TEXT KEY 0 — TEXT DESC

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- EXCEPTION CODE / CLAIM STATUS INDICATORS

C	COMMITTED	O	EXCEPTION MAY BE FORCED
D	DENIED	1	EXCEPTION CAN NOT BE FORCED
E	ERROR	2	EXCEPTION CAN NEVER BE FORCED
F	FORCED		
L	HOLD FOR LEGISLATIVE RELIEF	1	SUPER SUSPEND
R	RETURNED	2	DENY
		3	SUSPEND
		4	PAY BUT REPORT
		5	PAY
		A	AUTO DENY "2" UNLESS AUTH "3"

A	IN TAPE BILLING CYCLE	I	TO BE PAID
B	IN PROCESS	K	TO BE DENIED
C	SUSPENDED	L	TO BE PAID, NOW A CR BAL
D	SUSPENDED, READY TO PROCESS	M	TO BE DENIED, NOW A CR BAL
E	SUSPENDED, TO BE DELETED	N	PAID
F	TO BE SUSPENDED (OR ADJUSTED)	P	DENIED
G	REVERSED CLAIM TO BE CREDITED	Q	HELD FOR LEGISLATIVE RELIEF
H	ADJUDICATED (NON CLAIM)	R	RETURNED TO PROVIDER

- ALLOWED CHARGE SOURCE

A	MANUALLY PRICED	R	DENTAL COMPOSITE/AMALGAM FEE
B	RELATIVE VALUE	S	EAC FROM SPECTIFIC PKG RECORD
C	MAXIMUM FEE	T	MAC FROM SPECIFIC PKG
D	PERCENT OF CHARGES	U	UNIT DOSE PRICE
E	REIMBURSEMENT RATE	V	TOS C - CHILDRENS SERVICES
F	EAC FROM STANDARD PKG RECORD	Z	PRICED BY PREVIOUS SYS
G	BILLED CHARGE		
H	DENIED RELATIVE VALUE		
I	AVERAGE WHOLESALE PRICE		
J	MAC FROM STANDARD PKG RECORD		
K	PROVIDER CHARGE FILE		
L	CHARGE FACTOR AND CHARGE FILE		
M	MANUAL PRICE OVERLAYED		
N	MEDICARE REALLOCATED ALLOWED		
Q	PRICED AS RECIPIENT HAS QMB		

SP	NOT YET PRICED
1	ALL TESTS FROM A DISEASE ORGAN PANEL ARE BILLED & PD AS A PANEL DIVIDED EQUALLY
2	AUTOMATED TESTS BILLED INDIVIDUALLY, BUT NOT A TOTAL PANEL & PD AT INTERNAL CODING PRICE.

DRG ALLOWED CHARGE SOURCE
SP NOT YET PRICED
A MANUAL PRICED
H DENIED
N LOW OUTLIER
O HIGH OUTLIER
P REL VALUE & PROVIDER %
Q PRO-RATED TRANSFER
R OUT-OF-STATE HOSPITAL

- PDDD PRICING ACTION CODES (TYPE)

1 RELATIVE VALUE SCALE (RVS)
2 ANESTHESIA BASE
3 CUT AND PAY MAXIMUM AMOUNT
4 PERCENT OF BILLED AMOUNT
5 MANUAL PRICE
6 NOT COVERED
7 SUSPEND MAXIMUM AMOUNT
8 MAXIMUM PARAMETER (AMBULATORY SURGERY CENTER PRICING)
9 IMMUNIZATION MATERIAL SUPPLIED BY HEALTH DEPARTMENT
A PREOPERATIVE % OF TOTAL SURGERY (MODIFIER 56)
B INTRAOPERATIVE % OF TOTAL SURGERY (MODIFIER 54)
C POSTOPERATIVE % OF TOTAL SURGERY (MODIFIER 55)
F FACILITY MAXIMUM AMOUNT (EFF 7/1/00 DOS)
G FACILITY TECHNICAL COMPONENT MAXIMUM AMOUNT (EFF 7/1/00 DOS)
H FACILITY PROFFESSIONAL COMPONENT MAXIMUM AMOUNT (EFF 7/1/00 DOS)
N NON-FACILITY MAXIMUM AMOUNT (EFF 7/1/00 DOS)
P PROFESSIONAL COMPONENT RVU'S
Q PROFESSIONAL COMPONENT MAXIMUM AMOUNT
Q NON-FACILITY PROFFESSIONAL COMPONENT (EFF 7/1/00 DOS)
R PROFESSIONAL COMPONENT PERCENTAGE
S PROFESSIONAL COMPONENT MANUAL PRICE
T TECHNICAL COMPONENT RVU'S
U TECHNICAL COMPONENT MAXIMUM AMOUNT
U NON-FACILITY TECHNICAL COMPONENT (EFF 7/1/00 DOS)
V TECHNICAL COMPONENT PERCENTAGE
W TECHNICAL COMPONENT MANUAL PRICE

LOCATIONS EFFECTIVE 9/22/00

01 PAY & REPORT & EXCEPTIONS NOT IN USE
02 TABLE OVERFLOW (SYSTEM)
03 TPR PREMIUMS
04 CASH CONTROL
05 TPR 165, 166
06 TPR - CASUALTY
07 COMMENTS - EXCEPTION 197
08 ECS
09 MANUAL PRICING
10 DRG REVIEW
11 LAB PANEL HISTORY/PRICING (OLD LOC 45)
12 DENTAL SURGERY/ANESTHESIA

13 DMM/DME(PRIOR AUTH)
14 SMC REVIEW (OLD LOC 14)
15 COB MEDICARE (AUDREY FINNIGAN)
16 MEDICAL REVIEW EXCEPTIONS
17 COB TEST
18 STERILIZATION/HYSTERECTOMIES (OLD LOC 26/20)
19 NON CONTRACT
20 COMPLEX RES/EXC 055
21 MEDICAL REVIEW
22 PRIOR AUTH PROBLEMS
23 PROBLEMS W/AUTH # VS CLAIM (OLD LOC 33)
24 DENTAL EXCEPTION
25 DENTAL AUTH (OLD LOC 25)
26 (UNUSED) MMIS
27 PROCEDURE DIAG NOT ALLWD/INCLD/RELATED (COMPLEX)
28 MED/DETOX
29 TPR HEALTH (OLD LOC 4)
30 TPL CAUSLTY (OLD LOC 6)
31 HOME HEALTH REVIEW (EXC 448)
32 MEDICARE (EXCEPTIONS POSTING TO X-OVERS)
33 NOT ALLOWED IN COMBINATION (MED VENDOR DIAPERS)
34 INTERMEDIATE RES (LIMITS) (SIMPLE)
35 POSSIBLE DUPES
36 SURGERY CLAIM REVIEW
37 THERAPY LIMITATIONS/EXCEPTIONS
38 CLAIMS REVIEW SUP/LEAD
39 MDCR ELIG
40 HOSP RE-ADMIT (OLD LOC 8)
41 (UNUSED)
42 HMO - CAPITATION EXCEPTIONS
43 AVAILABLE
44 EXCEPTION 899 - OVER 25 EXCEPTIONS POSTING
45 AVAILABLE
46 HOSP GENERAL EXCEPTIONS
47 QFFS NURSES CONSULTANTS (OLD LOC 34)
48 GENERAL EXCEPTIONS
49 RES AGED (OLD LOC 17)
50 HOSP BASIC EXCEPTIONS
51 (UNUSED)
52 BASIC EXCEPTIONS
53 FAMILY PLANNING REVIEW
54 PHARMACY GENERAL EXCEPTIONS
55 MANAGED MEDICARE (OLD LOC 02)
56 HOSP DIAG VS PROC
57 HMO REVIEW
58 AVAILABLE
59 MMIS - SANDY REVIEW (OLD LOC 50)
60 PROVIDER CONTRACT EXCEPTIONS
61 FSU SPEC
62 CP MAJOR EXCEPTIONS
63 OVERLOC'D TPL ADJUSTMENTS
64 MMIS - MANAGED MEDICARE REVIEW
65 ELIGIBILITY
66 RECIP NOT ELIGIBLE-CP REVIEW

67 MMIS REVIEW - CHRISTINE
68 HOSP DOS INVALID
69 AVAILABLE
70 QC TRAINING
71 HOSP PROV # ERRORS
72 MMIS SUE HILTON
73 PROV # OTHER ERRORS/CP REVIEW
74 PROV # ERROR
75 MMIS TEST (OLD LOC 10)
76 RECIP ON REVIEW
77 PROVIDER # PENDING
78 PROVIDER ON REVIEW
79 197 COMMENT (OLD LOC 80)
80 INTERPRETER SVCS
81 PRU (OLD LOC 59)
82 PRP/QRS
83 MMIS UNIT (OLD LOC 35)
84 QC
85 PCOP & HOSPITAL & 116 EXCEPTION
86 GROSS ADJUSTMENTS (CASH CONTROL)
87 MASS ADJUSTMENTS
88 DATA TRANSFER-SCANNER
89 ADJUSTMENTS

LOCATIONS ENDING 9/22/00 (OLD LOCATIONS)
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01 PAY & REPORT
02 MEDICARE PLUS
03 CASH CONTROL
04 TPR HEALTH INS
05 TPR/FBI - IRS
06 TPR - CASUALTY
07 CARMEN GIGSTEAD - HOSP
08 PRE-ADMIT REVIEW - HOSP
09 ADJ CREDIT (INTERNAL LOC)
10 MMIS UNIT
11 HOSP - GIGSTEAD
12 QRS - CASEY ZIMMER
13 CONSULTANTS
14 SMC REVIEW
15 COB MDCR - FINNIGAN
16 QFFS - HOME HEALTH
17 RES AGED
18 DRG APPROVALS
19 OAMR - NONCONTR HOSP/NO APPRVL
20 HYSTERECTOMIES RES
21 KAREN SPENCER E/E
22 JIM/REVIEW
23 KARIN RICHARDSON - TEST
24 OPS - HOLD GROSS ADJ-GARRISON
25 DENTAL AUTH
26 STERILIZATION DESK
27 RES/NEW EXCEPTIONS
28 RESOLUTIONS (HISTORY REL)

