Who	26
When	26
Relevance	26
Requirements	26
Guidelines	26
How To	27
Success	28
Practice	28
Summary	28
Save Process	29
Overview	29
System checks	29
Three Steps	29
Conflicts	31
Check Your Understanding	32
Summary	32
Creating and Saving Rules	33
What	33
Who	33
When	33
Relevance	33
Requirements	33
Guidelines	33
How To	34
Success	35
Practice	35
Summary	35
Rule Options	36
Overview	36
Yes/No Editing	36
Include/Exclude/No Editing	37
Include/Exclude/No with Multiple Selection Fields Editing	38
Simplify	39
Add Requirement	39
Check Your Understanding	40
Summary	40
Updating/Modifying Rules Data	41
What	41
Who	41
When	41
Relevance	41
Requirements	41
How To	41
Success	43
Practice	43
Summary	43

Introduction to Rule Diagnosis Editing.....	44
Overview.....	44
Types.....	44
Diagnosis Editing Panel.....	45
Example.....	46
Check Your Understanding.....	47
Summary.....	47
Configuring Rule Diagnosis.....	48
What.....	48
Who.....	48
When.....	48
Requirements.....	48
Guidelines.....	48
How To.....	48
Success.....	51
Practice.....	51
Summary.....	52
Introduction to Rule Modifier Editing.....	53
Overview.....	53
Modifier Editing Panel.....	53
Examples.....	55
Reimbursement Modifier Types.....	56
Check Your Understanding.....	57
Summary.....	57
Configuring Rule Modifiers.....	58
What.....	58
Who.....	58
When.....	58
Relevance.....	58
Requirements.....	58
How To.....	58
Success.....	61
Practice.....	61
Summary.....	62
Introduction to Removing a Rule.....	63
Overview.....	63
Three ways.....	63
Example.....	64
Check Your Understanding.....	64
Summary.....	64
Excluding/Inactivating Rules.....	65
What.....	65
Who.....	65
When.....	65
Relevance.....	65
Requirements.....	65
How To.....	65
Success.....	67
Practice.....	67
Summary.....	67

Introduction to Plan Groups.....	68
Overview.....	68
Purpose of the Plan Group Types.....	68
How Groups Affect Ohio Medicaid Policy.....	69
Check Your Understanding.....	70
Summary.....	71
Maintaining Benefit Plan Groups.....	72
What.....	72
Who.....	72
When.....	72
Relevance.....	72
Viewing Benefit Plan Groups.....	72
Adding, Updating, or Deleting a Recipient Plan Group type.....	73
Associating a Recipient Plan to a Group Type.....	74
Success.....	74
Practice #1.....	75
Practice #2.....	75
Summary.....	75
Introduction to Plan Hierarchy Data.....	76
Overview.....	76
Panels.....	76
Processing.....	78
Check Your Understanding.....	79
Summary.....	79
Maintaining Plan Hierarchy Data.....	80
What.....	80
Who.....	80
When.....	80
Relevance.....	80
Viewing a Plan Hierarchy.....	80
Adding, Updating, or Deleting Plan Hierarchy Threads.....	81
Success.....	82
Summary.....	82
Introduction to Conflict Report Errors.....	83
Overview.....	83
Conflict Error Report.....	83
Benefit Plan Spreadsheet.....	84
Contract Spreadsheet.....	86
Check Your Understanding.....	87
Summary.....	87
Reports.....	87
Correcting Conflict Report Errors.....	89
What.....	89
Who.....	89
When.....	89
Relevance.....	89
Requirements.....	89
How To.....	89
Success.....	92
Practice.....	92

Summary 92
Review..... 93
Objectives 93

Course Overview

Overview

The goal of this course is to provide you with the skills required to perform tasks related to recipient plans in Ohio MITS. You will learn how to view and add recipient plans, as well as configure and maintain recipient rules. You will also learn how the rules relate to the edits/audits in the claims engine.



Objective(s)

After completing this course you should be able to:

- Search for and view recipient plans
- Create, update, and delete benefit plans
- Create, update, and delete assignment plans
- Maintain dependent and excluded plan data
- Maintain benefit plan groups
- Maintain plan hierarchy data
- Search for and view existing rules
- Create and save new rules
- Exclude/modify rules
- Correct conflict report errors

Agenda

Topic	Time
Welcome and Introductions	5 minutes
Introduction to Recipient Plans	10 minutes
Maintaining Recipient Plans	30 minutes
Benefit Dependent and Excluded Plan Data	10 minutes
Maintaining Dependent and Excluded Plan Data	20 minutes
Introduction to Rules	25 minutes
Searching for Rules	25 minutes
Break	15 minutes
Save Process	10 minutes
Creating and Saving Rules	20 minutes
Rule Options	15 minutes
Updating/Modifying Rules Data	15 minutes
Lunch	1 hour
Introduction to Rule Diagnosis Editing	10 minutes
Configuring Rule Diagnosis	20 minutes

Topic	Time
Introduction to Rule Modifier Editing	10 minutes
Configuring Rule Modifiers	20 minutes
Introduction to Removing a Rule	10 minutes
Excluding/Inactivating Rules	15 minutes
Introduction to Plan Groups	15 minutes
Maintaining Benefit Plan Groups	20 minutes
Break	15 minutes
Introduction to Plan Hierarchy Data	10 minutes
Maintaining Plan Hierarchy Data	20 minutes
Introduction to Conflict Report Errors	10 minutes
Correcting Conflict Report Errors	15 minutes
Review	5 minutes

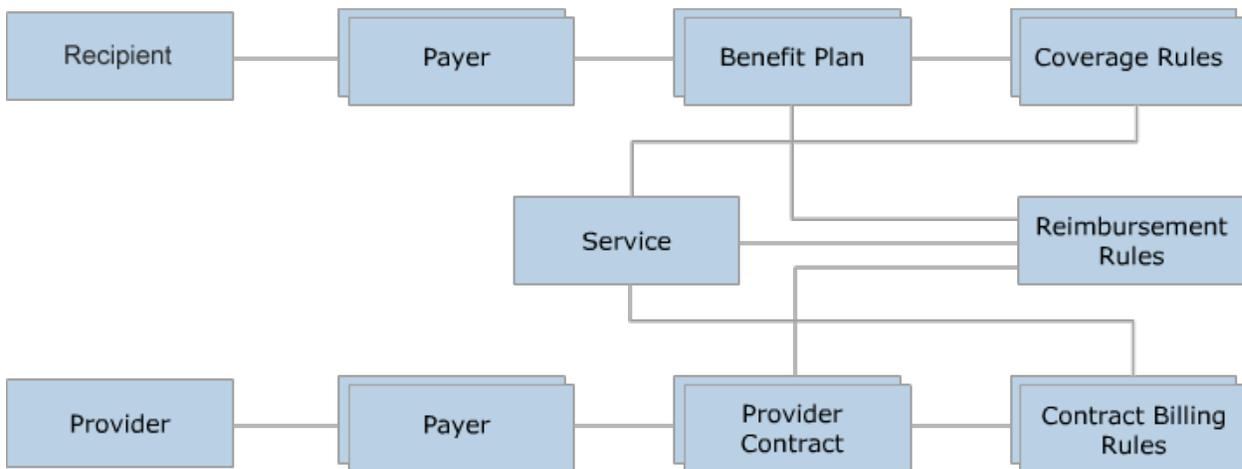
Introduction to Recipient Plans

Overview

In this topic you learn about the two types of recipient plans: benefit plans and assignment plans.

Benefit Plans and MITS

The diagram represents the various components of Benefit Plan Administration. The **Benefit Plan** component relates to the recipient:



Types of Plans

A **benefit plan** identifies a group of covered services (benefits) granted to a recipient who is deemed eligible for the services the benefit plan represents. The benefit plan maintains information about all the services covered under various benefit packages (such as Medicaid, Waiver, and others), including scope of services and reimbursement rate information. Both benefit plans and assignment plans display in the **Recipient Plan** panel.

Review the **Recipient Plan** panel example.

Recipient Plan

Both benefit and assignment plans display in this list.

Search Results

Recipient Plan	Description	Plan Type	Financial Payer	Effective Date	End Date	Inactive Date
MSP	Medicaid Schools	Benefit Plan	DEFAULT	07/01/2005	12/31/2299	12/31/2299
OBRA	Obra-Waiver VII	Benefit Plan	DEFAULT	01/01/1900	04/30/2007	12/31/2299
OHC	Ohio Home Care redesign.w	Benefit Plan	DEFAULT	07/01/2006	12/31/2299	12/31/2299
OMH	Ohio Mental health	Benefit Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
OOHC	Old Ohio Home Care Waiver	Benefit Plan	DEFAULT	07/01/1998	11/05/2007	12/31/2299
PACEA	PACE Assignment Plan	Assignment Plan	DEFAULT	09/30/1996	12/31/2299	12/31/2299
PACEB	PACE Benefit Plan	Benefit Plan	DEFAULT	09/30/1996	12/31/2299	12/31/2299
PACTD	PACT Pharmacy	Assignment Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
PACTP	PACT Physician	Assignment Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
PAS14	Passport Waiver > 14 Hour	Benefit Plan	DEFAULT	01/01/1900	04/09/2004	12/31/2299

Clicking on a row in the search results displays the plan details below.

Benefit Plan- Type changes below.

*Recipient Plan OMH

*Description Ohio Mental health

*Long Description Ohio Mental health

*Effective Date 01/01/1900

*Plan Type Benefit Plan

*Financial Payer DEF DEFAULT

*Inactive Date 12/31/2299

*End Date 12/31/2299

add Copy Plan

- Dependent Plan Data- The data below is for the row selected above.

- Excluded Plan Data- The data below is for the row selected above.

- Benefit Coverage-

- Benefit Plan Group Type- The data below is for the row selected above.

You use Benefit Plan Administration (BPA) to define the benefits a recipient may receive, as well as the services for which a provider may be reimbursed. Services (procedure codes, revenue codes, diagnosis codes, and drugs) are grouped into logical units called recipient plans. Within a single recipient plan, authorized users can configure how the individual services will be covered. The various recipient populations within Medicaid are then given eligibility to one or more of these recipient plans, and their claims are adjudicated based on these user-configured rules.

Benefit plans and assignment plans are both types of recipient plans. The plan type field indicates the type of plan (assignment or benefit). **Benefit plans** are used for fee-for-service plans. **Assignment plans** are used to tie a recipient to a specific provider for specified services. This table describes the two types of plans.

Benefit Plans	Assignment Plans
Benefit plans are a list of covered benefits that are granted to a recipient who is deemed eligible for the services the benefit plan represents. Benefit plans are assigned to a recipient on the Benefit Plan panel in the Recipient subsystem. The recipient may be enrolled in several benefit plans at the same time; however, each benefit plan will have only one financial payer assigned to each plan.	Assignment plans are a list of covered benefits that are granted to a recipient who is deemed eligible for the services the assignment plan represents. Like benefit plans, assignment plans are assigned to a recipient on the Benefit Plan panel in the Recipient subsystem. The recipient may also be enrolled in several assignment plans at the same time; however, each assignment plan will have only one financial payer

Benefit Plans	Assignment Plans
	assigned to each plan.
Benefit plans are instructions to claims processing. They indicate what coverage is necessary for the recipient. If a recipient has only one benefit plan, the system can look to it for coverage of the particular procedures and conditions. However, if the recipient has more than one benefit plan, the system needs to know where to look for coverage first. In this case, the benefit plan hierarchy is used to control the order in which the plans are processed in the system.	Assignment plans are also instructions to claims processing. They indicate what coverage is necessary for the recipient. If a recipient has only one assignment plan, the system can look to it for coverage of the particular procedures and conditions. However, if the recipient has more than one assignment plan, the system needs to know where to look for coverage first. In this case, the assignment plan hierarchy is used to control the order in which the plans are processed in the system.
All Ohio Health Plans (OHP) recipients are eligible for Title XIX benefits and will be enrolled in at least one benefit plan representing the total Title XIX benefit coverage. However, some recipients will also be eligible for waiver or managed care services. In this circumstance, the recipient will also be enrolled in the additional benefit plan. A benefit plan hierarchy will be developed to process the order of the benefit coverage.	Assignment Plans are used when there are special circumstances around the covered services, such as when: <ul style="list-style-type: none"> • Services must be provided by an individual provider (by provider ID) • Services must be provided by a particular provider type/provider specialty • Services are covered under Lock-in only • Services require Level of Care • Services are covered under Managed Care only

Example: An assignment plan is used on the lock-in panels in the Recipient subsystem to assign a recipient to specific services provided by a specific provider or provider organization, in order to receive the covered services (benefits). Only plans identified as assignment plans can be used on the lock-in details panel.

Benefit Classification

The **+Benefit Coverage** area below the Benefit Plan panel identifies the benefit classification and the actual services covered. You can search for a medical service or code by type and code, or you can navigate the tree structure by expanding the benefit levels, starting with the Procedures level. Nodes in the classification tree represent services, or groups of services, for which rules can be created.

*Directive Version

Type Code Description

Search: Procedure [] [] Find

Active Rules All Rules

You select a benefit classification from the drop-down list to the left of the service. In this example, to the left of Procedures.

In this example, the expanded tree structure shows the custom benefit classification called **OH MH Benefit Plan**.

The tree structure also contains branches, such as **Medicine**.

The lowest level in a tree structure is sometimes referred to as a leaf. In this example, the benefit code is the lowest level.