29 DEA/SENN
30 DETAIL LIST (W/S)
31 DETAIL LIST (W/S)
32 SURG/RES/J
33 AUTHORIZATION RESOLUTIONS
34 QFFS -IP HOSP/MRI/SS/PAIN CL/OXYGEN/INFUSION/MED NUTRITION
35 MMIS UNIT
36 ELIGIBILITY
37 RECIPIENT X-REFERENCE
38 RECIPIENT DEATH
39 MEDICARE ELIGIBILITY - DCS/COB
40 PROVIDER ENROLLMENT
41 PROV ENROLL - NO PROV NUMBER
42 N/H-MARY F
43 TPR PREMIUM PAYMENTS
44 RES/MANUAL PRICING (J L O)
45 RES/LAB PRICING (J,L,M)
46 THROUGH 49 NOT USED
50 MMIS/SANDY
51 SPECIAL HANDLING
52 MMIS/SANDY
53 RES/THERAPIES
57 E/E KARIN RICHARDSON
58 RES/HMO
59 WORKSHEET TO FIELD SERVICES
60 X-OVER REVIEW 1/1/98 (MMIS)
61 MMIS/DEBBIE
62 MMIS/ALLON
63 THROUGH 79 NOT USED
64 TRINA HOGAN REVIEW
80 HMO REVIEW (PCOP)
81 QC MODE REVIEW - KARIN RICHARDSON
85 MMIS - PATSY
87 MICHELL SENN - ENROLLMENTS
88 SCANNER CLAIMS (J,P,L)
89 ADJUSTMENTS (INTERNAL)
90 THROUGH 91 (SYSTEM LOCATIONS)
92 ADJUDICATED NON-CLAIM (SYSTEM)
93 TO BE PAID/DENIED (SYSTEM)
94 TO BE PD/DENIED (SYSTEM)
95 PAID/DENIED/RETURNED (SYSTEM)
97 FINAL DISPOSITION

- PLACE OF SERVICE AND SITE OF SERVICE (SOS) PAYMENT DIFFERENTIAL

PLACE OF SERVICE	REIMBURSEMENT
1 INPATIENT	FACILITY (F)
2 OUTPATIENT HOSP	FACILITY (F)
3 OFFICE	NON-FACILITY (NF)
4 CLIENTS RESIDENCE	NON-FACILITY (NF)
5 EMERGENCY ROOM	FACILITY (F)
6 PROFFESSIONAL SERVICES IN AN ASC	NF PRIOR TO 07/01/01 F 07/01/01 AND AFTER
7 NURSING HOME (ICF/IMR)	FACILITY (F)

8	NURSING HOME (ICF/SNF)	FACILITY (F)
9	CONGEGRATE CARE/GROUP HOME AND OTHER	NON-FACILITY (NF)

NATIONAL PLACE OF SERVICE (POS) CODE SET AND SITE OF SERVICE (SOS) PAYMENT DIFFERENTIAL

PLACE OF SERVICE	REIMBURSEMENT
03 SCHOOL	NON-FACILITY (NF)
04 HOMELESS SHELTER	NON-FACILITY (NF)
05 INDIAN HEALTH SERVICE (FREESTANDING)	NON-FACILITY (NF)
06 INDIAN HEALTH SERVICE (PROVIDER BASED)	FACILITY (F)
07 TRIBAL 638 FREESTANDING FACILITY	NON-FACILITY (NF)
08 TRIBAL 638 PROV. BASED FACILITY	FACILITY (F)
11 OFFICE	NON-FACILITY (NF)
12 HOME	NON-FACILITY (NF)
13 ASSISTED LIVING FACILITY	NON-FACILITY (NF)
14 GROUP HOME	NON-FACILITY (NF)
15 MOBILE UNIT	NON-FACILITY (NF)
20 URGENT CARE FACILITY	NON-FACILITY (NF)
21 INPATIENT HOSPITAL	FACILITY (F)
22 OUTPATIENT HOSPITAL	FACILITY (F)
23 EMERGENCY ROOM-HOSPITAL	FACILITY (F)
24 AMBULATORY SURGICAL CENTER	FACILITY (F)
25 BIRTHING CENTER	NON-FACILITY (NF)
26 MILITARY TREATMENT FACILITY	FACILITY (F)
31 SKILLED NURSING FACILITY	FACILITY (F)
32 NURSING FACILITY	NON-FACILITY (NF)
33 CUSTODIAL CARE FACILITY	NON-FACILITY (NF)
34 HOSPICE	FACILITY (F)
41 AMBULANCE - LAND	FACILITY (F)
42 AMBULANCE - AIR OR WATER	FACILITY (F)
49 INDEPENDENT CLINIC	NON-FACILITY (NF)
50 FEDERALLY QUALIFIED HEALTH CENTER	NON-FACILITY (NF)
51 INPATIENT PSYCHIATRIC FACILITY	FACILITY (F)
52 PSYCHIATRIC FACILITY-PARTIAL HOSP.	FACILITY (F)
53 COMMUNITY MENTAL HEALTH CENTER	FACILITY (F)
54 INTER. CARE FAC./MENTALLY RETARDED	NON-FACILITY (NF)
55 RESIDENTIAL SUBSTANCE ABUSE TRTMT FAC.	NON-FACILITY (NF)
56 PSYCHIATRIC RESIDENTIAL TREATMENT CNTR	FACILITY (F)
57 NON-RESIDENTIAL SUBSTANCE ABUSE TF	NON-FACILITY (NF)
60 MASS IMMUNIZATION CENTER	NON-FACILITY (NF)
61 COMPREHENSIVE IP REHAB FACILITY	FACILITY (F)
62 COMPREHENSIVE OP REHAB FACILITY	NON-FACILITY (NF)
65 END STAGE RENAL DISEASE TRTMT FAC.	NON-FACILITY (NF)
71 STATE OR LOCAL PUBLIC HEALTH CLINIC	NON-FACILITY (NF)
72 RURAL HEALTH CLINIC	NON-FACILITY (NF)
81 INDEPENDENT LABORATORY	NON-FACILITY (NF)
99 OTHER PLACE OF SERVICE	NON-FACILITY (NF)

NOTE: EXCEPTIONAL THERAPY CARE (PT 80/SPEC 46) ALWAYS PAYS AT THE NON-FACILITY RATE.
NOTE: PT 28/29 WHEN PROVIDING SOME SERVICES IN POS 7 & 8 PAY AT NON-FACILITY RATE.

TYPE OF SERVICE

0	ICD-9 SURGERY PROCEDURE CODES USED IN DRG PRICING
3	PHYSICIAN
4	DENTAL
9	MEDICAL VENDOR
C	CHILDRENS SERVICES RATE
R	RENTAL FOR MEDICAL VENDOR
X	OUTPATIENT HOSPITAL
Z	AMBULATORY SURG CTR

- CONVERSION FACTORS

MATERNITY	ANESTHESIA	CHILD PHC	ADULT PHC	ALL OTHER PC	CL LAB
070103	070103	070103	070103	070103	070103
45.59	20.23	35.62	25.00	22.75	0.81
010103	010103	010103	010103	010103	010103
45.59	20.23	35.62	25.00	22.75	0.81
070102	070102	070102	070102	070102	070102
45.59	15.70	35.62	20.44	22.75	.719
070101	070101	070101	070101	070101	070101
45.34	15.49	36.52	21.27	22.41	.720
070100	070100	070100	070100	070100	070100
45.33	15.10	35.89	21.17	22.37	.694
070199	070199	070199	070199	070199	070199
44.20	12.96	37.49	22.47	21.93	.689
070198	070198	070198	070198	070198	070198
43.19	12.75	39.11	23.67	22.27	.667
070197	070197	070197	070197	070197	
43.34	12.75	40.77	24.86	22.25	
070796	070196	070196	070196	070196	
45.07	12.63	43.60	27.33	23.04	
	100195				
	12.23				
JUL01,95	JUL01,95	JUL01,95	JUL01,95	JUL01,95	
44.17	12.41	43.19	26.13	22.05	
AUG01,94	AUG01,94	AUG01,94	AUG01,94	AUG01,94	
40.78	12.17	40.85	25.38	21.42	
MAY01,94	MAY01,94	MAY01,94	MAY01,94	MAY01,94	
40.78	11.75	40.85	25.38	21.42	
AUG01,93	AUG01,93	AUG01,93	AUG01,93	AUG01,93	
43.97	11.75	37.60	24.69	20.83	
JAN01,93	JAN01,93	JAN01,93	JAN01,93	JAN01,93	
49.02	11.75	38.14	23.86	20.00	

EFF 01AUG94 - ANESTHESIA IS CALCULATED: BASE X 12 PLUS TIME X
CONVERSION FACTOR DIVIDED BY 12 = ALLOWED AMOUNT

- OUTPATIENT FEE SCHEDULE SPLIT BILL INDICATOR VALUES

A	100%	C	55%
B	70%	D	30%

- OUT OF STATE HOSPITAL PAYMENT PERCENTAGES AND CONVERSION RATES

DRG CONVERSION FACTORS

EFFECTIVE DATE	AMOUNT/PERCENT
07/01/87	$2394
07/01/86	1773

INPATIENT PERCENTAGE OF CHARGE

EFFECTIVE DATE	AMOUNT/PERCENT
07/01/92	70.2%
10/01/88	84.2%
04/01/88	85.5%

OUTPATIENT PERCENT OF CHARGE

EFFECTIVE DATE	AMOUNT/PERCENT
07/01/92	62.4%
07/01/89	80.7%
10/01/88	84.2%
04/01/88	85.5%

- CLAIM INPUT MEDIUM INDICATORS

0 EXAM ENTRY
1 DIRECT ENTRY
2 TAPE
3 ELECTRONIC MEDIA CLAIMS
4 MACHINE GENERATED

- MODIFIERS

ALPHA HCPC MODIFIERS;

AA	ANESTHESIA SERVICES FURNISHED BY ANESTHESIOLOGIST	1993
AB	MEDICAL DIRECTION OF OWN EMPLOYEE BY ANESTHESIOLOGIST.	1993-3/31/00
AC	MEDICAL DIRECTION OF OTHER THAN OWN EMPLOYEE BY ANES.	1993
AD	SUPERVISION OF MORE THAN 4 CONCURRENT ANESTHESIA SERVICES	1993
AE	DIRECTION OF RESIDENTS IN FURNISHING NOT MORE THAN 2 CONCURRENT ANES SERVICES-ATTENDING PHYSICIAN RELATIONSHIP MET (MAA N/C)	1993
AF	ANESTHESIA COMPLICATED BY TOTAL BODY HYPOTHERMIA (MAA N/C)	1993
AG	ANESTHESIA FOR EMERG SURG ON PATIENT WHO IS MORIBUND OR HAS AN INCAPACITATING SYST DISEASE THAT IS A THREAT TO LIFE (MAA N/C)	1993
AH	CLINICAL PSYCHOLOGIST	
AJ	CLINICAL SOCIAL WORKER	
AL	NURSE PRACTITIONER, NON-RURAL, TEAM MEMBER	1994
AM	PHYSICIAN, TEAM MEMBER SERVICE	1993
AN	PHYSICIAN ASSIST	ENDED 6/1999
AP	DET OF REFRACTIVE ST NOT PERF IN COURSE OF DX EXAM	
AS	PA SERVICES FOR ASSISTANT AT SURGERY, NON TEAM MEMBER	1993
AT	ACUTE TREATMENT (S/B USED WITH 98940,98941,98942)	
AU	PHYSICIAN ASSISTANT	ENDED 6/1999
AU	ITEM FURNISHED IN CONJUNCTION WITH UROLOGICAL, OSTOMY, TRACHEOSTOMY SUPPLY	OR START 1/2003
AV	NURSE PRACTITIONER	ENDED 6/1999

AV - ITEM FURNISHED IN CONJUNCTION WITH PROSTHETIC DEVICE, PROSTHETIC OR ORTHOTIC START 1/2003
AW - ITEM FURNISHED IN CONJUNCTION WITH A SURGICAL DRESSING 2003
AX - ITEM FURNISHED IN CONJUNCTION WITH DIALYSIS SERVICES 2003
A1 - DRESSING FOR ONE WOUND 2003
A2 - DRESSING FOR TWO WOUNDS 2003
A3 - DRESSING FOR THREE WOUNDS 2003
A4 - DRESSING FOR FOUR WOUNDS 2003
A5 - DRESSING FOR FIVE WOUNDS 2003
A6 - DRESSING FOR SIX WOUNDS 2003
A7 - DRESSING FOR SEVEN WOUNDS 2003
A8 - DRESSING FOR EIGHT WOUNDS 2003
A9 - DRESSING FOR NINE OR MORE WOUNDS 2003
BA - ITEM FURNISHED IN CONJUNCTION WITH PARENTERAL ENTERAL NUTRITION (PEN) SERVICES 2003
BO - ORALLY ADMINISTERED NUTRITION, NOT BY FEEDING TUBE 2003
BP - BENEFICIARY HAS ELECTED TO PURCHASE ITEM
BR - BENEFICIARY HAS ELECTED TO RENT ITEM
BU - BENEFICIARY HAS NOT INFORMED SUPPLIER OF RENT/PURCH DECISION
CA - PAYABLE IP SETTING WHEN PERFORMED EMERGENTLY ON OP WHO EXPIRES
CB - ESRD BENEFICIARY DIALYSIS BENEFIT, SEPARATELY REIMBURSABLE
CC - PROCEDURE CODE CHANGE
CS - BABY ON PARENTS PIC 1993
CS - BABY ON MOMS PIC 1992
DL - USE TO SUSPEND AN EXCEPTION FOR DETAIL LINE DENIAL (INTERNAL) 2002
DY - DAYTIME USUAGE ONLY (UROLOGICAL SUPPLIES - MAA) 2000
EJ - SUBSEQUENT CLMS FOR DEFINED COURSE OF THERAPY
EM - EMERGENCY RESERVE SUPPLY (FOR ESRD BENEFIT ONLY)
EP - SERVICES PROVIDED AS PART OF MEDICAID EPSDT PROGRAM 2003
ET - EMERGENCY SERVICES
EY - NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE 2003
E1 - UPPER LEFT, EYELID
E2 - LOWER LEFT, EYELID
E3 - UPPER RIGHT, EYELID
E4 - LOWER RIGHT, EYELID
FA - LEFT HAND, THUMB
FP - SERVICE PROVIDED AS PART OF MEDICAID FAMILY PLANNING PROGRAM
F1 - LEFT HAND, SECOND DIGIT
F2 - LEFT HAND, THIRD DIGIT
F3 - LEFT HAND, FOURTH DIGIT
F4 - LEFT HAND, FIFTH DIGIT
F5 - RIGHT HAND, THUMB
F6 - RIGHT HAND, SECOND DIGIT
F7 - RIGHT HAND, THIRD DIGIT
F8 - RIGHT HAND, FOURTH DIGIT
F9 - RIGHT HAND, FIFTH DIGIT
GA - WAIVER OF LIABILITY STATEMENT ON FILE
GB - PROCEDURES PERFORMED ON DIFF SITES, DIFF SESSIONS 2001
GB - CLAIM RESUBMIT AS NO LONGER GLOBAL (INFO) 2002
GC - SERVICE PERFORMED IN PART BY A RESIDENT UNDER DIRECTION OF A TEACHING PHYSICIAN. (MUST BE RETAINED IN COMMENTS OR ON LINE) 2002
GE - PERFORMED BY RESIDENT UNDER PRIMARY CARE EXCEPTION
GF - NON-PHYSICIAN SERVICES IN A CRITICAL ACCESS HOSPITAL

GG - PERFORM & PAY OF SCREEN & DX MAMMOGRAM SAME PATIENT,SAME DAY	2002
GH - DIAGNOSTIC MAMMOGRAM CONVERTED FRM SCREEN. MAMMO, SAME DAY	
GJ - OPT OUT PHYSICIAN OR PRACTITIONER EMERGENCY OR URGENT SERVICE	
GK - ACTUAL ITEM/SERVICE ORDERED BY PHYS,ASSOCIATED W/MOD GA/GZ	2002
GL - MEDICALLY UNNECESSARY UPGRADE FROM STANDARD, NO CHARGE/NOTICE	2002
GM - MULTIPLE PATIENTS ON ONE AMBULANCE TRIP (INFO)	2002
GN - SERVICE BY SPEECH THERAPIST	
GO - SERVICE BY OCCUPATIONAL THERAPIST (PERSONAL)	1999
GP - SERVICE BY PHYSICAL THERAPIST (PERSONAL)	1999
GQ - TELEHEALTH VIA ASYNCHRONOUS TELECOM SYSTEM (INFO ONLY)	2001
GT - VIA INTERACTIVE AUDIO/VIDEO TELECOMMUNICATION	1999
GU - NON FEE SCEDULE POS THRU	2001
GV - ATTENDING PHYS NOT EMPLOYED OR PD BY THE PATIENTS HOSPICE	2002
GW - SERVICE NOT RELATED TO THE HOSPICE PATIENTS TERMINAL CONDITION	2002
GX - SERVICE NOT COVERED BY MEDICARE (END 2001)	1999
GY - ITEM/SERVICE STATUTORILY EXCLUDED/DOES NOT MEET DEFINITION OF ANY MEDICARE BENEFIT	2002
GZ - ITEM/SERVICE EXPECTED TO BE DENIED,NOT REASONABLE/NECESSARY	2002
G1 - MOST RECENT URR READING OF LESS THAN 60	
G2 - MOST RECENT URR READING OF 60 TO 64.9	
G3 - MOST RECENT URR READING OF 65 TO 69.9	
G4 - MOST RECENT URR READING OF 70 TO 74.9	
G5 - MOST RECENT URR READING OF 75 OR GREATER	
G6 - ESRD PATIENT FOR WHOM LESS THAN 6 DIALYSIS SESSIONS IN A MO	1999
G7 - PREG RESULT FROM RAPE/INCEST OR CERTIFIED AS LIFE THREATENING	1999
G8 - MONITORED ANES/DEEP,COMPLEX,INVASIVE SURGICAL PROCEDURE	1999
G9 - MONITORED ANES/HX OF SEVERE CARDIO-PULMONARY CONDITION	1999
HA - CHILD/ADOLESCENT PROGRAM(REPLACES 1C)	2003
HB - HOMEBOUND	1992
HB - ADULT PROGRAM, NON GERIATRIC	2003
HC - ADULT PROGRAM, GERIATRIC	2003
HD - MATERIALS FROM HEALTH DEPT	1992
HD - PREGNANT/PARENTING WOMEN'S PROGRAM	2003
HE - MENTAL HEALTH PROGRAM	2003
HF - SUBSTANCE ABUSE PROGRAM	2003
HG - OPIOID ADDITION TREATMENT PROGRAM	2003
HH - INTEGRATED MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM	2003
HI - INTEGRATED MENTAL HEALTH AND MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES PROGRAM	2003
HJ - EMPLOYEE ASSISTANCE PROGRAM	2003
HK - SPECIALIZED MENTAL HEALTH PROGRAMS FOR HIGH-RISK POPULATIONS	2003
HL - INTERN	2003
HM - LESS THAN BACHELOR DEGREE LEVEL	2003
HN - BACHELORS DEGREE LEVEL	2003
HO - MASTERS DEGREE LEVEL	2003
HP - DOCTORAL LEVEL	2003
HQ - GROUP SETTING	2003
HR - FAMILY/COUPLE WITH CLIENT PRESENT	2003
HS - FAMILY/COUPLE WITHOUT CLIENT PRESENT	2003
HT - MULTI-DISCIPLINARY TEAM	2003
HU - FUNDED BY CHILD WELFARE AGENCY	2003
HV - FUNDED STATE ADDICTIONS AGENCY	2003
HW - FUNDED BY STATE MENTAL HEALTH AGENCY	2003
HX - FUNDED BY COUNTY/LOCAL AGENCY	2003