The procedure code 90862 is Medication Management.

In this example, the Procedures level is assigned a custom benefit classification. A **custom** classification has a limited number of benefits, like a subset of the full standard classification. The other levels shown in the example (Drugs and the rest of the benefits) have a **standard** benefit classification as shown in the drop-down list.

Assignment Plans

Assignment plans, although structurally very similar to benefit plans, have different functionality within the system. A recipient is enrolled in an assignment plan **when** special circumstances exist. Special circumstances could include the following requirements:

- A particular provider or provider type or specialty must render the service.
- The service requires a specific level of care.

Additional conditions regarding assignment plans include the following:

- The assigned provider must provide or refer the services.
- The services may be reimbursed on a fee for service or capitation basis.
- The services do not entitle a recipient to have the coverage. The recipient must also be enrolled in a recipient plan that covers the service:
 - Procedure
 - Diagnosis
 - Modifier
 - National Drug Code (NDC)

- Revenue Code
- Diagnosis Related Groups (DRG)

The example shows the list of plans with an assignment plan selected.

Recipient Plan

Recipient Plan

Search Results

Recipient Plan ▲	Description	Plan Type	Financial Payer	Effective Date	End Date	Inactive Date
OBRA	Obra-Waiver VII	Benefit Plan	DEFAULT	01/01/1900	04/30/2007	12/31/2299
OHC	Ohio Home Care redesign w	Benefit Plan	DEFAULT	07/01/2006	12/31/2299	12/31/2299
OMH	Ohio Mental health	Benefit Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
OOHC	Old Ohio Home Care Waiver	Benefit Plan	DEFAULT	07/01/1998	11/05/2007	12/31/2299
PACEA	PACE Assignment Plan	Assignment Plan	DEFAULT	09/30/1996	12/31/2299	12/31/2299
PACEB	PACE Benefit Plan	Benefit Plan	DEFAULT	09/30/1996	12/31/2299	12/31/2299
PACTD	PACT Pharmacy	Assignment Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
PACTP	PACT Physician	Assignment Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
PAS14	Passport Waiver > 14 Hour	Benefit Plan	DEFAULT	01/01/1900	04/09/2004	12/31/2299
PASSP	PASSPORT Waiver - ODA	Benefit Plan	DEFAULT	07/01/1990	12/31/2299	12/31/2299

< Previous 1 2 3 4 5 Next >

Clicking on a row in the search results displays similar results for an assignment plan.

Benefit Plan- Type changes below.

*Recipient Plan PACEA

*Description PACE Assignment Plan
Program of All-inclusive Care for the Elderly (Administered by ODA Sister Agency)

*Long Description

*Effective Date 09/30/1996

*Plan Type Assignment Plan

*Financial Payer DEF DEFAULT ⓘ

*Inactive Date 12/31/2299

*End Date 12/31/2299

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.

Recipient plans include the following: (select all that apply)

- Reimbursement agreement
- Provider contract
- Benefit plan
- Assignment plan

A list of covered benefits granted to a recipient who is deemed eligible for the services is called a _____.

- Plan group

- B. Dependent plan
- C. Provider contract
- D. Benefit plan

All recipients **must** be enrolled in at least one assignment plan.

- A. True
- B. False

Summary

In this topic you learned about benefit plans and assignment plans.

Maintaining Recipient Plans

What

In this topic you learn how to add and update benefit plans and assignment plans.

Who

A configuration analyst, medical policy analyst, or claims analyst performs this task.

When

You perform this task when researching medical policy, business rules or claims, or when updating benefit and assignment plans.

Relevance

In order to adjudicate and pay a claim, a recipient must have a recipient plan (benefit plan or assignment plan), a provider contract and a reimbursement agreement.

Requirements

To perform this task, you need a policy directive or change request.

How to

Follow these steps from the MITS home page to add or update a benefit plan or assignment plan:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Recipient Plan .
4	Click the Recipient Plan item link under the heading "Select area to add or modify below."
5	Find the recipient plan by following these steps:

Step	Action								
	<table border="1"> <thead> <tr> <th data-bbox="375 321 727 373">TO:</th> <th data-bbox="727 321 1377 373">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 373 727 457">Search</td> <td data-bbox="727 373 1377 457"> a. Type the recipient plan name in the Code field. b. Click Search. </td> </tr> <tr> <td data-bbox="375 457 727 548">Select from the list</td> <td data-bbox="727 457 1377 548"> Navigate the list using the page numbers and/or Next > page icon. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the recipient plan name in the Code field. b. Click Search .	Select from the list	Navigate the list using the page numbers and/or Next > page icon.		
TO:	THEN:								
Search	a. Type the recipient plan name in the Code field. b. Click Search .								
Select from the list	Navigate the list using the page numbers and/or Next > page icon.								
6	Click to select the desired recipient benefit plan or assignment plan.								
7	<p data-bbox="318 636 1369 699">Add or modify the recipient benefit plan or assignment plan by following these steps:</p> <table border="1"> <thead> <tr> <th data-bbox="375 747 727 800">TO:</th> <th data-bbox="727 747 1377 800">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 800 727 1230">Add a benefit plan</td> <td data-bbox="727 800 1377 1230"> a. Click Add to get a blank record panel. b. Type a description in the Description field. c. Type a longer description in the Long Description field. d. Type or change the date in the Effective Date field. e. Select Benefit from the Plan Type drop-down list. f. Select a financial payer from the Financial Payer drop-down list. g. Type or change the date in the Inactive Date field. h. Type or change the date in the End Date field. </td> </tr> <tr> <td data-bbox="375 1230 727 1650">Add an assignment plan</td> <td data-bbox="727 1230 1377 1650"> a. Click Add to get a blank record panel. b. Type a description in the Description field. c. Type a longer description in the Long Description field. d. Type or change the date in the Effective Date field. e. Select Assignment from the Plan Type drop-down list. f. Select a financial payer from the Financial Payer drop-down list. g. Type or change the date in the Inactive Date field. h. Type or change the date in the End Date field. </td> </tr> <tr> <td data-bbox="375 1650 727 1797">Assign a benefit classification to an existing benefit or assignment plan</td> <td data-bbox="727 1650 1377 1797"> a. Click + to expand the Benefit Coverage area. b. Select the desired directive from the Directive Version drop-down list. c. Select the tree level for the desired rule. </td> </tr> </tbody> </table>	TO:	THEN:	Add a benefit plan	a. Click Add to get a blank record panel. b. Type a description in the Description field. c. Type a longer description in the Long Description field. d. Type or change the date in the Effective Date field. e. Select Benefit from the Plan Type drop-down list. f. Select a financial payer from the Financial Payer drop-down list. g. Type or change the date in the Inactive Date field. h. Type or change the date in the End Date field.	Add an assignment plan	a. Click Add to get a blank record panel. b. Type a description in the Description field. c. Type a longer description in the Long Description field. d. Type or change the date in the Effective Date field. e. Select Assignment from the Plan Type drop-down list. f. Select a financial payer from the Financial Payer drop-down list. g. Type or change the date in the Inactive Date field. h. Type or change the date in the End Date field.	Assign a benefit classification to an existing benefit or assignment plan	a. Click + to expand the Benefit Coverage area. b. Select the desired directive from the Directive Version drop-down list. c. Select the tree level for the desired rule.
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Add an assignment plan	a. Click Add to get a blank record panel. b. Type a description in the Description field. c. Type a longer description in the Long Description field. d. Type or change the date in the Effective Date field. e. Select Assignment from the Plan Type drop-down list. f. Select a financial payer from the Financial Payer drop-down list. g. Type or change the date in the Inactive Date field. h. Type or change the date in the End Date field.								
Assign a benefit classification to an existing benefit or assignment plan	a. Click + to expand the Benefit Coverage area. b. Select the desired directive from the Directive Version drop-down list. c. Select the tree level for the desired rule.								

Step	Action								
	<table border="1"> <tr> <td data-bbox="375 279 727 426"></td> <td data-bbox="727 279 1373 426"> d. Click the Benefit Classification drop-down arrow. e. Select the desired benefit classification from the Benefit Classification drop-down list. </td> </tr> <tr> <td data-bbox="375 426 727 541">Modify an existing benefit or assignment plan</td> <td data-bbox="727 426 1373 541">Update the field values as necessary.</td> </tr> <tr> <td data-bbox="375 541 727 594">End-date a benefit plan</td> <td data-bbox="727 541 1373 594">Enter the new date in the End Date field.</td> </tr> <tr> <td data-bbox="375 594 727 688">End-date an assignment plan</td> <td data-bbox="727 594 1373 688">Enter the new date in the End Date field.</td> </tr> </table>		d. Click the Benefit Classification drop-down arrow. e. Select the desired benefit classification from the Benefit Classification drop-down list.	Modify an existing benefit or assignment plan	Update the field values as necessary.	End-date a benefit plan	Enter the new date in the End Date field.	End-date an assignment plan	Enter the new date in the End Date field.
	d. Click the Benefit Classification drop-down arrow. e. Select the desired benefit classification from the Benefit Classification drop-down list.								
Modify an existing benefit or assignment plan	Update the field values as necessary.								
End-date a benefit plan	Enter the new date in the End Date field.								
End-date an assignment plan	Enter the new date in the End Date field.								
8	Click Save .								

Success

You have successfully completed this task when the appropriate recipient plan data displays or a confirmation message of success displays.

Practice #1

Practice adding a **benefit plan** using this information:

- **Recipient Plan** name - TestBXXX (your initials)
- **Description** - your name
- **Long Description** - your name's benefit plan
- **Effective Date** - today's date
- **Plan Type** - benefit plan
- **Financial Payer** - default
- **Inactive Date** - 12/31/2299
- **End Date** - 12/31/2299
- Assign the Standard benefit classification to your new benefit plan.

Practice #2

Practice adding an **assignment plan** using this information:

- **Recipient Plan** name - TestAXXX (your initials)
- **Description** - your name
- **Long Description** - your name's assignment plan
- **Effective Date** - today's date
- **Plan Type** - assignment plan
- **Financial Payer** - default

- **Inactive Date** - 12/31/2299
- **End Date** - 12/31/2299
- Assign the Standard benefit classification to your new assignment plan.

Summary

In this topic you learned how to add and update benefit plans and assignment plans.

Benefit Dependent and Excluded Plan Data

Overview

This topic introduces you to dependent and excluded plan data as it relates to benefit and assignment plans.

Dependent Plan Data

Benefit plans and assignment plans can both have dependent plans, meaning they **must** co-exist on the recipient eligibility.

Plan Type	Panels
Benefit Plan	The Benefit Plan Dependent Plan Data panel maintains the list of benefit plans that are dependent and must exist together on recipient eligibility within the selected benefit plan.
Assignment Plan	The Assignment Plan Dependent Plan Data panel maintains the list of assignment plans that are dependent and must exist together on recipient eligibility within the selected assignment plan.

Review the **Dependent Plan Data** panel example.

The screenshot displays the 'Search Results' table with the following data:

Recipient Plan	Description	Plan Type	Financial Payer	Effective Date	End Date	Inactive Date
MSP	Medicaid Schools	Benefit Plan	DEFAULT	07/01/2005	12/31/2299	12/31/2299
OBRA	Obra-Waiver VII	Benefit Plan	DEFAULT	01/01/1900	04/30/2007	12/31/2299
OHM	Ohio Mental health	Benefit Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
OHRL	Old Ohio Home Care Waiver	Benefit Plan	DEFAULT	07/01/1999	11/09/2007	12/31/2299
PACEA	PACE Assignment Plan	Assignment Plan	DEFAULT	09/30/1996	12/31/2299	12/31/2299
PACEB	PACE Benefit Plan	Benefit Plan	DEFAULT	09/30/1996	12/31/2299	12/31/2299
PACTD	PACT Pharmacy	Assignment Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
PACTP	PACT Physician	Assignment Plan	DEFAULT	01/01/1900	12/31/2299	12/31/2299
PAS14	Passport Waiver > 14 Hour	Benefit Plan	DEFAULT	01/01/1900	04/09/2004	12/31/2299

The 'Benefit Plan' details for 'OHM' are as follows:

- *Recipient Plan: OHM
- *Description: Ohio Mental health
- *Long Description: Ohio Mental health
- *Effective Date: 01/01/1900
- *Plan Type: Benefit Plan
- *Financial Payer: DEF DEFAULT
- *Inactive Date: 12/31/2299
- *End Date: 12/31/2299

The 'Dependent Plan Data' panel shows the following dependent plans:

- Dependent Plan: MCAID Medicaid
- Dependent Plan: REF Refugee

A text box explains: "Dependent plan data must exist with the selected plan (for example, OMH) on a recipient's eligibility."

Excluded Plan Data

Benefit plans and assignment plans can both have excluded plans, meaning they must **not** co-exist on the recipient eligibility.

Plan Type	Panels
Benefit Plan	The Benefit Plan Excluded Plan Data panel maintains the list of recipient plans that cannot exist with the selected recipient plan. The recipient enrollment process uses this data to detect errors during enrollment transactions or update transactions.
Assignment Plan	The Assignment Plan Excluded Plan Data panel maintains the list of recipient plans that cannot exist with the selected recipient plan. The recipient enrollment process uses this data to detect errors during enrollment transactions or update transactions.

Review the **Excluded Plan Data** panel example.