HY - FUNDED BY JUVENILE JUSTICE AGENCY	2003
HZ - FUNDED BY CRIMINAL JUSTICE AGENCY	2003
H9 - COURT-ORDERED	2003
IH - SITE OF TRANSFER TO HOSPITAL	1994
JW - DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT	2003
KA - ADD ON OPTION/ACCESSORY FOR WHEELCHAIR	1994
KB - 16 SQUARE INCHES OR LESS	1994
KB - BENEFICIARY REQUESTED UPGRADE FOR ABN,MORE THAN 4 MODIFIERS IDENTIFIED ON CLAIM	2003
KC - MORE THAN 16, BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES	1994
KD - MORE THAN 48 SQUARE INCHES	1994
KE - 1 OUNCE	1994
KF - 1 LINEAR YARD	1994
KG - 1 CUBIC CENTIMETER	1994
KH - DMEPOS ITEM, INITIAL CLAIM, PURCHASE OR 1ST MONTH RENTAL	1994
KI - DMEPOS ITEM, 2ND OR 3RD MONTH RENTAL	1994
KJ - DMEPOS ITEM, PARENTERAL ENTERAL NUTRITION PUMP/CAPPED RENTAL	1994
KK - INHALATION SOLUTION COMPOUNDED FROM AN FDA APPVD FORMULARY	
KL - PRODUCT CHARACTERISTICS DEFINED IN MED POLICY ARE MET	
KM - REPLACEMENT OF FACIAL PROSTHESIS INCL NEW IMPRESSION/MOULAGE	
KN - REPLACEMENT OF FACIAL PROSTHESIS USING PREV MASTER MODEL	
KO - SINGLE DRUG UNIT DOSE FORMULATION	
KP - FIRS DRUG OF MULTIPLE DRUG UNIT DOSE FORMULATION	
KQ - SECOND OR SUB. DRUG OF MULT DRUG UNIT DOSE FORMULATION	
KR - RENTAL ITEM, BILLING FOR PARTIAL MONTH	2002
KS - NON-INSULIN DEPENDENT	1999
KX - SPECIFIC REQUIRED DOCUMENTATION ON FILE	2003
KZ - NEW COVERAGE NOT IMPLEMENTED BY MANAGED CARE	
K0 - LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 0	
K1 - LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 1	
K2 - LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 2	
K3 - LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 3	
K4 - LOWER ECTREMITY PROSTHESIS FUNCTIONAL LEVEL 4	
LC - LEFT CIRCUMFLEX CORONARY ARTERY	
LD - LEFT ANTERIOR DESCENDING CORONARY ARTERY	
LL - LEASE/RENTAL (WHEN RENTAL IS TO BE APPLIED TO PURCHASE PRICE	
LP - NOT DONE AS A PANEL	1992,1993
LR - LABORATORY ROUND TRIP	
LS - FDA-MONITORED INTRAOCULAR LENS IMPLANT	
LT - LEFT	1992,1993
MP - MULTI PATIENTS SEEN (90300-90470)	
MS - SIX MONTHS MAINTENANCE AND SERVICE FEE	
NB - NOT HOMEBOUND	1992
NH - NURSING HOME TO HOSPITAL	
NM - NO MEDICARE	1992
NP- SKILLED NURSING FACILITY TO PHYSICIANS OFFICE	2002
NR - NEW WHEN RENTED	
NU - NEW EQUIPMENT	
PL - PROGRESSIVE ADDITIONAL LENSES	
PR - PHYSICIANS OFFICE TO RESIDENCE	
Q2 - HCFA/ORD DEMO PROJECT PROC/SERVICE	
Q6 - SERVICES BY A LOCUM TENENS	
Q7 - 1 CLASS A FINDING	
Q8 - 2 CLASS B FINDINGS	

Q9 - 1 CLASS B AND 2 CLASS C FINDINGS
QA - FDA INVESTIGATIONAL DEVICE EXEMPTION
QB - RURAL HLTH IN PHYSICIAN SHORTAGE AREA
QC - SINGLE CHANNEL MONITORING
QD - RECORDING AND STORAGE IN SOLID STATE MEMORY BY DIGITAL REC
QE - PRESCRIBED AMT OF OXYGEN LESS THAN 1 LPM
QF - PRESCRIBED AMT OF OXY EXCEEDS 4 LPM & PORTABLE OXY IS PRESCRIBED
QG - PRESCRIBED AMT OF OXYGEN IS GREATER THAN 4 LPM
QH - OXYGEN CONSERVING DEVICE IS BEING USED WITH OXY DELIVERY SYSTEM
QI - DECISION FOR MAJOR SURGERY 1993
QI - LIMITATION OF AMBULATION 1997
QJ - MEDICALLY DIRECTED BY PHYSICIAN- 2 CONCURRENT PROCEDURES 1993/1995
QJ - SERVICES/ITEMS PROVIDED TO A PRISONER OR PATIENT IN STATE/LOCAL CUSTODY, HOWEVER THE STATE OR LOCAL GOVERNMENT, AS APPLICABLE, MEETS THE REQUIREMENTS IN 42 CFR 411.4(B) 2003
QK - MEDICAL DIRECTION OF 2,3 OR 4 CONCURRENT PROCEDURES 1995
QL - PATIENT PRONOUNCED DEAD AFTER AMBULANCE CALLED 1999
QM - AMBULANCE SERVICE PROVIDED UNDER ARRANGEMENT OF PROV 1998
QN - AMBULANCE SERVICE FURNISHED DIRECTLY BY HOSPITAL 1998
QO - MEDICALLY DIRECTED BY PHYSICIAN - 3 CONCURRENT PROCEDURES 1993
QP - NOT DONE AS A PANEL (DOS THROUGH 6/30/98) 1997
QQ - MEDICALLY DIRECTED BY PHYSICIAN - 4 CONCURRENT PROCEDURES 1993
QR - REPEAT CLINICAL DIAGNOSTIC LAB TEST PERFORMED ON SAME DAY TO OBTAIN SUBSEQUENT PORTABLE TEST VALUE(S). (SEPARATE SPECIMENS TAKEN IN SEPARATE ENCOUNTERS). (DOS 7/1/98 AND AFTER) REPLACED BY MOD 91 ON 1/1/00 1998
QS - MONITORED ANESTHESIA CARE SERVICE (NOT COVERED BY MAA) 1993
QT - RECORDING AND STORAGE ON TAPE BY AN ANALOG RECORDER
QU - PHYSICIAN PROVIDING SERVICE IN AN URBAN HPSA
QV - ITEM/SERV PROVIDED AS PART OF ROUTINE CARE IN CLINICAL TRIAL
QW - CLIA WAIVED TEST 1997
QX - CRNA SERVICE - WITH MEDICAL DIRECTION BY PHYSICIAN 1993
QY - PHYSICIAN PERFORMING MEDICAL DIRECTION OF CRNA 1998
QZ - CRNA SERVICE: WITHOUT MEDICAL DIRECTION BY PHYSICIAN 1993
Q2 - HCFA/ORD DEMONSTRATION PROJECT PROCEDURE/SERVICE
Q3 - LIVE KIDNEY DONOR
Q4 - SERVICE FOR ORDERING/REFERRING PHYSICIAN 1994
Q5 - SERVICE FURNISHED BY A SUBSTITUTE PHYSICIAN UNDER RECIPROCAL 1993
Q6 - SERVICE FURNISHED BY A LOCUM TENENS PHYSICIAN 1993
Q7 - ONE CLASS A FINDING
Q8 - TWO CLASS B FINDINGS
Q9 - ONE CLASS A AND TWO CLASS B FINDINGS
RC - RIGHT CORONARY ARTERY
RI - RESIDENCE TO SITE OF TRANSFER 2002
RP - REPLACEMENT
RR - RENTAL 1992,1993
RT - RIGHT 1992,1993
SA - NURSE PRACTITIONER RENDERING SERVICE WITH PHYSICIAN 2001
SB - NURSE MIDWIFE 2001
SC - MEDICALLY NECESSARY SERVICE OR SUPPLY 2001
SD - SERVICES PROVIDED BY RN WITH SPECIALIZED INFUSION TRAINING 2001
SE - STATE AND/OR FEDERALLY-FUNDED PROGRAMS/SERVICE 2001
SF - SECOND OPINION ORDERED BY PROF REVIEW ORGANIZATION
SG - AMBULATORY SURGICAL CENTER FACILITY SERVICE

SH - SECOND CONCURRENTLY ADMINISTERED INFUSION THERAPY 2001
SI - SCENE TO TRANSFER SITE
SJ - THIRD OR MORE CONCURRENTLY ADMINISTERED INFUSION THERAPY 2001
SK - MEMBER OF HIGH RISK POPULATION(USE ONLY WITH IMMUNIZATION CODE)2003
SL - STATE SUPPLIED VACCINE(REPLACES 1H) 2003
SM - SECOND SURGICAL OPINION
SN - THIRD SURGICAL OPINION
SQ - ITEM ORDERED BY HOME HEALTH
ST - SCENE TO TRAUMA CENTER(REPLACES 9T FOR J'S) (P)2002 (J)2003
SU - PROCEDURE PERFORMED IN PHYSICIAN'S OFFICE(TO DENOTE USE OF FACILITY AND EQUIPMENT)REPLACES 1M 2003
SV - PHARMACEUTICALS DELIVERED TO PATIENTS HOME BUT NOT UTILIZED 2003
TA - LEFT FOOT, GREAT TOE
TC - TECHNICAL COMPONET 1992,1993
TD - RN (REGISTERED NURSE) 2001
TE - LPN/LVN 2001
TF - INTERMEDIATE LEVEL OF CARE 2001
TG - COMPLEX/HIGH TECH LEVEL OF CARE 2003
TH - OBSTETRICAL TREATMENT/SERVICES, PRENATAL OR POSTPARTUM 2001
TJ - PROGRAM GROUP, CHILD AND/OR ADOLESCENT 2001
TK - EXTRA PATIENT OR PASSENGER, NON-AMBULANCE 2002
TL - EARLY INTERVENTION/INDIVIDUALIZED FAMILY SERVICE PLAN 2002
TM - INDIVIDUALIZED EDUCATION PROGRAM (IEP) 2002
TN - RURAL/OUTSIDE PROVIDERS' CUSTOMARY SERVICE AREA 2002
TP - MEDICAL TRANSPORT, UNLOADED VEHICLE 2002
TQ - BASIC LIFE SUPPORT TRANSPORT BY A VOLUNTEER AMBULANCE PROVIDER 2002
TR - SCHOOL-BASED INDIVIDUALIZED EDUCATION PROGRAM (IEP) SERVICES PROVIDED OUTSIDE THE PUBLIC SCHOOL DISTRICT RESPONSIBLE FOR THE STUDENT 2002
TS - FOLLOW-UP SERVICES 2003
TT - INDIVIDUALIZED SERVICE PROVIDED TO MORE THAN ONE PATIENT IN SAME SETTING 2003
TU - SPECIAL PAYMENT RATE, OVERTIME 2003
TV - SPECIAL PAYMENT RATES, HOLIDAYS/WEEKENDS 2003
TW - BACK-UP EQUIPMENT 2003
T1 - LEFT FOOT, SECOND DIGIT
T2 - LEFT FOOT, THIRD DIGIT
T3 - LEFT FOOT, FOURTH DIGIT
T4 - LEFT FOOT, FIFTH DIGIT
T5 - RIGHT FOOT, GREAT TOE
T6 - RIGHT FOOT, SECOND DIGIT
T7 - RIGHT FOOT, THIRD DIGIT
T8 - RIGHT FOOT, FOURTH DIGIT
T9 - RIGHT FOOT, FIFTH DIGIT
UA - MEDICAID LEVEL OF CARE 10, AS DEFINED BY EACH STATE 2003
UB - MEDICAID LEVEL OF CARE 11, AS DEFINED BY EACH STATE 2003
UC - MEDICAID LEVEL OF CARE 12, AS DEFINED BY EACH STATE 2003
UD - GRAVELY DISABLED (DASA)/LEV OF CARE 13, DEF BY STATE 2003
UE - USED DURABLE MEDICAL EQUIPMENT
UF - SERVICES PROVIDED IN THE MORNING
UG - SERVICES PROVIDED IN THE AFTERNOON
UH - SERVICES PROVIDED IN THE EVENING
UJ - SERVICES PROVIDED AT NIGHT
UK - SERVICES PROVIDED ON BEHALF OF THE CLIENT TO SOMEONE OTHER

UN - TWO PATIENTS SERVED	
UP - THREE PATIENTS SERVED	
UQ - FOUR PATIENTS SERVED	
UR - FIVE PATIENTS SERVED	
US - SIX OR MORE PATIENTS SERVED	
U1 - SYSTEM PRICE AT 100% (REPLACES 5A)	2003
U2 - SYSTEM PRICE AT 50% (REPLACES 5B)	2003
U3 - SYSTEM PRICE AT 100% + TRAUMA ENHANCEMENT	2003
U4 - SYSTEM PRICE AT 50% + TRAUMA ENHANCEMENT	2003
U5 - SYSTEM PRICE AT 100% OF ASSIST FEE + TRAUMA ENHANCEMENT	2003
U6 - SYSTEM PRICE AT 50% OF ASSIST FEE + TRAUMA ENHANCEMENT	2003
U7 - LOCALLY SANCTIONED (DASA)/LEV OF CARE 7, DEF BY STATE	2003
U8 - MEDICAID LEVEL OF CARE 8, AS DEFINED BY EACH STATE	2003
U9 - MEDICAID LEVEL OF CARE 9, AS DEFINED BY EACH STATE	2003
VP - APHAKIC PATIENT	
X1 - DRESSING USED AS PRIMARY/SECONDARY/1 SURG/DEBRIDED WOUND	1996
X2 - DRESSING USED AS PRIMARY/SECONDARY/2 SURG/DEBRIDED WOUND	1996
X3 - DRESSING USED AS PRIMARY/SECONDARY/3 SURG/DEBRIDED WOUND	1996
X4 - DRESSING USED AS PRIMARY/SECONDARY/4 SURG/DEBRIDED WOUND	1996
X5 - DRESSING USED AS PRIMARY/SECONDARY/5 SURG/DEBRIDED WOUND	1996
X6 - DRESSING USED AS PRIMARY/SECONDARY/6 SURG/DEBRIDED WOUND	1996
X7 - DRESSING USED AS PRIMARY/SECONDARY/7 SURG/DEBRIDED WOUND	1996
X8 - DRESSING USED AS PRIMARY/SECONDARY/8 SURG/DEBRIDED WOUND	1996
X9 - DRESSING USED AS PRIMARY/SECONDARY/9 SURG/DEBRIDED WOUND	1996
XX - USE TO SUSPEND AN EXCEPTION FOR DETAIL LINE DENIAL (INTERNAL)	2002
YR - YES REFERRAL	1993
ZX - INSULIN DEPENDENT	1999
ZZ - 3RD SURGICAL OPTION	1993
00 - SURGERY, PRE-OP AND POST-OP	1993
1A - NURSE ANESTHESTIC	1993 - 2003
1C - BABY ON MOMS PIC	1993 - 2003
1H - IMMUNIZATION DRUG OBTAINED FROM HEALTH DEPARTMENT	1993 - 2002
1L - STAT CHARGE	1993
1M - SPECIAL AGREEMENT - SPLIT BILLER OR OTHER (MANUAL PRICE)	1993 - 2003
1P - PURCHASE	1992
1R - CONSULTATION ON X-RAY EXAM (PAYS AS PROFF COMP)	1993 - 2003
2A - SUPERVISORY ANESTHESIA	1993
2B - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 1	2000-2003
2C - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 2	2000-2003
2D - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 3	2000-2003
2E - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 4	2000-2003
2F - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 5	2000-2003
2G - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 6	2000-2003
2H - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 7	2000-2003
2N - NOT DONE AS A PANEL (THRU 1/1/97)	1993
2R - RABIES W/IMMUNIZATION 90742	1998
2T - MEDICAL NUTRITION: ORAL NON-SPEC PROD - PED CRITERIA 8	2000-2003
3A - ANESTHESIA SERVICES	1993
3B - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 1	2000-2003
3C - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 2	2000-2003
3D - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 3	2000-2003
3E - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 4	2000-2003
3F - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 5	2000-2003
3G - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 6	2000-2003