The screenshot displays the 'Search Results' interface. A table lists recipient plans with columns for Recipient Plan, Description, Plan Type, Financial Payer, Effective Date, End Date, and Inactive Date. The plan 'OMH - Ohio Mental health' is highlighted. Below the table, the 'Benefit Plan' details are shown, including Recipient Plan (OMH), Description (Ohio Mental health), Effective Date (01/01/1900), and End Date (12/31/2299). The 'Excluded Plan Data' panel is expanded, showing a list of excluded plans such as 'DMA Disability Medical Assistance' and 'ALIEN Emergency Aliens'. A message states: 'Excluded plan data cannot exist with the selected plan (for example OMH) on a recipient's eligibility.' The 'Managed Care Plan Exclusion' is set to 'NO'.

The **Excluded Plan Data** panel for an assignment plan is similar to the **Excluded Plan**

Data panel for a benefit plan.

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.

When a benefit plan has excluded plans, the plans **must** exist together on the recipient eligibility.

- A. True
- B. False

Which of these panels is used to maintain the list of benefit plans that are dependent and **must** exist together on recipient eligibility within the selected benefit plan?

- A. Assignment Plan Excluded Plan
- B. Benefit Plan Excluded Data
- C. Assignment Plan Dependent Plan
- D. Benefit Plan Dependent Plan

Summary

In this topic you learned about dependent and excluded plans.

Maintaining Dependent and Excluded Plan Data

What

In this topic you learn how to add and delete dependent and excluded plan data in recipient plans.

Who

A Configuration Analyst performs this task.

When

You perform this task when you need to view, add, or delete dependent and/or excluded plan data for a recipient plan.

Relevance

Recipient **dependent** plans make payment of a claim dependent on a recipient's being eligible for another plan **in addition to** the selected benefit plan.

Recipient **excluded** plans define plans for which a recipient should **not** be eligible in addition to the selected benefit plan.

How To

Follow these steps from the MITS home page to add or delete recipient dependent and excluded plan data:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Recipient Plan on the left side of the Benefit Administration panel.
4	Click Recipient Plan on the right side of the Benefit Administration panel.
5	Select the desired recipient benefit plan.
6	Update the plan data by following these steps:

Step	Action										
	<table border="1"> <thead> <tr> <th data-bbox="375 321 727 373">TO:</th> <th data-bbox="727 321 1373 373">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 373 727 489">Add dependent plan data</td> <td data-bbox="727 373 1373 489"> a. Click '+' to expand Dependent Plan Data. b. Click add. c. Select the recipient plan from the drop-down list. </td> </tr> <tr> <td data-bbox="375 489 727 604">Delete dependent plan data</td> <td data-bbox="727 489 1373 604"> a. Click '+' to expand Dependent Plan Data. b. Select the recipient plan from the drop-down list. c. Click delete. </td> </tr> <tr> <td data-bbox="375 604 727 779">Add excluded plan data</td> <td data-bbox="727 604 1373 779"> a. Click '+' to expand Excluded Plan Data. b. Click add. c. Select the recipient plan from the drop-down list. d. Select the desired option in the Managed Care Plan Exclusion drop-down list. </td> </tr> <tr> <td data-bbox="375 779 727 932">Delete excluded plan data</td> <td data-bbox="727 779 1373 932"> a. Click '+' to expand Excluded Plan Data. b. Select the appropriate plan under Excluded Plan Data. c. Click delete. </td> </tr> </tbody> </table>	TO:	THEN:	Add dependent plan data	a. Click '+' to expand Dependent Plan Data. b. Click add . c. Select the recipient plan from the drop-down list.	Delete dependent plan data	a. Click '+' to expand Dependent Plan Data. b. Select the recipient plan from the drop-down list. c. Click delete .	Add excluded plan data	a. Click '+' to expand Excluded Plan Data. b. Click add . c. Select the recipient plan from the drop-down list. d. Select the desired option in the Managed Care Plan Exclusion drop-down list.	Delete excluded plan data	a. Click '+' to expand Excluded Plan Data. b. Select the appropriate plan under Excluded Plan Data. c. Click delete .
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Delete excluded plan data	a. Click '+' to expand Excluded Plan Data. b. Select the appropriate plan under Excluded Plan Data. c. Click delete .										
7	Click Save .										

Success

You have successfully completed this task when the additions or deletions are reflected in the recipient dependent and/or excluded plan data.

Practice

Practice adding recipient dependent and excluded plan data using this information:

- 1) Open the benefit plan you created (**TESTBXXX**)
- 2) Add a dependent plan - **MCAID**
- 3) Add an excluded plan - **Alien**

Summary

In this topic you learned how to add and delete dependent and excluded plan data for benefit and assignment plans.

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.

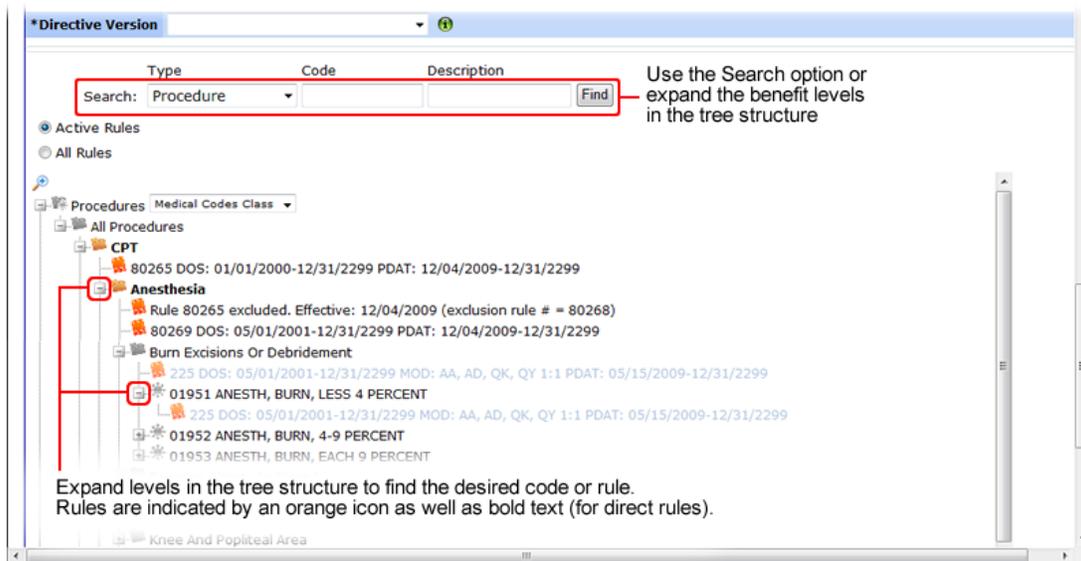
Another rule you might consider is for Other Insurance (OI), also referred to as Third Party Liability. The OI plan includes a list of services covered by the other carriers. OI plans might also cover services that the State Healthcare program covers. During the adjudication process, MITS compares service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

Benefit Type	Code Type and Source of the information
	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.

The screenshot shows the 'Provider Type/Specialty' application interface. A search for 'Procedure' is active. The left sidebar shows a tree view with 'Anesthesia' selected. A red box highlights the 'Anesthesia' node in the tree, and a red arrow points from it to a 'Restriction Choices' pop-up window. The pop-up window displays a table with the following data:

Rule	Modifier	Act/Inact Dates
225	AA, AD, QK, QY 1:1	05/15/2009-12/31/2299

Below the table, a text box says: 'Click on the benefit code to see a summary view of the rules.'

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

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

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

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

Rule Categories

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

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

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

- Provider Type/Specialty:** CNV2009 v1 Release SYSTEM IMP
- Search:** Procedure
- Active Rules:** Selected
- Medical Codes Class:** CPT
- Anesthesia Group:**
 - 225 DOS: 05/01/2001-12/31/2299 MOD: AA, AD, OK, QY 1:1 PDAT: 05/15/2009-12/31/2299 (Direct rule – The benefit level is bold; and the rule displays normally.)
 - Burn Excisions Or Debridement
 - 225 DOS: 05/01/2001-12/31/2299 MOD: AA, AD, QK, QY 1:1 PDAT: 05/15/2009-12/31/2299
 - 01951 ANESTH, BURN, LESS 4 PERCENT (Inherited 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.)
 - 01952 ANESTH, BURN, 4-9 PERCENT
 - 01953 ANESTH, BURN, EACH 9 PERCENT
- Other Groups:** Forearm, Wrist, And Hand; Head; Intrathoracic; Knee And Popliteal Area; Lower Abdomen

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

Check Your Understanding

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

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

- True
- False

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

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

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

- A. Waterfall rule
- B. Inherited 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. Initiative
- B. Rule Category
- C. Directive

Summary

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

Searching for Rules

What

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

Who

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

When

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

Relevance

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

Requirements

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

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

Guidelines

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

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

How To

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

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Recipient Plan .						
4	Select the recipient plan with these instructions: <table border="1" data-bbox="371 718 1373 1071"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the recipient plan in the search field. b. Click search. Note: The matching plan 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 recipient plan row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the recipient plan in the search field. b. Click search . Note: The matching plan 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 recipient plan row from the Search Results list.
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Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the recipient plan row from the Search Results list.						
5	Click < + > in front of Benefit Coverage.						
6	Find the benefit code in the medical classification with these instructions: <table border="1" data-bbox="371 1241 1373 1675"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search the medical classification</td> <td> a. Select the desired type from the Type (i.e., Procedures, HCPCS, etc.) drop-down list. b. Enter the appropriate code in the Code field. c. You can search with the Description field, as well (if this would be effective). d. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service. </td> </tr> </tbody> </table>	TO:	THEN:	Search the medical classification	a. Select the desired type from the Type (i.e., Procedures, HCPCS, etc.) drop-down list. b. Enter the appropriate code in the Code field. c. You can search with the Description field, as well (if this would be effective). d. Click Find .	Navigate the tree	a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service.
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Navigate the tree	a. Click the "+" symbol for the appropriate benefit group. b. Continue to click the "+" symbol until you reach the desired level and to reveal existing rules for that service.						
7	Click the benefit/service code level to view the rule summary.						
8	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 **recipient plan rule** using the following instructions:

Practice #1 - Navigating the tree

- Recipient plan - **REF (Refugee)**.
- Expand Benefit Coverage.
- Expand Procedures>All Procedures > HCPCS>Administrative, Miscellaneous, Investigational
- View rules and answer the following questions:
 - What is the high-level direct rule at the HCPCS level?
 - What procedure code has excluded the HCPCS direct rule?
 - What is the indicator that lets you know the procedure has an excluded rule?
 - What is the new rule that was put in when the HCPCS rule was modified/excluded?

Practice #2 - Searching

- Assignment plan - **PACEA**
- Search for procedure code Y9999
- View the rules and answer these questions:
 - What is the name of the procedure for Y9999?
 - What rule is on procedure Y9999?
 - Is it a direct or inherited rule?
 - What is the patient age criterion?

Summary

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

Save Process

Overview

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

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

System checks

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

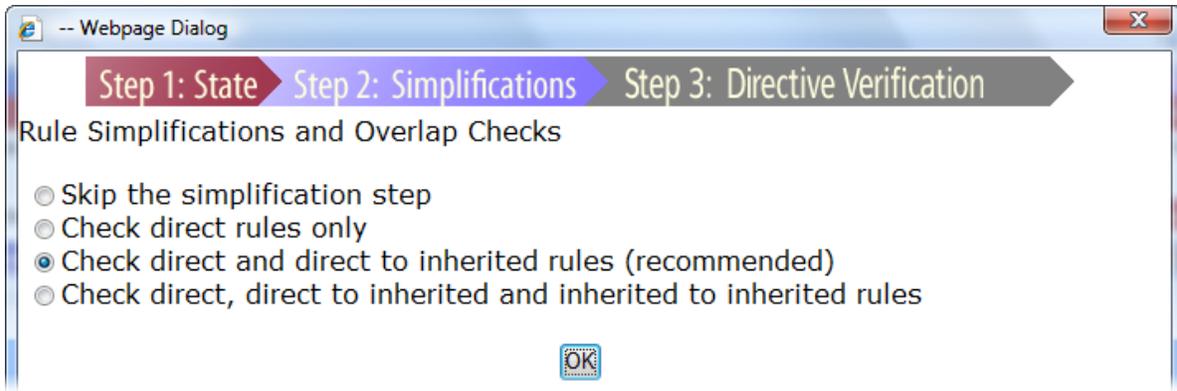
- 1) The **State** step identifies conflicting rules. When this happens, the claim engine is unable to process the claim properly. The system does not save changes until you correct or remove the ambiguity. Click Cancel to return to the previous screen to make the appropriate changes. Refer to the Summary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

Three Steps

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

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





Three steps in the save process

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, IR, ID, IE, IG, IH, II, IJ, IN, IP, IR, JD, JE, JH,
76453	DS, ES, GG, GJ, GS, HS, IS, JG, JJ, JS, NS, PS, RR, RS, 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. Directive Verification step
- B. Simplification step
- C. State step

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

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

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

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

Summary

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

Creating and Saving Rules

What

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

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

Who

A configuration analyst performs this task.

When

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

Relevance

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

Requirements

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

Guidelines

Each rule can be configured to include, exclude, or bypass parameters when defining coverage for places of service, claim types, recipient plans, provider contracts, types of bills, diagnoses, provider types or specialties, modifiers, occurrence codes, and condition codes, just to name a few.

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

How To

Follow these steps from the MITS home page to add recipient plan rules:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Recipient Plans under “Select area to add or modify below”. Recipient Plans is the default submenu under Benefit Administration.						
4	Select the recipient plan with these instructions: <table border="1" data-bbox="371 718 1375 1121"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the recipient plan (or the first letter) in the search field. b. Click search. c. Click the recipient plan row from the Search Results list; or the matching recipient plan will display. </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 recipient plan row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the recipient plan (or the first letter) in the search field. b. Click search . c. Click the recipient plan row from the Search Results list; or the matching recipient plan will display.	Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the recipient plan row from the Search Results list.
TO:	THEN:						
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Navigate the search results list	a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the recipient plan row from the Search Results list.						
5	Click the “+” for Benefit Coverage.						
6	Find the level where you want to add a rule by following these steps: <table border="1" data-bbox="371 1289 1375 1633"> <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:						
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Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
7	Select a directive from the Directive Version drop-down list. Note: If the directive for the new rule does not exist, you need to create the directive before completing this task.						

Step	Action
8	Right click the line item.
9	Select the Add Rule option.
10	Enter the desired information for the new rule. Note: Different types of codes display different options and criteria. Some options do not apply to every type of benefit code (i.e. procedure, diagnosis, etc.).
11	Click Save to launch a three-step save process. Note: The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen directive and version.
12	<u>If the save is successful</u> , click OK to dismiss the confirmation window.
13	If the system finds a conflict: a. Click Cancel Save . b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again).

Success

You have successfully completed this task when the confirmation window displays stating that the save was successful.

Practice

Practice creating a **benefit plan** rule using this information:

- **Recipient Plan** - TESTBXXX (your initials)
- Expand Benefit Coverage
- Add your new rule at the Procedures>HCPCS>Alcohol and Drug Abuse level
- **Directive version** - CNV2009
- Require Prior Authorization
- Change "to" age to 21
- **Place of Service Editing** (Include) 14 - Group Home
- Save

Question: Does your rule make it all the way through the 3-step save process successfully?

When you complete the practice, drill back down to see that all procedures under that level inherited the rule.

Summary

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

Rule Options

Overview

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

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

Field options include edits for the following:

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

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

Yes/No Editing

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

The screenshot displays the 'Provider Type/Specialty' rule edit panel. The left sidebar shows a tree view of procedure categories, with 'Anesthesia' selected. The main panel shows a table of rule details for '225 for Procedures - All Procedures - CPT - Anesthesia'. The 'Options' section at the bottom is expanded, showing a 'Modifier Editing' field set to 'Yes' with a 'Simplify' button next to it. A text box explains: '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

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

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

Include/Exclude/No with Multiple Selection Fields Editing

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

The table describes fields that use this option:

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

Example Logic:

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

Simplify

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

The screenshot shows the 'Diagnosis Detail Any Editing' section of the MITS interface. The 'Diagnosis Detail Any Editing' dropdown is set to 'Yes', and the 'Simplify' button is highlighted with a red box. Below this, the 'Options' section contains an 'Add Option' button and a 'Test Claim Value' field. The 'Diagnoses Assigned' section shows a 'Maximum' field set to 8 and a 'Minimum' field set to 0. The 'Available Diagnoses' section shows a range from 0010 to V8909.

Add Requirement

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

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

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

The screenshot shows the 'Diagnosis Detail Any Editing' section of the MITS interface. The 'Diagnosis Detail Any Editing' dropdown is set to 'Yes', and the 'Simplify' button is visible. Below this, the 'Options' section contains an 'Add Option' button and a 'Test Claim Value' field. The 'Diagnoses Assigned' section shows a 'Maximum' field set to 4 and a 'Minimum' field set to 0. The 'Available Diagnoses' section shows a range from 0010 to 500, 501 to 501, and 7010 to V8909. The 'Add Requirement' button is highlighted with a red box.

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

Check Your Understanding

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

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

- A. Yes/No
- B. Multiple Choice
- C. Include/Exclude
- 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. Cancel
- B. Validate
- C. Check
- D. Simplify

Summary

In this topic, you learned about the rule options.

Updating/Modifying Rules Data

What

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

Who

A Configuration Analyst performs this task.

When

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

Relevance

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

Requirements

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

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

How To

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

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Recipient Plan under "Select area to add or modify below". Recipient Plan is

Step	Action						
	the default submenu under Benefit Administration.						
4	Select the recipient plan with these instructions: <table border="1" data-bbox="375 426 1377 774"> <thead> <tr> <th data-bbox="375 426 727 478">TO:</th> <th data-bbox="727 426 1377 478">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 478 727 636">Search</td> <td data-bbox="727 478 1377 636"> a. Type the recipient plan in the search field. b. Click search. Note: The matching plan will display (or a list if you only typed the first letter). </td> </tr> <tr> <td data-bbox="375 636 727 774">Navigate the search results list</td> <td data-bbox="727 636 1377 774"> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the recipient plan row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the recipient plan in the search field. b. Click search . Note: The matching plan 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 recipient plan row from the Search Results list.
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5	Click <+> to open Benefit Coverage .						
6	To search for the level where you want to add a rule, follow these steps: <table border="1" data-bbox="375 951 1377 1283"> <thead> <tr> <th data-bbox="375 951 727 1003">TO:</th> <th data-bbox="727 951 1377 1003">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1003 727 1140">Search</td> <td data-bbox="727 1003 1377 1140"> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td data-bbox="375 1140 727 1283">Navigate the tree</td> <td data-bbox="727 1140 1377 1283"> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.
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Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
7	Click to expand rule criteria and review before making changes according to policy/directive.						
8	Select a directive from the Directive Version drop-down list.						
9	For a direct rule, click to expand the rule criteria. For an inherited rule, right click the rule and select Modify Rule (Excl/New) .						
10	Expand the desired area, and make the applicable changes in the rule.						
11	Click Close . Note: If it was an inherited rule, both the excluded rule and new rule displays.						
12	Click Save . This launches a three-step save process. The first two steps interpret the rules and						

Step	Action
	compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen directive and version.
13	<u>If the save is successful</u> , click OK to dismiss the confirmation window.
14	If the system finds a conflict: <ol style="list-style-type: none"> Click Cancel Save Make the appropriate changes to the rule to resolve the conflict. Click Save (again).

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

Success

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

Practice

Practice modifying an existing **recipient plan rule** using this information:

- **Recipient Plan** - TESTBXXX
- Rule - Use the rule that you created in the Creating and Saving Rules lesson at the HCPCS>Alcohol and Drug Abuse level
- Add a Billing Provider Type Specialty editing to the rule (79/791)
- Save

When you complete the practice, drill back down in the tree structure to verify that the text is bold where you added the rule.

Summary

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

Introduction to Rule Diagnosis Editing

Overview

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

Types

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

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

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

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

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

Diagnosis Editing Panel

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

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

Business examples:

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

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

The screenshot displays the 'Diagnosis Editing' interface. At the top, there are two dropdown menus: 'Aid Category Code Editing' (set to 'No') and 'Level of Care Editing' (set to 'No'). Below these are two main sections, each with a dropdown menu set to 'Yes' and highlighted with a red box:

- Primary Diagnosis Header Editing:** This section has an 'Assigned Diagnoses' box containing '501 - 501'. To its right is the 'Available Diagnoses' section, which includes two ranges: '0010 to 500' and '502 to V8909'. Navigation arrows (<, >, <>, >>) are visible between the boxes.
- Diagnosis Header Secondary Editing:** This section is identical to the primary editing section, with 'Assigned Diagnoses' containing '501 - 501' and 'Available Diagnoses' containing the same two ranges.

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

Examples include:

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

Example

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

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

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

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

Check Your Understanding

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

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

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

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

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

Summary

In this topic, you learned about Diagnosis editing options.

Configuring Rule Diagnosis

What

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

Who

A configuration analyst performs the task.

When

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

Requirements

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

Guidelines

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

How To

Follow these steps from the MITS home page to configure a recipient rule for diagnosis editing:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Recipient Plan under "Select area to add or modify below". Recipient Plan is the default submenu under Benefit Administration.
4	Select the recipient plan with these instructions:

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7	Select a directive from the Directive Version drop-down box.						
8	Single click the rule to expand the rule window.						
9	Click the + to expand the Diagnosis section.						
10	Click the Diagnosis Editing drop-down list and select Yes next to the desired selection. Note: Additional options may be applied to the Coverage Rule display.						
11	Configure the Diagnosis Editing by following these steps: <table border="1"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Add/split a diagnosis range</td> <td> a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Press the Enter key. </td> </tr> </tbody> </table>	TO:	THEN:	Add/split a diagnosis range	a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Press the Enter key.		
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	<table border="1"> <tr> <td data-bbox="375 279 727 331"></td> <td data-bbox="727 279 1377 331">d. Continue splitting the ranges as necessary.</td> </tr> <tr> <td data-bbox="375 331 727 537">Create a single diagnosis segment</td> <td data-bbox="727 331 1377 537"> a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Type the single diagnosis in both the From and To fields. d. Click outside the To field. </td> </tr> <tr> <td data-bbox="375 537 727 863">Modify the current option where applicable</td> <td data-bbox="727 537 1377 863"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter. e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. </td> </tr> <tr> <td data-bbox="375 863 727 1287">Add diagnoses to the header Editing Rule</td> <td data-bbox="727 863 1377 1287"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter. e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list. </td> </tr> <tr> <td data-bbox="375 1287 727 1488">Remove diagnoses from the Assigned list</td> <td data-bbox="727 1287 1377 1488"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list. </td> </tr> <tr> <td data-bbox="375 1488 727 1774">Add multiple diagnosis options</td> <td data-bbox="727 1488 1377 1774"> a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Type the total number of diagnoses allowed in the Maximum field, if required. c. Type the least amount of diagnoses allowed in the Minimum field, if required. d. Enter a valid diagnosis code that falls within the range of the original From and To fields. </td> </tr> </table>		d. Continue splitting the ranges as necessary.	Create a single diagnosis segment	a. Click the To field. b. Enter a valid diagnosis code that falls within the range of the original From and To fields. c. Type the single diagnosis in both the From and To fields. d. Click outside the To field.	Modify the current option where applicable	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter . e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list.	Add diagnoses to the header Editing Rule	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter . e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list.	Remove diagnoses from the Assigned list	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list.	Add multiple diagnosis options	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Type the total number of diagnoses allowed in the Maximum field, if required. c. Type the least amount of diagnoses allowed in the Minimum field, if required. d. Enter a valid diagnosis code that falls within the range of the original From and To fields.
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Add diagnoses to the header Editing Rule	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the To diagnosis field. c. Enter a valid diagnosis code that falls within the range of the original From and To fields. d. Press Enter . e. Add a single diagnosis or a diagnosis range by clicking the left arrow beside the Available Diagnoses list. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list.												
Remove diagnoses from the Assigned list	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Click the single right (>) Assigned Diagnoses range to move the desired range to the Available Diagnoses list.												
Add multiple diagnosis options	a. Click the current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. b. Type the total number of diagnoses allowed in the Maximum field, if required. c. Type the least amount of diagnoses allowed in the Minimum field, if required. d. Enter a valid diagnosis code that falls within the range of the original From and To fields.												

Step	Action				
	<table border="1"> <tr> <td data-bbox="375 279 727 422"></td> <td data-bbox="727 279 1377 422"> e. Press Enter. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list. </td> </tr> <tr> <td data-bbox="375 422 727 814">Add a diagnosis requirement</td> <td data-bbox="727 422 1377 814"> a. When the Maximum or Minimum fields are modified, the Add Requirement button appears in the Options box. b. Click Add Requirement. c. Click the Current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. d. Click the single right (>) arrow beside the desired Assigned Diagnoses range to move the desired range to the Available Diagnoses list. Note: The item is added to the existing line or as a new option. </td> </tr> </table>		e. Press Enter. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list.	Add a diagnosis requirement	a. When the Maximum or Minimum fields are modified, the Add Requirement button appears in the Options box. b. Click Add Requirement . c. Click the Current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. d. Click the single right (>) arrow beside the desired Assigned Diagnoses range to move the desired range to the Available Diagnoses list. Note: The item is added to the existing line or as a new option.
	e. Press Enter. f. Click the single left (<) arrow beside the desired Available Diagnoses range to move the desired range to the Assigned Diagnoses list.				
Add a diagnosis requirement	a. When the Maximum or Minimum fields are modified, the Add Requirement button appears in the Options box. b. Click Add Requirement . c. Click the Current default option (the gray box under Options with the brackets []). Note: A dotted line surrounds the current selected option. d. Click the single right (>) arrow beside the desired Assigned Diagnoses range to move the desired range to the Available Diagnoses list. Note: The item is added to the existing line or as a new option.				
12	Optional: Click Simplify .				
13	Click Save .				
14	<u>If the save is successful</u> , click OK to dismiss the confirmation window.				
15	If the system finds a conflict: <ol style="list-style-type: none"> Click Cancel Save. Make the appropriate changes to the rule to resolve the conflict. Click Save (again). 				

Success

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

Practice

Configure a **recipient plan** rule with diagnosis editing using this information:

- **Recipient Plan** - TESTBXXX (the one you created)
- **Rule:** Use the same rule as previous lesson at the HCPCS>Alcohol and Drug Abuse level
- Open **Diagnosis Detail Any Editing** - Yes
- Split diagnosis range into 000 to 500
- Add new single **Diagnosis:** 501
- Remaining diagnosis range: 502 to V8909
- Assign just the one individual diagnosis (501) to the Assigned box

Review your rule. Good job!