3H - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 7	2000-2003
3J - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 8	2000-2003
3K - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 9	2000-2003
3M - MEDICAL NUTRITION: ORAL SPEC PROD - PED CRITERIA 10	2000-2003
3N - MEDICAL NUTRITION: TUBE FED NON-SPEC PROD-PED CRITERIA 1	2000-2003
3Q - MEDICAL NUTRITION: TUBE FED SPECIALTY PROD-PED CRITERIA 1	2000-2003
3R - MEDICAL NUTRITION: TUBE FED SPECIALTY PROD-PED CRITERIA 2	2000-2003
3T - MEDICAL NUTRITION: TUBE FED NON-SPEC PROD-PED CRITERIA 2	2000-2003
3V - MEDICAL NUTRITION: TUBE FED NON-SPEC PROD-PED CRITERIA 3	2000-2003
3W - MEDICAL NUTRITION: TUBE FED NON-SPEC PROD-PED CRITERIA 4	2000-2003
4A - MEDICAL NUTRITION: ORAL NON-SPEC PROD-ADULTS CRITERIA 1	2000-2003
4B - MEDICAL NUTRITION: ORAL SPECIALTY PROD-ADULTS CRITERIA 1	2000-2003
4C - MEDICAL NUTRITION: TUBE FED NON-SPEC PROD-ADULTS CRITERIA	2000-2003
4D - MEDICAL NUTRITION: TUBE FED SPECIALTY PROD-ADULTS CRIT.	2000-2003
4N - HOMEBOUND	1993
5A - PRIMARY SURGICAL PROCEDURE	1992-2003
5B - SECONDARY SURGICAL PROCEDURE/SECONDARY VENTILATOR	1992-2003
5C - THIRD SURGICAL PROCEDURE	1992-1994
5D - FOURTH SURGICAL PROCEDURE	1992-1994
6N - NO MEDICARE	1993
9A - MEDICAL NUTRITION: PROTEIN - PEDIATRIC CRITERIA 1	2000-2003
9B - MEDICAL NUTRITION: PROTEIN - ADULTS CRITERIA 1	2000-2003
9C - MEDICAL NUTRITION: FATS - PEDIATRIC CRITERIA 1	2000-2003
9D - MEDICAL NUTRITION: FATS - ADULTS CRITERIA 1	2000-2003
9E - MEDICAL NUTRITION: CARBOHYDRATES - PEDIATRIC CRITERIA 1	2000-2003
9F - MEDICAL NUTRITION: CARBOHYDRATES - ADULTS CRITERIA 1	2000-2003
9G - MEDICAL NUTRITION: THICKENERS - PEDIATRIC/ADULTS CRITERIA	2000-2003
9T - MAJOR TRAUMA SERVICE	1998-2003
20 - MICROSURGERY	1992
21 - PROLONGED EVALUATION & MANAGEMENT SERVICES	1993
21 - FOSTER PAYMENT ENHANCEMENT AGE 18 & UNDER (99381-99385,99391-99395) FOR DOS 11/1/01 & AFTER.	2001
22 - UNUSUAL SERVICES	1992,1993
23 - UNUSUAL ANESTHESIA	1993
24 - UNRELATED E/M	1992,1993
25 - SIGNIFICANT SEPARATELY IDENTIFIABLE SERVICE,SAME PHYS	1992,1993
26 - PROFESSIONAL COMPONENTS	1992,1993
27 - TECHNICAL COMPONENTS	1992,1993
28 - TECHNICAL COMPONENT - CAT SCAN OR PROFESSIONAL PATH	1992
29 - PROFESSIONAL COMPONET-CAT SCAN OR TECHNICAL FOR PATH	1992
30 - GENERAL ANESTHESIA / EPIDURAL	1992
32 - MANDATED SERVICES	1993
46 - NURSE ANESTHETISTS	1992
47 - ANESTHESIA BY SURGEON	1993-0000
50 - BILATERAL PROCEDURES	1992,1993
51 - MULTIPLE PROCEDURES OR SURGEONS	1993
52 - REDUCED SERVICES	1992,1993
53 - DISCONTINUED/TERMINATED PROCEDURE	1997
54 - SURGICAL CARE ONLY	1993
55 - POST OP ONLY	1993
56 - PRE OP ONLY	1993
57 - DECISION FOR SURGERY	1994
58 - STAGED OR RELATED PROCEDURE/SERVICE BY SAME DR DURING POST-OP	1994
59 - SEPARATE PROCEDURE	1997

60	ALTERED SURGICAL FIELD	THRU 2001
62	CO-SURGEONS,SAME PROCEDURE	1992,1993
66	TEAM SURGEONS	1993
76	REPEAT PROCEDURE,SAME PHYSICIAN	1992,1993
77	REPEAT PROCEDURE,DIFFERENT PHYSICIAN	1993
78	RETURN TO OPERATING ROOM FOR RELATED PROC DURING POST-OP	1993
79	UNRELATED PROCEDURE	1993
80	ASSISTANT SURGEON	1992,1993
81	MINIMUM ASSISTANT SURGEON	1993
82	ASSISTANT SURGEON (WHEN QUALIFIED RESIDENT SURG NOT AVAIL)	1993
90	REFERENCE LAB	1992,1993
91	REPEAT CLINICAL DIAG LAB TEST (REPLACES QR)	2000
91	STAT CHARGES	1992
95	SUPERVISORY ANESTHESIA	1992
96	SPECIAL AGREEMENT CODES	1992
97	SPECIAL AGREEMENT CODES	1992
98	TEACHING FACILITY	1993
99	MULTIPLE MODIFIERS	1993

- PROVIDER TYPES

15	INDIAN HEALTH CENTERS
17	NOT USED
18	EMERGENCY ROOM PHYSICIAN
19	PSYCHIATRIST
20	PHYSICIAN
21	PHYSICIAN OPERATORY (NOT USED)
22	AMBULATORY SUGERY CENTER
23	CASE MANAGEMENT (EG: MATERNITY, AIDS)
24	HEALTH DEPT
25	RADIOLOGIST
26	PHARMACIST
27	DENTIST (INCLUDES HYGENISTS)
28	OPTOMETRIST
29	OPTICIAN
30	CHIROPRACTOR
31	PSYCHOLOGIST
32	PODIATRIST
33	NURSES SERVICE/NURSE DELEGATION
34	PHYSICAL THERAPIST
35	MATERNITY SUPPORT SERVICES
36	NEURODEVELOPMENTAL CENTERS
37	AUDIOLOGY/SPEECH LANGUAGE PATHOLOGISTS
38	PROSTHETIST/ORTHOTIST
39	DME SUPPLIERS
40	OTHER PROVIDERS
41	BLOOD BANK
42	PRIVATE TRANSPORTATION
43	LAB FACILITY
44	HOME HEALTH AGENCY/NURSE DELEGATION
45	TAXI
46	NURSING FACILITY - EXTENDED CARE FACILITY (ECF)
47	NURSING FACILITY - INTERMEDIATE CARE FACILITY (ICF)
48	ANESTHESIOLOGIST

49 NURSE ANESTHETIST
50 CABULANCE
51 TRANSPORTATION - AMBULANCE
53 AIR AMBULANCE
54 TRANSPORTATION-NON-PROFIT
55 TRANSPORTATION - ITA
57 HOSPITAL-TYPE I(NOT USED)
58 SCHOOL MEDICAL SERVICES
59 HOSPITAL - TYPE III
61 HOSPITAL - FULL CARE (OUT OF STATE/DETOX/CUP)
62 HOSPITAL - KIDNEY CENTERS & WEIGHT LOSS CENTERS
63 HOSPICE AGENCY
64 HOSPITAL - PSYCHIATRIC
65 HOSPITAL - FREE STANDING PSYCH
66 EPSDT/HEALTHY KIDS
71 FAMILY PLANNING CLINIC
73 VOLUNTARY COMMUNITY MENTAL HEALTH
74 INVOLUNTARY COMMUNITY MENTAL HEALTH
75 SUBSTANCE ABUSE
78 OXYGEN - CONTRACT
79 OXYGEN - NON CONTRACT
80 NURSING HOME SKILLED NURSING FACILITY
81 INHALATION THERAPY CONTRACT(EXPIRED 1/1/86)
82 INHALATION THERAPY NON-CONTRACT
83 OXYGEN (REPLACED)
84 HEARING AIDS
85 UNIT DOSE DRUG
86 CONGREGATE CARE (TERM 2/1/84)
87 DAY HEALTH CARE
88 RURAL HEALTH CLINIC
89 IMR FACILITY
90 HEALTH MAINT ORG
93 ADVANCED REGISTERED NURSE PRACTITIONER (NEW CRN)
94 MIDWIFE
95 RN/SURGICAL ASSIST
96 NON-DESIGNATED MEDICAL TRANSPORTATION
97 CORRESPONDENCE
98 LIEN HOLDER
99 TAPE INTERMEDIARY

- PROVIDER SPECIALTIES

01 GENERAL PRACTICE
02 GENERAL SURGERY
03 ALLERGY
04 OTOLOGY-LARYNGOLOGY-RHINOLOGY
05 ANESTHESIOLOGY
06 CARDIOVASCULAR (INTERNAL)
07 DERMATOLOGY
08 FAMILY PRACTICE
09 ORAL SURGERY
10 GASTROENTEROLOGY (INTERNAL)
11 AVIATION MEDICINE (INTERNAL)
12 ORTHODONTICS

13 NEUROLOGY
14 NEUROLOGICAL SURGERY
15 ARNP - MIDWIFE
16 OB - GYNECOLOGY
17 NON-ARNP - MIDWIFE
18 OPHTHALMOLOGY
19 GENERAL DENTIST
20 ORTHOPEDIC SURGERY
22 PATHOLOGY
23 VASCULAR SURGERY
24 PLASTIC SURGERY
25 PHYS MED/REHAB (PHYSIATRIST)
26 DENTAL HYGIENISTS
27 DENTURISTS
28 PROCTOLOGY
29 PULMONARY DISEASE (INTERNAL)
30 RADIOLOGY - DIAGNOSTIC
31 TPL PREMIUM PAYMENTS
32 NUCLEAR MEDICINE
33 THORACIC SURGERY
34 UROLOGY
35 PEDIATRIC PSYCHIATRY
36 PSYCHIATRY
37 SPECIAL CHAMPUS PROVIDERS
40 PEDIATRICS
41 INTERNAL MEDICINE
44 PUBLIC HEALTH
46 EXCEPTIONAL THERAPY CARE
47 MISCELLANEOUS PHYSICIAN
48 PODIATRY
50 AIDS WAIVER/CASE MANAGEMENT
51 MEDICAL SUPPLY/PROSTHETICS/ORTHOTICS
52 MATERNITY CASE MANAGEMENT
53 AIDS CASE MANAGEMENT
54 CHILD CASE MANAGEMENT
55 VULNERABLE ADULT CASE MANAGEMENT
56 MATERNITY SUPPORT SERVICES
57 I.V. THERAPY
59 MEDICAL TRANSPORTATION
60 AGENCY INTERPRETER
61 GENETIC COUNSELING
62 PSYCHOLOGY
63 INDIVIDUAL INTERPRETER
64 AUDIOLOGY
65 PHYSICAL THERAPY
66 OCCUPATIONAL THERAPY
67 RESPIRATORY THERAPY
68 CERTIFIED DIETICIANS
69 LABORATORY - DIAGNOSTIC
70 CLINIC
71 CUPS
72 NURSE FLUORIDE VARNISH
73 CMH PREPAID HEALTH PLANS
75 PHARMACIST

76 SPEECH/LANGUAGE PATHOLOGY & NEURODEVELOPMENTAL CENTERS
77 HOSPITAL PEER A
78 HOSPITAL PEER A
79 HOSPITAL PEER B
80 HOSPITAL PEER C
81 HOSPITAL PEER D
82 ONCOLOGY
83 ENDOCTINOLOGY
84 HEMATOLOGY
85 NEPHROLOGY
86 OTHER HOSPITALS/NURSING HOME
87 MISC. NON/PHY SCHOOL MED
88 OPTICIAN/OPTOMETRY
89 GERIATRICS
90 FQHC
91 HOSPICE
92 DETOX - HOSPITAL
93 DETOX - FREESTANDING
94 BILLING INTERMEDIARY, OTHER STATES MEDICAID, STATE EMPLOYEES-NOT ON NUMBERED MEMO, OTHER WA STATE AGENCIES
95 SPECIAL REQUESTS-CERTAIN CLAIM TYPES ONLY-PROF ASSN
96 ANYONE ON NUMBERED MEMO LIST - CSO, ETC
98 CHIROPRACTOR
99 TAPE INTERMEDIARIES

- BATCH RANGES AND CLAIM TYPES

HARDCOPY (MANUALLY PROCESSED) FOR CLAIMS PRIOR TO JULIAN DATE 00115:

DESCRIPTION	CLAIM TYPE	BATCH RANGE	CAMERA	REEL
PHYSICAN	J			
DOUBLES 1ST REEL		001-025	1	1
DOUBLES 2ND REEL		026-040	1	2
DOUBLES 3RD REEL		041-050	1	3
SINGLES 1ST REEL		051-094	9	1
SINGLES 2ND REEL		095-125	9	2
SINGLES 3RD REEL		126-156	9	3
SINGLES 4TH REEL		157-187	9	4
SINGLES 5TH REEL		188-218	9	5
EPSDT	L			
SPECIALS &				
DOUBLES 1ST REEL		250-274	2	1
SINGLES 2ND REEL		275-299	2	2
MED VENDOR	P			
SPECIALS &				
DOUBLES 1ST REEL		300-325	2	3
SINGLES 2ND REEL		326-350	2	4
UB-92 HOME HEALTH/				
3RD REEL		351-399	2	5

HARDCOPY (KODAK IL70 SCANNED)

PHYSICIAN	J			
EPSDT	L			
MED VENDOR	P			
SINGLES 1ST REEL		126-156	9	6
SINGLES 2ND REEL		157-187	9	7
SINGLES 3RD REEL		188-218	9	8
SINGLES 4TH REEL		219-249	9	9

HARDCOPY (CCIS 7800 SCANNED) EFF 11/15/99, JULIAN DATE: 099319

PHYSICIAN	J			
DOUBLES		001-050	1	1
SINGLES		051-249	9	1
EPSDT	L			
DOUBLES		250-274	2	1
SINGLES		275-299	2	2
MED VENDORS	P			
DOUBLES		300-325	2	3
SINGLES		326-350	2	4
NOT IN USE	N/A	400 - 500	-	-
DRUGS	D	501 - 599	3	1
NURSING HOME (TAD)	T	600 - 674	4	1
	T	690 - 699	5	1
NOT IN USE	N/A	675 - 689	-	-
IN PATIENT	S	700 - 720	5	1
DRG INPATIENT	R	721 - 749	5	1
OUT PATIENT	M	750 - 799	5	1
DENTAL	K	800 - 825	6	1
	K	826 - 849	6	2
NATIONAL STANDARD FORMAT-NSF		000 - 999	7	0
J,P,K,L(ELECTRONIC BATCH WEB)		000 - 999	7	1
		000 - 999	7	2
		000 - 999	7	3
		000 - 999	7	4
		000 - 999	7	5
ELECTRONIC CLAIMS SUB -ECS		000 - 999	7	6
J,P,K,L		000 - 999	7	7
		000 - 999	7	8
ECS ADJUSTMENTS J,P,K,L		000 - 999	7	9
OP/IP HOSP X-OVER	W/V	850 - 860	8	1
PHYS X-OVERS	O	861 - 875	8	1
	O	876 - 899	8	2
EMC CLAIMS			8	8
EMC-MAINFRAME TO MAINFRAME			8	9
R-BASE CLAIMS			9	8
CONSULTEC SPECIAL RUNS			9	9
TAPE CLAIMS			0	0

ADJUSTMENTS	CLAIM TYPE	BATCH RANGE	CAMERA	REEL

PHYSICIANS	I/J	900 - 911	7	1
EPSDT	I/L	-	7	1
MED VENDOR	I/P	-	7	1
DENTAL	I/K	-	7	1
PRU	I	912 - 914	7	1
NURSING HOME	I/T	915 - 919	7	1
OUT PATIENT	I/M	920 - 923	7	1
IN PATIENT	I/S	924 - 926	7	1
DRG	I/R	927 - 929	7	1
CLAIM CREDITS	Z	930	7	1
PHARMACY	I/D	931 - 935	7	1
TPR PHARMACY	I/D	994 - 997	7	1
TPR ADJUSTMENT	I/O	936 - 946	7	1
TPR TRAUMA ADJ	I/O HIST ONLY	947	7	1
MEDICARE ADJS	I/D,V,W	948 - 950	7	1
CASH CONTROL ADJ	I,Q,Z	951 - 952	7	1
HISTORY ONLY:				
CASH CONTROL	I,Q,Z	953 - 957	7	1
RECIPIENT MASS ADJ		958 - 959	7	1
MANAGED CARE ADJ		960 - 968	7	1
CASH CONTROL ADJ		969	7	1
PHYS ADJ - MRS		970 - 979	7	2
MED VENDOR ADJ - MRS		980	7	2
DENTAL ADJ - MRS		NOT NEEDED		
PHARMACY ADJ - MRS (NOT USED)		981	7	2
OUTPATIENT ADJ - MRS		982 - 986	7	2
INPATIENT ADJ - MRS		987 - 988	7	2
DRG ADJ - MRS		989 - 990	7	2
MEDICARE ADJ - MRS		991	7	2
NURSING HOME ADJ - MRS		992	7	2
HOSP. X-OVER ADJ - MRS		993	7	2

--NOTE: BATCH RANGES 994-997 USED ON PREVIOUS PAGE--

MASS ADJ + MASS CREDITS - ELIG	001 - WHATEVER IT TAKES
MASS ADJ + MASS CREDITS	301 - 610

HARDCOPY (MANUALLY PROCESSED) FOR CLAIMS JULIAN DATE 00115 & AFTER:

DESCRIPTION	CLAIM TYPE	BATCH RANGE	CAMERA/REEL	BATCH COVER	
PHYSICAN	J				
MULTI'S		001-025	1	2	ORANGE
MULTI'S 2ND REEL		026-040	1	3	ORANGE
MULTI'S 3RD REEL		041-050	1	4	ORANGE
SINGLES 1ST REEL		051-094	9	2	ORANGE
SINGLES 2ND REEL		095-125	9	3	ORANGE
SINGLES 3RD REEL		126-156	9	4	ORANGE
SINGLES 4TH REEL		157-187	9	5	ORANGE
SINGLES 5TH REEL		188-218	9	6	ORANGE
SINGLES 6TH REEL		219-249	9	7	ORANGE
EPSDT	L				
SPECIALS & MULTI'S		250-274	2	6	CELESTIAL BLUE

SINGLES	275-299	2	7	CELESTIAL BLUE
MED VENDOR P				
SPECIALS & MULTI'S	300-325	2	8	BRIGHT YELLOW
SINGLES	326-350	2	9	BRIGHT YELLOW
HOSPITALS	351-399	2	5	CHERRY
DRUG D	501-599	3	1	SALMON
NURSING HOME (TADS)		4	1	MANILLA ENVELOPE
HOSPITALS				
NURSING HOME (T)	690-699	5	1	BUFF
INPATIENT (S)	700-720	5	1	WHITE/BLUE
DRG (R)	721-749	5	1	BLUE/WHITE/BUFF
OUTPATIENT (M)	750-799	5	1	MINT GREEN/BUFF
DENTAL K				
SPECIALS & MULTI'S	800-814	6	1	YELLOW
SINGLES	815-834	6	2	YELLOW
SINGLES	835-849	6	3	YELLOW
ADJUSTMENTS I				
PHYSICIANS I/J	900	7	1	PINK
EPSDT I/L		7	1	PINK
MED VENDOR I/P		7	1	PINK
NON-INST CROSSOVER I/O	910	7	1	PINK
DENTAL I/K	911-912	7	1	PINK
PRU	913-914	7	1	BRIGHT GREEN
NURSING HOME I/NH	915-919	7	1	PINK
OUTPATIENT I/M	920-923	7	1	PINK
INPATIENT I/S	924-926	7	1	PINK
DRG I/R	927-929	7	1	PINK
CLAIM CREDITS Z	930	7	1	DARK GREEN
PHARMACY I/D	931-933	7	1	PINK
MEDICARE CROSSOVER I/W	934-935	7	1	PINK
TPL ADJ I/OI	936-946	7	1	CANARY
TPL TRAUMA	947	7	1	CANARY
MEDICARE ADJ	948-950	7	1	PINK
CASH CONTROL I/Q	951-952	7	1	GREEN
CASH CONTROL I/Q,Z	953-957	7	1	GREEN
RECIPIENT MASS ADJ	958-959	7	1	GREEN
MANAGED CARE I/J	960-968	7	1	GREEN
CASH CONTROL ADJ	969	7	1	GREEN
MRS PHYSICIANS	970-978	7	2	SALMON
MRS DENTAL	979	7	2	SALMON
MRS MED VENDOR	980-981	7	2	SALMON
MRS OUTPATIENT	982-986	7	2	SALMON
MRS INPATIENT	987-988	7	2	SALMON
MRS DRG	989-990	7	2	SALMON
MRS MEDICARE	991	7	2	SALMON
MRS NURSING HOME	992	7	2	SALMON
MRS HOSPITAL CROSSOVER	993	7	2	SALMON
MRS PHARMACY	994-997	7	2	CELESTIAL BLUE