Summary

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

Introduction to Rule Modifier Editing

Overview

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

Modifier Editing Panel

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

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

Review the descriptions of the panel features.

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

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

Panel Features	Description
Options (gray area)	Each claim can combine up to four modifiers for a benefit code. You

Panel Features	Description
	<p>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.</p>
Add Option button	<p>When you want to add an “OR” option, use Add Option. MITS displays a new option below the first line.</p>
Maximum and Minimum	<p>For a procedure code to adjudicate:</p> <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	<p>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.</p>
Inclusive checkbox	<p>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.</p>
Test Claim Values	<p>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.</p>
Matches?	<p>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.</p>
Simplify	<p>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.</p>

Examples

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

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

For a procedure code to be adjudicated:

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

Example 1: Current option modifier with additional options

The screenshot displays the 'Diagnosis Header Other Editing' window. The 'Options' section is active, showing a table of modifier rules. The first rule is highlighted with a red dashed box: [TH]₁ and [24]₀ and [GC, GE]₀ and [25]₀. Below this, the 'Maximum' and 'Minimum' fields are both set to 1. The 'Modifiers Assigned' list contains 'TH - OB TX/SRVCS PRENATL/POS'. The 'Available Modifiers' list includes: ** - AUDIT DEFAULT MODIFIER, 20 - MICROSURGERY, 21 - PROLONGED E&M SERVICE, 22 - UNUSUAL PROCEDURAL SE, 23 - UNUSUAL ANESTHESIA, and 24 - UNRELATED E&M SAME MC. On the right, a list of 'Possible modifier combinations' is shown, including 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, and TH and 24 and GE and 25. The 'Inclusive' checkbox is checked, and the 'Occurrence Editing' is set to 'No'.

Example 2: No modifiers allowed

The screenshot shows a software interface for editing modifiers. At the top, it says "Provider Type/Specialty" and "Modifier Editing Yes" with a "Simplify" button. Under "Options", there is an "Add Requirement" button with a red dashed box around the input field containing "***". Below it is an "Add Option" button. The "Test Claim Value:" section has four empty input boxes and a "Matches?" label. The "Modifiers Assigned" section has a red solid box around the entry "*** - AUDIT DEFAULT MODIFIER". To the right is a list of "Available Modifiers" with codes 20 through 25. The "Inclusive" checkbox is checked, and the "Maximum" and "Minimum" fields are set to 0. At the bottom, it says "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

Code	Title	Purpose
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. Inclusive checkbox
- B. White Test Claim Value boxes
- 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.

Configuring Rule Modifiers

What

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

Who

A configuration analyst performs the task.

When

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

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

Relevance

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

Requirements

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

How To

Follow these steps from the MITS home page to configure a recipient rule for modifier editing:

Step	Action
1	Click Reference .

Step	Action						
2	Click Benefit Administration .						
3	Click Recipient Plan under “Select area to add or modify below”. Recipient Plan is the default submenu under Benefit Administration.						
4	Select the recipient plan with these instructions: <table border="1" data-bbox="371 520 1377 873"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the recipient plan in the search field. b. Click search. Note: The matching plan 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 recipient plan row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the recipient plan in the search field. b. Click search . Note: The matching plan 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 recipient plan row from the Search Results list.
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5	Click <+> to open Benefit Coverage .						
6	To search for the level where you want to add a rule, follow these steps: <table border="1" data-bbox="371 1041 1377 1381"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td>Navigate the tree</td> <td> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.
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Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.						
7	Select a directive from the Directive Version drop-down box.						
8	To modify an existing rule, click the rule to expand the rule window. To create a new rule, right click on the benefit level or code and select Add Rule.						
9	Select Yes in the Modifier Editing drop-down list.						
10	Click the Options (gray area) to start the editing.						
11	Configure Modifier Options by following these steps:						

Step	Action												
	<table border="1"> <thead> <tr> <th data-bbox="375 279 724 331">TO:</th> <th data-bbox="724 279 1373 331">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 331 724 478">Add assigned modifier codes</td> <td data-bbox="724 331 1373 478"> a. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. b. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box. </td> </tr> <tr> <td data-bbox="375 478 724 867">Modify the current option</td> <td data-bbox="724 478 1373 867"> a. Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. b. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. c. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. d. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. e. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list. </td> </tr> <tr> <td data-bbox="375 867 724 1073">Disallow any modifier codes on claim</td> <td data-bbox="724 867 1373 1073"> 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 1073 724 1434">Add modifier requirements (AND condition)</td> <td data-bbox="724 1073 1373 1434"> 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 number of Modifier codes allowed (1-4) in the Maximum field. g. Type the minimum number of Modifier codes allowed (0-4) in the Minimum field. </td> </tr> <tr> <td data-bbox="375 1434 724 1764">Add modifier option (OR condition)</td> <td data-bbox="724 1434 1373 1764"> 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 (0-4) in the Minimum field. </td> </tr> </tbody> </table>	TO:	THEN:	Add assigned modifier codes	a. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. b. Click the left (<) to move the selected Modifiers to the Modifiers Assigned box.	Modify the current option	a. Click the current default option. A dotted line surrounds the current selected option and the panel expands to apply available modifiers to the rule. b. Type the Maximum number of Modifier codes allowed (0-4) in the Maximum field. c. Type the Minimum number of Modifier codes allowed (0-4) in the Minimum field. d. Click to select the combination of Modifier code(s) from the Available Modifiers pick list. e. Click the left (<) to move the selected Modifiers to the Modifiers Assigned list.	Disallow any modifier codes on claim	a. Ensure the Inclusive checkbox is checked. b. Select the first available modifier option ** - Audit Default Modifier . c. Type the maximum and minimum number of modifier codes allowed as 0 (i.e. maximum is 0 and minimum is 0).	Add modifier requirements (AND condition)	a. Click Add Requirement . b. Click the area with the dotted line after and . c. Click the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned pick list. e. Click to select (or deselect) the Inclusive checkbox. f. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. g. Type the minimum number of Modifier codes allowed (0-4) in the Minimum field.	Add modifier option (OR condition)	a. Click Add Option . b. Click the brackets inside the dotted line box. c. Click to select the desired modifiers in the Available list. d. Click the left (<) to move them to the Assigned list. e. Type the maximum number of Modifier codes allowed (1-4) in the Maximum field. f. Type the minimum number of Modifier codes allowed (0-4) in the Minimum field.
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Step	Action						
12	<p data-bbox="318 279 854 310">Additional modifier options you can use:</p> <table border="1" data-bbox="375 359 1377 989"> <thead> <tr> <th data-bbox="375 359 727 415">TO:</th> <th data-bbox="727 359 1377 415">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 415 727 674">Simplify</td> <td data-bbox="727 415 1377 674"> <p data-bbox="735 426 914 457">Click Simplify.</p> <p data-bbox="735 468 1349 657">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="375 674 727 989">Test Claim Matches</td> <td data-bbox="727 674 1377 989"> <p data-bbox="735 684 1049 747">a. Type modifier value(s). b. Click Matches?.</p> <p data-bbox="735 758 1349 968">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 data-bbox="735 426 914 457">Click Simplify.</p> <p data-bbox="735 468 1349 657">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	<p data-bbox="735 684 1049 747">a. Type modifier value(s). b. Click Matches?.</p> <p data-bbox="735 758 1349 968">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>
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13	Click Save .						
14	<p data-bbox="318 1073 708 1104">If the system finds a conflict:</p> <ol data-bbox="318 1115 1227 1209" style="list-style-type: none"> Click Cancel Save. Make the appropriate changes to the rule to resolve the conflict. Click Save (again). 						

Success

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

Practice

Practice configuring a **recipient plan rule** with modifier editing using the following information and the same rule you used in last practice:

- **Recipient Plan** - TESTBXXX (the one you created)
- Use the same procedure code you used in the previous lesson at the HCPCS>Alcohol and Drug Abuse level
- Configure modifier editing using "and" options as follows:
 - Option 1 - modifier 51 (0:1)
 - Option 2 - modifier 50 (0:1)
 - Option 3 - modifiers GC and GE (0:1)

Note: Remember that "and" options are across the same line, not below each other on separate lines.

Summary

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

Introduction to Removing a Rule

Overview

There are three different ways to remove existing rules:

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

Three ways

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

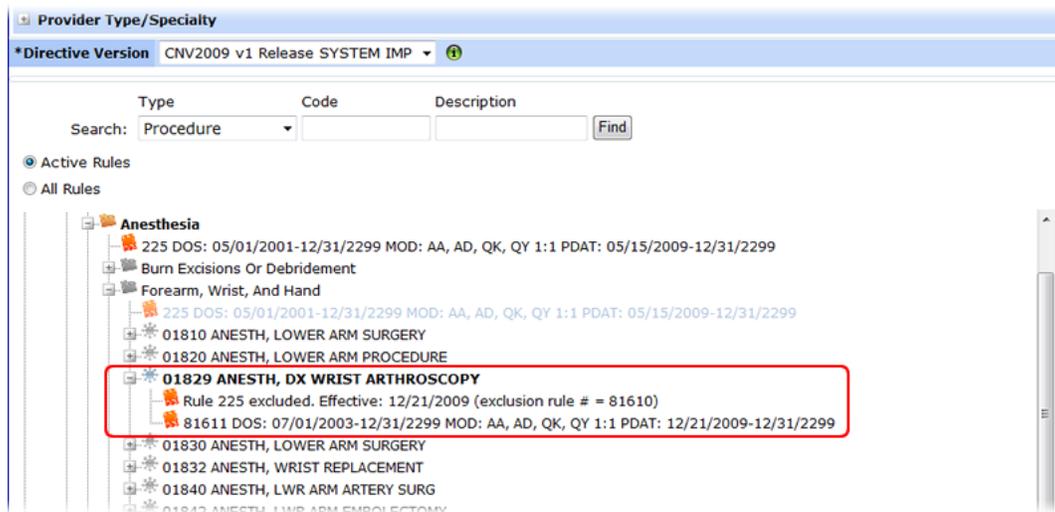
- The rule is a **direct** rule at the highest level that it applies.
- The rule is an **inherited** rule on codes that fall beneath the top level.

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

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

Example

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



Check Your Understanding

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

The Modify (Exclude/New) option:

- 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.

Excluding/Inactivating Rules

What

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

Who

A Configuration Analyst performs this task.

When

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

Relevance

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

Requirements

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

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

How To

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

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Recipient Plan under "Select area to add or modify below". Recipient Plans is the default submenu under Benefit Administration.
4	Select the recipient plan with these instructions:

Step	Action								
	<table border="1"> <thead> <tr> <th data-bbox="375 321 724 373">TO:</th> <th data-bbox="724 321 1373 373">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 373 724 527">Search</td> <td data-bbox="724 373 1373 527"> a. Type the recipient plan in the search field. b. Click search. Note: The matching plan will display (or a list if you only typed the first letter). </td> </tr> <tr> <td data-bbox="375 527 724 674">Navigate the search results list</td> <td data-bbox="724 527 1373 674"> a. Navigate the list by clicking the page numbers and/or the Next > page icon. b. Click the recipient plan row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the recipient plan in the search field. b. Click search . Note: The matching plan 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 recipient plan row from the Search Results list.		
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Search	a. Type the recipient plan in the search field. b. Click search . Note: The matching plan 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 recipient plan row from the Search Results list.								
5	Click <+> to open Benefit Coverage .								
6	<p>To search for the level where you want to find a rule, follow these steps:</p> <table border="1"> <thead> <tr> <th data-bbox="375 842 724 894">TO:</th> <th data-bbox="724 842 1373 894">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 894 724 1041">Search</td> <td data-bbox="724 894 1373 1041"> a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find. </td> </tr> <tr> <td data-bbox="375 1041 724 1182">Navigate the tree</td> <td data-bbox="724 1041 1373 1182"> a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.		
TO:	THEN:								
Search	a. Select the desired type from the Type drop-down list. b. Type the appropriate code in the Code field. c. Click Find .								
Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.								
7	Click to expand rule criteria and review before making changes according to policy/directive.								
8	Select a directive from the Directive Version drop-down list.								
9	<p>Remove a rule based on the type of rule by following these steps:</p> <table border="1"> <thead> <tr> <th data-bbox="375 1451 724 1503">TO:</th> <th data-bbox="724 1451 1373 1503">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1503 724 1566">Remove a direct rule</td> <td data-bbox="724 1503 1373 1566">Right click the rule and select Inactivate.</td> </tr> <tr> <td data-bbox="375 1566 724 1650">Remove an inherited rule</td> <td data-bbox="724 1566 1373 1650">Right click the rule and select Exclude Rule.</td> </tr> <tr> <td data-bbox="375 1650 724 1797">Remove an inherited rule, but add a new rule in its place</td> <td data-bbox="724 1650 1373 1797">Right click the rule and select Modify Rule (excl/new). The existing rule is now excluded; and a new rule edit panel displays. Now you can configure a new rule.</td> </tr> </tbody> </table>	TO:	THEN:	Remove a direct rule	Right click the rule and select Inactivate .	Remove an inherited rule	Right click the rule and select Exclude Rule .	Remove an inherited rule, but add a new rule in its place	Right click the rule and select Modify Rule (excl/new) . The existing rule is now excluded; and a new rule edit panel displays. Now you can configure a new rule.
TO:	THEN:								
Remove a direct rule	Right click the rule and select Inactivate .								
Remove an inherited rule	Right click the rule and select Exclude Rule .								
Remove an inherited rule, but add a new rule in its place	Right click the rule and select Modify Rule (excl/new) . The existing rule is now excluded; and a new rule edit panel displays. Now you can configure a new rule.								

Step	Action		
	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; padding: 5px;">Remove a rule before saving it</td> <td style="width: 50%; padding: 5px;">Click Cancel.</td> </tr> </table>	Remove a rule before saving it	Click Cancel .
Remove a rule before saving it	Click Cancel .		
10	<p>Click Save.</p> <p>This launches a three-step process. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen Directive and Version.</p>		
11	<p><u>If the save is successful</u>, click OK to dismiss the confirmation window.</p>		
12	<p>If the system finds a conflict:</p> <ol style="list-style-type: none"> a. Click Cancel Save b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again). 		

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

Success

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

Practice

Practice modifying and excluding a **recipient plan rule** using this information:

- **Recipient Plan** -TESTBXXX
- Benefit Coverage
- **Rule:** Use the rule you created at the Procedures>HCPCS>Alcohol and Drug Abuse level
- Exclude your rule at the procedure code H0001 level and modify the new rule with Age 1 to 4
- Save

When you complete the practice, drill down in the tree structure to your rule and verify it is excluded and modified.

Summary

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

Introduction to Plan Groups

Overview

This topic introduces you to benefit plan groups and group types.

Purpose of the Plan Group Types

The **Recipient Plan Group Type** panel maintains recipient plan groups for a specific benefit plan group type. MITS uses benefit plan group types in claims processing to group similar benefits together, as in:

- Assignment plans that are included in part of an MCO (Managed Care Organization)
- Benefit plans that require an assigned Primary Care Case Manager (PCCM) - not currently used in Ohio

In addition, an assignment plan may be used to assign a recipient to a specific provider type and/or provider specialty through the use of benefit plan group types. Grouping **assignment plans** into a specific group type allows MITS to edit and process claims more efficiently.

Waiver is a Recipient Plan Group type that is only used for reporting purposes.

Review the **Recipient Plan Group Type** panel example.

Ohio.gov Medicaid Information Technology System

August 3, 2010 11:48 AM EDT

Home Claims Drug EDI Healthchek Financial Managed Care MAR Prior Authorization Provider Recipient Reference RetroDUR TPL Security

Tools Site

home diagnosis directive drg drug error disposition modifier procedure revenue related data benefit administration release

Benefit Administration Select area to add or modify below.

Benefit Classification
Copay
Financial Payer
Form Edits
Global Restrictions
Recipient Plan
Other Insurance
Provider Contract
Reimbursement Agreement
Rule Catalog

Assignment Plan Hierarchy
Recipient Plan

Benefit Plan COB
Recipient Plan Group Type

Benefit Plan Hierarchy

When you click the Recipient Plan Group Type area, the Recipient Plan Group Type panel displays.

save cancel

Recipient Plan Group Type

Benefit Plan Group Type	Description
2004	BENEFIT PLAN
1000	INFORMATIONAL
2002	LOC
2001	LOCKIN
2003	LOCKIN TO PROGRAMS COVERING AL
3002	MANAGED CARE
105	OIEXCLUSIONS
3019	OTHER CARRIER SERVICE
3001	PCCM
3003	PCCMRN

1 2 Next >

How Groups Affect Ohio Medicaid Policy

Managed Care and Lockin are just two of the benefit plan group types currently in use within MITS. These group types may be used to arrange claims processing logic for Ohio benefit plans. Detailed descriptions of these two benefit plan group types are listed in the following table:

Benefit Plan Group Type	Description
Managed Care	<p>The Managed Care Organization (MCO) pays claims for services provided to a recipient.</p> <p>MITS processes encounter claims to record service information and to calculate allowed amounts for rate setting, but MITS does not pay encounter claims directly through the financial system.</p> <p>If MITS receives a fee-for-service (FFS) claim for a recipient that is assigned to an MCO, MITS determines whether the MCO should cover that service. If the MCO should cover that service, MITS denies the claim, indicating that the MCO should cover this service. If the MCO does not cover that service, MITS tries to pay the claim under one of the recipient's other benefit plans.</p>

Benefit Plan Group Type	Description
Lockin	This type of assignment plan relates to services that must be provided only by the designated provider.

Review the **Benefit Plan Group** panel example.

The screenshot displays the 'Recipient Plan Group Type' interface. At the top, a list of benefit plan group types is shown, with '3002 MANAGED CARE' selected. Below this, the 'Benefit Plan Group Type' is set to '3002' and the 'Description' is 'MANAGED CARE'. A red box highlights the 'Description' field and the 'Long Description' text area, which contains the text: 'THIS TYPE OF ASSIGNMENT PLAN RELATES TO SERVICES PROVIDED BY THE ASSIGNED PROVIDER UNDER A CAPITATION AGREEMENT.' To the right, a text box explains: 'The Benefit Plan Group Type defines a specific list of benefit plans that are treated or reported in the same manner.' Below this, a table titled '-Benefit Plan Group--' shows the data for the selected row. The table has columns for 'Benefit Plan', 'Effective Date', and 'End Date'. The data rows are: MCABD (01/01/1990 to 12/31/2299) and MCCFC (01/01/1990 to 12/31/2299). Below the table, the 'Benefit Plan' is set to 'MCABD', 'Effective Date' is '01/01/1990', and 'End Date' is '12/31/2299'. There are 'delete' and 'add' buttons at the bottom right of the table and form sections.

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.

Waiver is a benefit plan group type that aids in reporting.

- A. True
- B. False

Benefit plan group types are used in claims processing to group similar benefits together.

- A. True

B. False

Summary

In this topic you learned about benefit plan groups and group types.

Maintaining Benefit Plan Groups

What

In this topic you learn how to view, add, update, or delete a recipient plan group type. You also learn how to associate a benefit plan to a group type.

Who

This task may be performed by a Configuration Analyst, a Medical Policy Analyst, a Claims Analyst, or other OHP staff members.

When

You may perform this task when you receive a request to add, update, or delete a recipient plan group type.

Relevance

When you group assignment plans into a specific group type, MITS edits and processes claims more efficiently. You can group similar benefits together, for example:

- Assignment plans that are included in part of a Managed Care Organization
- Benefit plans that require reporting to be generated, such as Waivers

Viewing Benefit Plan Groups

Follow these steps from the MITS home page to view benefit plan groups:

Step	Action
1	Click Reference .
2	Click Benefit Administration .
3	Click Recipient Plan .
4	Click to select a recipient plan.
5	Click + to expand the Benefit Plan Group Type at the bottom of the panel. Note: The group types display.

Step	Action
6	Click Benefit Plan under Benefit Plan Group Type .
7	Click the Recipient Plan Group Types link at the top.
8	Click the desired benefit plan group type. Note: All group plans for that group type display.

Adding, Updating, or Deleting a Recipient Plan Group type

Follow these steps from the MITS home page to add, update, or delete a recipient plan group type:

Step	Action										
1	Click Reference .										
2	Click Benefit Administration .										
3	Click Recipient Plan under "Select area to add or modify below". Recipient Plan is the default submenu under Benefit Administration.										
4	Click Recipient Plan Group Type .										
5	Maintain recipient plan group types by following these steps: <table border="1" data-bbox="371 1188 1377 1709"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Add a recipient plan group type</td> <td>a. Click add. b. Enter information in the required fields - Recipient Plan Group Type, Description, and Long Description.</td> </tr> <tr> <td>Update a recipient plan group type</td> <td>a. Click to select the recipient plan group type row. b. Modify the fields as necessary (Description or Long Description).</td> </tr> <tr> <td>Update an end date to an existing Benefit Plan Group</td> <td>a. Click to select the recipient plan group type row. b. Click to select a Benefit Plan Group row. c. Modify the End Date.</td> </tr> <tr> <td>Delete a recipient plan group type</td> <td>a. Click to select the recipient plan group type. b. Click delete.</td> </tr> </tbody> </table>	TO:	THEN:	Add a recipient plan group type	a. Click add . b. Enter information in the required fields - Recipient Plan Group Type, Description, and Long Description .	Update a recipient plan group type	a. Click to select the recipient plan group type row. b. Modify the fields as necessary (Description or Long Description).	Update an end date to an existing Benefit Plan Group	a. Click to select the recipient plan group type row. b. Click to select a Benefit Plan Group row. c. Modify the End Date .	Delete a recipient plan group type	a. Click to select the recipient plan group type. b. Click delete .
TO:	THEN:										
Add a recipient plan group type	a. Click add . b. Enter information in the required fields - Recipient Plan Group Type, Description, and Long Description .										
Update a recipient plan group type	a. Click to select the recipient plan group type row. b. Modify the fields as necessary (Description or Long Description).										
Update an end date to an existing Benefit Plan Group	a. Click to select the recipient plan group type row. b. Click to select a Benefit Plan Group row. c. Modify the End Date .										
Delete a recipient plan group type	a. Click to select the recipient plan group type. b. Click delete .										
6	Click Save .										

Associating a Recipient Plan to a Group Type

Follow these steps from the MITS home page to associate a benefit plan to a group type:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Recipient Plan .						
4	Click Recipient Plan Group Type .						
5	Select the appropriate Recipient Plan Group Type from the list of group types displayed.						
6	View any benefit plans that display to see if it is already associated.						
7	Click add in the Benefit Plan Group panel.						
8	Select the benefit plan with these instructions: <table border="1" data-bbox="371 976 1373 1297"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Search</td> <td> a. Type the benefit plan (or a portion of it) in the search field. b. Click search. Note: The matching plan will display (or a list if you only typed the first letter). </td> </tr> <tr> <td>Enter the code</td> <td> a. Enter the benefit plan code. b. Press Enter. </td> </tr> </tbody> </table>	TO:	THEN:	Search	a. Type the benefit plan (or a portion of it) in the search field. b. Click search . Note: The matching plan will display (or a list if you only typed the first letter).	Enter the code	a. Enter the benefit plan code. b. Press Enter .
TO:	THEN:						
Search	a. Type the benefit plan (or a portion of it) in the search field. b. Click search . Note: The matching plan will display (or a list if you only typed the first letter).						
Enter the code	a. Enter the benefit plan code. b. Press Enter .						
9	Enter the effective date in the Effective Date field (current date is the default).						
10	Enter the end date in the End Date field (12/31/2299 is the default).						
11	Click save .						

Success

You have successfully completed this task when you are able to view the benefit or assignment plan hierarchy, or when the hierarchy reflects your changes

Practice #1

Practice adding a recipient plan group type using this information:

- **Recipient Plan Group Type** = TestGXXX (replace XXX with your initials)
- **Description** = Test Benefit Group type - your name
- **Long Description** = Test Benefit Group type - your name

Practice #2

Practice associating your recipient plan to the new group type using this information:

- **Recipient Plan** = TestBXXX (replace XXX with your initials)
- **Recipient Plan Group Type** = TestGXXX (replace XXX with your initials)

When you complete the practice, view the group.

Summary

In this topic you learned how to view, add, update, and delete benefit plan groups. You also learned how to associate a recipient plan to a group type.

Introduction to Plan Hierarchy Data

Overview

This topic introduces you to benefit plan hierarchies and assignment plan hierarchies.

Panels

Use either the **Benefit Plan Hierarchy** panel or **Assignment Plan Hierarchy** panel to control plan relationships as well as the order in which MITS adjudicates recipient plans during claim processing. The **Benefit Plan Hierarchy** panel controls adjudication at the **benefit plan** level, while the **Assignment Plan Hierarchy** panel controls adjudication at the **assignment plan** level.

Both plan types include a hierarchy **thread** that represents an ordered set of plans -- starting at Hierarchy 1 through Hierarchy 10, which may cover recipients concurrently. Benefit plans and assignment plans **cannot** be together in a thread since the two plan types are different -- one grants coverage (benefit) and the other restricts service delivery (assignment).

Benefit Plan Hierarchy Example

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

- Benefit Classification
- Copay
- Financial Payer
- Form Edits
- Global Restrictions
- Recipient Plan**
- Other Insurance
- Provider Contract
- Reimbursement Agreement
- Rule Catalog

Assignment Plan Hierarchy Benefit Plan COB Benefit Plan Hierarchy
Recipient Plan Recipient Plan Group Type

When you click the Benefit Plan Hierarchy area, the Benefit Plan Hierarchy panel displays.

Benefit Plan Hierarchy Top Nav ? A ↕ X

Thread ▲	Effective Date	End Date	Inactive Date	1	2	3	Benefit	Plan	Hierarchy	7	8	9	10
3	01/01/2000	12/31/2299	12/31/2299	QMB									
4	01/01/2000	12/31/2299	12/31/2299	SLMB									
5	01/01/2000	12/31/2299	12/31/2299	QI 1									
6	01/01/2000	12/31/2299	12/31/2299	QWDI									
7	01/01/2000	12/31/2299	12/31/2299	ALIEN									
8	01/01/2000	12/31/2299	12/31/2299	PACEB									
9	01/01/2000	12/31/2299	12/31/2299	DMA									
10	01/01/2000	12/31/2299	12/31/2299	OMH	ALCRX	MRTCM	MCAID						
11	01/01/2000	12/31/2299	12/31/2299	OMH	ALCRX	MRTCM	MSP	MCAID					
12	01/01/2000	12/31/2299	12/31/2299	OMH	ALCRX	MRTCM	REF						

Click an individual thread to display information about that thread.

1 2 3 Next >

Type changes below.

Thread

***Effective Date**

***End Date**

***Inactive Date**

***Financial Payer**

Benefit Plan Hierarchy 1

Benefit Plan Hierarchy 2

Benefit Plan Hierarchy 3

Benefit Plan Hierarchy 4

Benefit Plan Hierarchy 5

Benefit Plan Hierarchy 6

Benefit Plan Hierarchy 7

Benefit Plan Hierarchy 8

Benefit Plan Hierarchy 9

Benefit Plan Hierarchy 10

MITS processes recipient plans in the order listed in an individual thread starting at Benefit Plan Hierarchy 1 through Benefit Plan Hierarchy 10.

delete add

Assignment Plan Hierarchy Example

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

- Benefit Classification
- Copay
- Financial Payer
- Form Edits
- Global Restrictions
- Recipient Plan**
- Other Insurance
- Provider Contract
- Reimbursement Agreement
- Rule Catalog

Assignment Plan Hierarchy **Benefit Plan COB** **Benefit Plan Hierarchy**
Recipient Plan **Recipient Plan Group Type**

When you click the Assignment Plan Hierarchy area, the Assignment Plan Hierarchy panel displays.

Assignment Plan Hierarchy Top Nav ? A

Thread	Effective Date	End Date	InActive Date	1	2	3	4	5	6	7	8	9	10
2	01/01/2000	12/31/2299	12/31/2299	MCABD									
3	01/01/2000	12/31/2299	12/31/2299	MCCFC									
4	01/01/2000	12/31/2299	12/31/2299	CONV									
5	01/01/2000	12/31/2299	12/31/2299										
6	01/01/2000	12/31/2299	12/31/2299	PACEA									
7	01/01/2000	12/31/2299	12/31/2299	PACTD									
8	01/01/2000	12/31/2299	12/31/2299	PACTP									
9	01/01/2000	12/31/2299	12/31/2299	PACTP	PACTD								

Click an individual thread to display information about that thread.

Type changes below.

Thread 9

*Effective Date 01/01/2000

*End Date 12/31/2299

*Inactive Date 12/31/2299

*Financial Payer DEFAULT

*Assign Plan Hierarchy 1 PACTP PACT Physician

*Assign Plan Hierarchy 2 PACTD PACT Pharmacy

*Assign Plan Hierarchy 3

*Assign Plan Hierarchy 4

*Assign Plan Hierarchy 5

*Assign Plan Hierarchy 6

*Assign Plan Hierarchy 7

*Assign Plan Hierarchy 8

*Assign Plan Hierarchy 9

*Assign Plan Hierarchy 10

MITS processes recipient plans in the order listed in an individual thread starting at Assign Plan Hierarchy 1 through Assign Plan Hierarchy 10.

delete add

Processing

A thread **must** exist for each valid combination of plans for a recipient. MITS determines the recipient plan(s) for which the recipient is eligible based on the **date of service**. The thread that matches the benefit plan(s) listed for that recipient is the thread that directs processing.

MITS pays the claim under the first recipient plan covering the service. Then MITS uses this information during the rest of the claim process to price and adjudicate the claim. The claim process loops through each recipient plan for a recipient until the process finds a plan that covers each service on the claim. If a claim does not pay under any recipient plan, MITS suspends or denies the claim under the last processed plan.



Assignment plans and benefit plans have their own hierarchy panels. A benefit plan should never be in the assignment plan hierarchy and an assignment plan should never be in the benefit plan hierarchy.

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 plan hierarchy identifies the order (hierarchy) in which recipient plans apply during claims processing.

- A. True
- B. False

A hierarchy thread must exist for each valid combination of plans for a recipient.

- A. True
- B. False

Summary

In this topic you learned about benefit plan hierarchies and assignment plan hierarchies.

Maintaining Plan Hierarchy Data

What

In this topic you learn how to view the benefit plan hierarchy and assignment plan hierarchy within Benefit Plan Administration (BPA). You also learn how to add, update, or delete a plan hierarchy thread.

Who

An Ohio Health Plans (OHP) Policy Analyst determines the order in which the benefit and assignment plans should process when a recipient is eligible for more than one benefit plan.

A Configuration Analyst, a Claims Analyst, a Policy Analyst, or other OHP staff member performs this task in MITS.

When

You perform this task when you receive a request to maintain benefit plan hierarchy relationships.

Relevance

You must use the hierarchy panels to maintain hierarchy relationships for benefit plans and assignment plans. This feature is important because the hierarchy controls the order of recipient plan processing for recipients who may be enrolled in more than one plan on the claim date of service.

Recipient plans are processed in the order listed in an individual thread starting at Benefit Plan Hierarchy 1 through Benefit Plan Hierarchy 10 for benefit plans and starting at Assign Plan Hierarchy 1 through Assign Plan Hierarchy 10 for assignment plans. There **must** be a thread for each valid combination of plans for a recipient.

Viewing a Plan Hierarchy

Follow these steps from the MITS home page to view a benefit plan hierarchy or assignment plan hierarchy:

Step	Action
1	Click Reference .

Step	Action						
2	Click Benefit Administration .						
3	Click Recipient Plan .						
4	Determine your next action: <table border="1" data-bbox="371 487 1373 688"> <thead> <tr> <th>TO view:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Benefit plan hierarchy</td> <td>Click Benefit Plan Hierarchy.</td> </tr> <tr> <td>Assignment plan hierarchy</td> <td>Click Assignment Plan Hierarchy.</td> </tr> </tbody> </table>	TO view:	THEN:	Benefit plan hierarchy	Click Benefit Plan Hierarchy .	Assignment plan hierarchy	Click Assignment Plan Hierarchy .
TO view:	THEN:						
Benefit plan hierarchy	Click Benefit Plan Hierarchy .						
Assignment plan hierarchy	Click Assignment Plan Hierarchy .						
5	Select the desired thread. Note: The plan hierarchy for the specific thread appears.						

Adding, Updating, or Deleting Plan Hierarchy Threads

Follow these steps from the MITS home page to add, update, or delete plan hierarchy threads:

Step	Action						
1	Click Reference .						
2	Click Benefit Administration .						
3	Click Recipient Plan .						
4	Select the appropriate submenu item by following these steps: <table border="1" data-bbox="371 1400 1373 1633"> <thead> <tr> <th>FOR:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Benefit Plan Hierarchy thread</td> <td>Click Benefit Plan Hierarchy.</td> </tr> <tr> <td>Assignment Plan Hierarchy thread</td> <td>Click Assignment Plan Hierarchy.</td> </tr> </tbody> </table>	FOR:	THEN:	Benefit Plan Hierarchy thread	Click Benefit Plan Hierarchy .	Assignment Plan Hierarchy thread	Click Assignment Plan Hierarchy .
FOR:	THEN:						
Benefit Plan Hierarchy thread	Click Benefit Plan Hierarchy .						
Assignment Plan Hierarchy thread	Click Assignment Plan Hierarchy .						
5	Maintain the plan hierarchy threads by following these steps: <table border="1" data-bbox="371 1740 1373 1793"> <thead> <tr> <th>TO:</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> </tr> </tbody> </table>	TO:	THEN:				
TO:	THEN:						

Step	Action												
	<table border="1"> <tr> <td data-bbox="375 279 724 485">Add a benefit plan hierarchy</td> <td data-bbox="724 279 1373 485"> <ol style="list-style-type: none"> Click add. Enter the required fields for the thread information. Click to select a plan from each benefit plan hierarchy drop-down list, starting with Benefit Plan Hierarchy 1. </td> </tr> <tr> <td data-bbox="375 485 724 659">Update a benefit plan hierarchy</td> <td data-bbox="724 485 1373 659"> <ol style="list-style-type: none"> Click to select a Benefit Plan Hierarchy row. Update the date, financial payer, and/or benefit plan hierarchy thread information. You may add more than one plan to a hierarchy thread. </td> </tr> <tr> <td data-bbox="375 659 724 747">Delete a benefit plan hierarchy</td> <td data-bbox="724 659 1373 747"> <ol style="list-style-type: none"> Click to select the benefit plan hierarchy thread. Click delete. </td> </tr> <tr> <td data-bbox="375 747 724 953">Add an assignment plan hierarchy</td> <td data-bbox="724 747 1373 953"> <ol style="list-style-type: none"> Click add. Enter the required fields for the thread information. Click to select a plan from each assignment plan hierarchy drop-down list, starting with Assign Plan Hierarchy 1. </td> </tr> <tr> <td data-bbox="375 953 724 1184">Update an assignment plan hierarchy</td> <td data-bbox="724 953 1373 1184"> <ol style="list-style-type: none"> Click to select an Assign Plan Hierarchy row. Update the date, financial payer, and/or assignment plan hierarchy thread information. <p>Note: You may add more than one plan to a hierarchy thread.</p> </td> </tr> <tr> <td data-bbox="375 1184 724 1308">Delete an assignment plan hierarchy</td> <td data-bbox="724 1184 1373 1308"> <ol style="list-style-type: none"> Click to select the assignment plan hierarchy thread. Click delete. </td> </tr> </table>	Add a benefit plan hierarchy	<ol style="list-style-type: none"> Click add. Enter the required fields for the thread information. Click to select a plan from each benefit plan hierarchy drop-down list, starting with Benefit Plan Hierarchy 1. 	Update a benefit plan hierarchy	<ol style="list-style-type: none"> Click to select a Benefit Plan Hierarchy row. Update the date, financial payer, and/or benefit plan hierarchy thread information. You may add more than one plan to a hierarchy thread. 	Delete a benefit plan hierarchy	<ol style="list-style-type: none"> Click to select the benefit plan hierarchy thread. Click delete. 	Add an assignment plan hierarchy	<ol style="list-style-type: none"> Click add. Enter the required fields for the thread information. Click to select a plan from each assignment plan hierarchy drop-down list, starting with Assign Plan Hierarchy 1. 	Update an assignment plan hierarchy	<ol style="list-style-type: none"> Click to select an Assign Plan Hierarchy row. Update the date, financial payer, and/or assignment plan hierarchy thread information. <p>Note: You may add more than one plan to a hierarchy thread.</p>	Delete an assignment plan hierarchy	<ol style="list-style-type: none"> Click to select the assignment plan hierarchy thread. Click delete.
Add a benefit plan hierarchy	<ol style="list-style-type: none"> Click add. Enter the required fields for the thread information. Click to select a plan from each benefit plan hierarchy drop-down list, starting with Benefit Plan Hierarchy 1. 												
Update a benefit plan hierarchy	<ol style="list-style-type: none"> Click to select a Benefit Plan Hierarchy row. Update the date, financial payer, and/or benefit plan hierarchy thread information. You may add more than one plan to a hierarchy thread. 												
Delete a benefit plan hierarchy	<ol style="list-style-type: none"> Click to select the benefit plan hierarchy thread. Click delete. 												
Add an assignment plan hierarchy	<ol style="list-style-type: none"> Click add. Enter the required fields for the thread information. Click to select a plan from each assignment plan hierarchy drop-down list, starting with Assign Plan Hierarchy 1. 												
Update an assignment plan hierarchy	<ol style="list-style-type: none"> Click to select an Assign Plan Hierarchy row. Update the date, financial payer, and/or assignment plan hierarchy thread information. <p>Note: You may add more than one plan to a hierarchy thread.</p>												
Delete an assignment plan hierarchy	<ol style="list-style-type: none"> Click to select the assignment plan hierarchy thread. Click delete. 												
6	Click save .												

Success

You have successfully completed this task when you are able to view the benefit or assignment plan hierarchy.

Summary

In this topic you learned how to view a benefit plan hierarchy and an assignment plan hierarchy. You also learned how to add, update, or delete a plan hierarchy thread.

Introduction to Conflict Report Errors

Overview

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

Conflict Error Report

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

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

```

Decision [AD] with 2 rules.
  SAK_FUB_HLTH 42 with 1 rules
  SAK_FUB_HLTH 40 with 1 rules
Decision [AD] with 0 rules.
Decision [AI] with 0 rules.
Decision [ANI] with 0 rules.
Decision [APJ] with 529 rules.
  SAK_FUB_HLTH 42 with 1 rules
  SAK_FUB_HLTH 40 with 527 rules
  Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
    Rule # 94086 for benefit [50163] doesn't have a container.
  Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
    Rule # 94087 for benefit [50163] doesn't have a container.
  Overlaps and/or orphaned exclusions exist for Procedure 00069. Has 4 rules (2 not inherited)
    Rule #93951 is an orphaned exception for rule 80269
    --Date Range - 01/01/2002-06/30/2003
    --OVERLAPPED RULE -- 93952 has the same output variable(s) but overlaps 93888
      First rule eclipsed by second.
      93952 DOS: 01/01/2002-06/30/2003 CHP: 40 PROC: 00869--ANESTH, VASECTOMY PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 2...
      93888 DOS: 05/01/2001-12/31/2299 BGRP: 320003--Anesthesia CHP: 40 PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 20/050,...
  Overlaps and/or orphaned exclusions exist for Procedure 20930. Has 2 rules (2 not inherited)
    Rule #93955 is an orphaned exception for rule 93886
  Overlaps and/or orphaned exclusions exist for Procedure 20936. Has 2 rules (2 not inherited)
    Rule #93957 is an orphaned exception for rule 93886
  Overlaps and/or orphaned exclusions exist for Procedure 36489. Has 3 rules (3 not inherited)
    --Date Range - 01/01/2000-12/31/2299
    --OVERLAPPED RULE -- 94002 has the same output variable(s) but overlaps 94003
  
```

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

1st letter	Description	2nd letter	Description
A	Assignment Plan	D	Diagnosis
B	Benefit Plan	I	ICD-9 Procedure
C	Copay	G	DRG

1st letter	Description	2nd letter	Description
G	Global Restrictions	N	Drug/NDC
O	Other Insurance	P	Procedure
P	Provider Contract	R	Revenue Code
R	Reimbursement Agreement		

Examples:

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

Benefit Plan Spreadsheet

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

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

```

Decision [AD] with 2 rules.
SAK_PUB_HLTH 42 with 1 rules
SAK_PUB_HLTH 40 with 1 rules
Decision [AS] with 0 rules.
Decision [AI] with 0 rules.
Decision [AN] with 0 rules.
Decision [AP] with 528 rules.
SAK_PUB_HLTH 42 with 1 rules
SAK_PUB_HLTH 40 with 527 rules
Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
Rule # 94056 for benefit [50163] doesn't have a container.
Odd. There's a rule for a benefit [50163]. But that benefit doesn't exist in any classification.
Rule # 94057 for benefit [50163] doesn't have a container.
Overlaps and/or orphaned exclusions exist for Procedure 00869. Has 4 rules (2 not inherited)
Rule #93951 is an orphaned exception for rule 80269
--Date Range = 01/01/2002-06/30/2003
--OVERLAPPED RULE -- 93952 has the same output variable(s) but overlaps 93888
First rule eclipsed by second.
93952 DOS: 01/01/2002-06/30/2003 CHP: 40 PROC: 00869--ANESTH, VASECTOMY PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 2...
93888 DOS: 05/01/2001-12/31/2299 BGRP: 320003--Anesthesia CHP: 40 PDAT: 06/10/2010-12/31/2299 PPTS: 04/040, 04/047, 05/050, 12/121, 12/126, 20/000,...
Overlaps and/or orphaned exclusions exist for Procedure 20930. Has 2 rules (2 not inherited)
Rule #93955 is an orphaned exception for rule 93886
Overlaps and/or orphaned exclusions exist for Procedure 20936. Has 2 rules (2 not inherited)
Rule #93957 is an orphaned exception for rule 93886
Overlaps and/or orphaned exclusions exist for Procedure 36489. Has 3 rules (3 not inherited)
--Date Range = 01/01/2000-12/31/2299
--OVERLAPPED RULE -- 94002 has the same output variable(s) but overlaps 94003
    
```

No Errors or Conflicts

Conflicts - Overlapping Dates

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P																
1	SAK_PUB	SAK_PUB	CDE	PGM	DSC	PGM	CDE	TYP	IND	RECI	IND	MAJ	CIN	STAN	IND	CT	E	IND	COP	IND	DUAL	IND	TPL	_NUM	HIEF	NUM	HEF	DT	EFFE		
2	0	1	ALL	All Benefit	All Benefit	BNFT	N																						0	19900101	
3	1	1	MCAD	Medicaid	Full medic	BNFT	N																						0	19900101	
4	2	1	UDN	Unusual	chronic	BNFT	N																						0	19900101	
5	3	1	DMA	Disability	Disability	BNFT	N																						0	19900101	
6	4	1	DISV	Disability	Disability	BNFT	N																						0	19900701	
7	5	1	CHOIC	Choices	V	BNFT	N																						0	20011101	
8	9	1	ASL	Assisted	L	BNFT	N																						0	20060701	
9	10	1	ALIEN	Emergenc	Temporary	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	10	0	19900101
10	11	1	ALCRX	ODADAS	ODADAS	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	11	0	19900101
11	12	1	AIDS	Aids	Waiv	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	12	0	19880101
12	13	1	VNT50	Model	50	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	13	0	19860917	
13	14	1	VENT	Ventilator	Ventilator	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	14	0	19891215	
14	15	1	TRCO	Transitions	Transitions	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	15	0	20060701	
15	16	1	TMRDD	Transitions	Transitions	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	16	0	20020101	
16	17	1	SLMB	SLMB	Special	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	17	0	19900101	
17	18	1	RES14	Residentia	Residentia	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	18	0	19900101	
18	19	1	RES	Residentia	Residentia	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	19	0	19900101	
19	20	1	REF	Refugee	Refugee	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	20	0	19900101	
20	21	1	QWDI	Qualified	V	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	21	0	19900101		
21	22	1	QMB	Qualified	V	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	22	0	19900101		
22	23	1	Q1	Q1	Q1	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	23	0	19900101		
23	24	1	PASSP	Passport	V	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	24	0	19900101		
24	25	1	PAS14	Passport	V	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	25	0	19900101		
25	26	1	PACE	Pace	Pace	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	26	0	19960930		
26	27	1	OOHC	Old	Ohio	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	27	0	19980701		
27	28	1	OMH	Ohio	Med	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	28	0	19900101		
28	29	1	OHC	Ohio	Home	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	29	0	20060701		
29	30	1	OBRA	Obra	Waiv	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	30	0	19900101		
30	31	1	MSP	Medicaid	S	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	31	0	20050701		
31	32	1	MRLV1	MIR	Level	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	32	0	20021201		
32	33	1	MRO	MIR	MIR	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	33	0	19910301		
33	34	1	MOD50	Model	50	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	34	0	19831001		
34	35	1	MCABD	HMO	ABC	BNFT	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	1	19900101		
35	36	1	KTRNA	Katrina	Waiv	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	2	20050901			
36	37	1	HOSPC	Hospice	Hospice	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	3	19900101			
37	38	1	CDPHY	County	Dn	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	4	19900101		
38	39	1	CDPHR	County	Dn	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	5	19900101		
39	40	1	PACTP	PACT	Phy	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	6	19900101		
40	41	1	PACTD	PACT	Pha	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	7	19900101		
41	42	1	PACEA	PAGE	PAGE	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	8	19900101		
42	43	1	MOCP	MO	CP	ASGN	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	0	6	19900101		

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

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

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

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

Contract Spreadsheet

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

```

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

```

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

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

Check Your Understanding

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

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

- A. True
- B. False

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

- A. True
- B. False

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

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

Summary

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

Reports

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

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

Correcting Conflict Report Errors

What

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

Who

A BPA Configuration analyst performs this task.

When

Perform this task as needed.

Relevance

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

- State conflicts
- Simplification
- Directive validation

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

Requirements

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

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

How To

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

Step	Action						
1	<p>Access the reports by following these steps:</p> <ol style="list-style-type: none"> From the iTrace home page, select Tech Design>Reference Data Maintenance. Scroll down to the BPA Reports heading and select Conflict Report. Select a conflict log report from the list (recommend selecting the most recent conflict report). If desired, print the report. Click Back on the iTrace browser window to return to the previous screen. Under Benefit Plan Administration heading, select Plan Spreadsheet. Note: The Benefit Plan Table Load opens as a separate spreadsheet, which you can view, print, or download. Under Benefit Plan Administration heading, select Contract Spreadsheet. Close the documents, when finished. 						
2	From the MITS home page, navigate to Reference>Benefit Administration .						
3	Click the appropriate menu (i.e., Provider Contract, Recipient Plan, Reimbursement Agreement, and Global Restrictions).						
4	<p>Select the appropriate contract/plan/agreement/restriction using these instructions:</p> <table border="1" data-bbox="371 1003 1375 1451"> <thead> <tr> <th data-bbox="375 1010 724 1062">TO:</th> <th data-bbox="724 1010 1372 1062">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1062 724 1310">Search</td> <td data-bbox="724 1062 1372 1310"> <ol style="list-style-type: none"> Type the contract/plan/agreement in the search field. Click search. <p>Note: The matching contract/plan/agreement/restriction will display (or a list if you only typed the first letter).</p> </td> </tr> <tr> <td data-bbox="375 1310 724 1451">Navigate the search results list</td> <td data-bbox="724 1310 1372 1451"> <ol style="list-style-type: none"> Navigate the list by clicking the page numbers and/or the Next > page icon. Click the provider contract row from the Search Results list. </td> </tr> </tbody> </table>	TO:	THEN:	Search	<ol style="list-style-type: none"> Type the contract/plan/agreement in the search field. Click search. <p>Note: The matching contract/plan/agreement/restriction will display (or a list if you only typed the first letter).</p>	Navigate the search results list	<ol style="list-style-type: none"> Navigate the list by clicking the page numbers and/or the Next > page icon. Click the provider contract row from the Search Results list.
TO:	THEN:						
Search	<ol style="list-style-type: none"> Type the contract/plan/agreement in the search field. Click search. <p>Note: The matching contract/plan/agreement/restriction will display (or a list if you only typed the first letter).</p>						
Navigate the search results list	<ol style="list-style-type: none"> Navigate the list by clicking the page numbers and/or the Next > page icon. Click the provider contract row from the Search Results list. 						
5	<p>To search for the level where you want to find a rule, follow these steps:</p> <table border="1" data-bbox="371 1598 1375 1793"> <thead> <tr> <th data-bbox="375 1604 724 1656">TO:</th> <th data-bbox="724 1604 1372 1656">THEN:</th> </tr> </thead> <tbody> <tr> <td data-bbox="375 1656 724 1793">Search</td> <td data-bbox="724 1656 1372 1793"> <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> </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. 		
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. 						

Step	Action												
	<table border="1" style="width: 100%;"> <tr> <td style="width: 40%; padding: 5px;">Navigate the tree</td> <td style="padding: 5px;"> 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> </table>	Navigate the tree	a. Click the “+” symbol for the appropriate benefit group to reveal existing rules for that service. b. Continue to click the “+” symbol until you reach the desired level.										
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6	<p>Left click the benefit code above where the rule was placed to view the rule summary.</p> <p>Note: Review the summary before making changes according to policy/directive.</p>												
7	Select a directive from the Directive Version drop-down list.												
8	<p>Correct the errors by following these steps:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; padding: 5px;">IF:</th> <th style="width: 50%; padding: 5px;">THEN:</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">A direct rule is incorrect and needs to be modified</td> <td style="padding: 5px;"> c. Left click the direct rule. d. Modify the rule edit panel as appropriate </td> </tr> <tr> <td style="padding: 5px;">An inherited rule is incorrect only and needs to be modified</td> <td style="padding: 5px;"> e. Right click the rule. f. Select Modify Rule (excl/new). g. Edit the new rule panel. </td> </tr> <tr> <td style="padding: 5px;">A direct rule is incorrect and needs to be removed</td> <td style="padding: 5px;"> h. Right click the rule. i. Select Inactivate. </td> </tr> <tr> <td style="padding: 5px;">An inherited rule is incorrect only and needs to be removed</td> <td style="padding: 5px;"> j. Right click the rule. k. Select Exclude. </td> </tr> <tr> <td style="padding: 5px;">A new rule is required</td> <td style="padding: 5px;"> l. Right click the benefit level m. Select Add rule. </td> </tr> </tbody> </table>	IF:	THEN:	A direct rule is incorrect and needs to be modified	c. Left click the direct rule. d. Modify the rule edit panel as appropriate	An inherited rule is incorrect only and needs to be modified	e. Right click the rule. f. Select Modify Rule (excl/new) . g. Edit the new rule panel.	A direct rule is incorrect and needs to be removed	h. Right click the rule. i. Select Inactivate .	An inherited rule is incorrect only and needs to be removed	j. Right click the rule. k. Select Exclude .	A new rule is required	l. Right click the benefit level m. Select Add rule .
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9	<p>Click Save.</p> <p>This launches a three-step process. The first two steps interpret the rules and compare the new rule to existing rules looking for overlaps and ambiguities. The third step validates the chosen Directive and Version.</p>												
10	<u>If the save is successful</u> , click OK to dismiss the confirmation window.												
11	<p>If the system finds a conflict:</p> <ol style="list-style-type: none"> a. Click Cancel Save b. Make the appropriate changes to the rule to resolve the conflict. c. Click Save (again). 												

Success

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

Practice

Practice correcting conflict report errors using this information:

- **There may not be anything to practice except for how to access the reports--by the time the system goes live, the BAs hope to have all conflicts resolved.**
- iTrace>Tech Design>Reference Data Maintenance
- Under BPA Reports, click Conflict Report
- Select the appropriate Conflict log from the list
- Locate an error (like Overlapped rule) and the associated rule and benefit to research
- MITS>Reference>

Learning points:

- The reports are in iTrace, and the errors are fixed in MITS.
- The Conflict Error Report would be a good backup to see if any rule errors have gotten through accidentally.
- The Conflict Error Report was developed for changes uploaded to the system using the loader spreadsheet.
- Any rules added or changed manually will be saved with the 3-step save process which performs the checks automatically.

Summary

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

Review

Objectives

In this course you learned how to:

- Search for and view recipient plans
- Create, update, and delete benefit plans
- Create, update, and delete assignment plans
- Maintain dependent and excluded plan data
- Maintain plan groups
- Maintain plan hierarchy data
- Search for and view existing rules
- Create and save new rules
- Exclude/modify rules
- Correct conflict report errors