QRS REGULAR		001-010	7	7	CELESTIAL BLUE
QRS HISTORY ONLY		011-448	7	7	AQUA
MMIS SERVICES/GROSS ADJ		449	7	7	CANARY YELLOW
QUS REGULAR		450-475	7	7	GAMMA GREEN
QUS HISTORY ONLY		476-500	7	7	GAMMA GREEN
PIP HISTORY ONLY		501-999	7	7	FIREBALL FUSCIA
MEDICARE/MEDICAID HOSP W		850-860	8	1	GREY
MEDICARE/MEDICAID O		861-875	8	2	GOLD
MEDICARE/MEDICAID O		876-899	8	3	GOLD

HARDCOPY (MANUALLY PROCESSED) EXAM ENTRY - NON-OCR
FOR CLAIMS JULIAN DATE 00308 & AFTER:

DESCRIPTION	CLAIM TYPE	BATCH RANGE	CAMERA/REEL		BATCH COVER
PHYSICAN	J				
MULTI'S		001-050	1	2	ORANGE
SINGLES		051-249	9	2	ORANGE
EPSDT	L				
MULTI'S		250-274	2	6	CELESTIAL BLUE
SINGLES		275-299	2	7	CELESTIAL BLUE
MED VENDOR	P				
MULTI'S		300-325	2	8	BRIGHT YELLOW
SINGLES		326-350	2	9	BRIGHT YELLOW
UB92 HOME HEALTH SINGLES		351-379	2	0	CHERRY
UB92 HOME HEALTHMULTI'S (EFFECTIVE 12/1/03 HOME HEALTH CLAIMS ARE PROCESSED M CLAIM TYPE)		380-399	2	5	CHERRY
DRUG	D	501-599	3	1	SALMON
NURSING HOME (TADS)			4	1	MANILLA ENVELOPE
HOSPITALS					
NURSING HOME (T)		690-699	5	1	BUFF
INPATIENT (S) MULTI'S		700-720	5	2	WHITE/BLUE
DRG (R) SINGLES		721-729	5	3	BLUE/WHITE/BUFF
DRG (R) MULTI'S		730-749	5	4	BLUE/WHITE/BUFF
OUTPATIENT (M) MULTI'S		750-784	5	5	MINT GREEN/BUFF
OUTPATIENT (M) SINGLES		785-799	5	6	MINT GREEN/BUFF
DENTAL	K				
MULTI'S		800-814	6	1	CANARY
SINGLES		815-849	6	2	CANARY
ADJUSTMENTS	I				
PHYSICIANS I/J		900	7	1	PINK
EPSDT I/L			7	1	PINK
MED VENDOR I/P			7	1	PINK
NON-INST CROSSOVER I/O		910	7	1	PINK
DENTAL I/K		911-912	7	1	PINK

PRU	913-914	7	1	BRIGHT GREEN
NURSING HOME I/NH	915-919	7	1	PINK
OUTPATIENT I/M	920-923	7	1	PINK
INPATIENT I/S	924-926	7	1	PINK
DRG I/R	927-929	7	1	PINK
CLAIM CREDITS Z	930	7	1	DARK GREEN
PHARMACY I/D	931-933	7	1	PINK
MEDICARE CROSSOVER I/W	934-935	7	1	PINK
TPL ADJ I/OI	936-946	7	1	CANARY
TPL TRAUMA	947	7	1	CANARY
MEDICARE ADJ	948-950	7	1	PINK
CASH CONTROL I/Q	951-952	7	1	GREEN
CASH CONTROL I/Q,Z	953-957	7	1	GREEN
RECIPIENT MASS ADJ	958-959	7	1	GREEN
MANAGED CARE I/J	960-968	7	1	GREEN
CASH CONTROL ADJ	969	7	1	GREEN
MRS PHYSICIANS	970-978	7	2	SALMON
MRS DENTAL	979	7	2	SALMON
MRS MED VENDOR	980-981	7	2	SALMON
MRS OUTPATIENT	982-986	7	2	SALMON
MRS INPATIENT	987-988	7	2	SALMON
MRS DRG	989-990	7	2	SALMON
MRS MEDICARE	991	7	2	SALMON
MRS NURSING HOME	992	7	2	SALMON
MRS HOSPITAL CROSSOVER	993	7	2	SALMON
MRS PHARMACY	994-995	7	2	CELESTIAL BLUE
H.O. FQHC RHC	996-997	7	2	BLUE
DRUG REBATE PHARMACY	998-999	7	2	LILAC
CROSSOVERS				
UB92 (V & W) MULTI'S	850-860	8	1	GREY
HCFA 1500 (O) MULTI'S	861-899	8	2	GOLD

- DRUG DISPENSING FEES

DATE	HIGH VOLUME	MID VOLUME	LOW VOLUME/UNIT DOSE
09-01-87	3.05	3.45	3.85
09-01-88	3.15	3.60	4.20
01-01-90	3.24	3.71	4.33
07-01-92	3.45	3.75	4.38
07-01-93	3.65	3.90	4.50
07-01-95	3.72	3.98	4.59
07-01-96	3.79	4.06	4.68
07-01-97	3.90	4.18	4.82
07-01-99	3.98	4.26	4.92
07-01-00	4.06	4.35	5.02
07-01-01	4.14	4.44	5.12
07-02-02	4.20	4.51	5.20

COMPOUNDING FEES:	EFFECTIVE 7/1/95-2/29/96	15.91/HR	1.33 / 5 MIN
	EFFECTIVE 1/1/93	15.60/HR	1.30 / 5 MIN
	EFFECTIVE 7/1/92	15.25/HR	1.27 / 5 MIN

- PROCEDURE CODE RANGES

PHYSICIAN'S SMAPD CODE RANGES

SURGERY: 10000-69999, 2960M-2977M, 5930M, 5941M-5959M

RADIOLOGY: 70000-79999, 7612M-7614M, 7698M, R0070-R0076, G0062-G0063

PATHOLOGY & LABORATORY: 80000-89999, 8000M-8001M, 8720M, G0001, G0026-G0027, G0050, G0058-G0060, G0095-G0098, P3001, Q0111-Q0115

MEDICINE: 99201-99999, 0001M-0002M, 9011M-9012M, 9018M-9019M, 9020M-9029M, 9076M, 9083M-9089M, 9084M, 9254M-9274M, 9301M-9303M, 9593M, 9907M, M0006-M0008, P0000,P0007

DEPARTMENT ASSIGNED CODES FOR SERVICES NOT COVERED IN CPT4

0100M	GENERAL DENTAL ANESTHESIA	0300M - 0305M	HMO ADJUSTMENTS
1600L	PODIATRY ORTHOTICS	0310M	DD PHYSICAL - IMR FACILITY
1601L	PAIR OF ORTHOTICS	5999M	INDIAN HEALTH

- PROCEDURE CODES

ITA

0264M	INTAKE EVALUATION IN-FACILITY
0265M	INTAKE EVALUATION OUT-FACILITY
0272M	MEDICATION MANAGEMENT, INDIVIDUAL IN-FACILITY
0273M	MEDICATION MANAGEMENT, INDIVIDUAL OUT-FACILITY
0274M	MEDICATION MANAGEMENT, GROUP IN-FACILITY

PM & R

0030M	BRIEF PM&R SERVICE
0031M	LIMITED PM&R SERVICE
0032M	INTERMEDIATE PM&R SERVICE
0033M	EXTENSIVE PM&R SERVICE
0034M	INTERMEDIATE PM&R SERVICE
0035M	COMPREHENSIVE PM&R SERVICE

AND PHYSICAL

SUBSTANCE ABUSE

REG TITLE XIX PRE/POSTPARTUM CLIENT SERVICE
(DIFFERENT CATEGORIES ARE ACCOUNTING PURPOSES ONLY)

0140M	0150M	CHEMICAL DEPENDENCE ASSESSMENT
0141M	0151M	INTAKE/EVALUATION
0142M	0152M	PHYSICAL EXAMINATION
0143M	0153M	IND THERAPY - FULL VISIT
0144M	0154M	IND THERAPY - BRIEF VISIT
0145M	0155M	GROUP THERAPY
0146M	0156M	CHEMOTHERAPY (METHADONE ONLY)
0147M	0157M	MEDICATION ADJUSTMENT (ONLY)

CMH - VOLUNTARY - OP

0260M	CRISIS SERVICE IN-FACILITY, 15 MINUTES
0261M	CRISIS SERVICE OUT-FACILITY, 15 MINUTES

0263M STABILIZATION SERVICE OUT-FACILITY, 1 HR.
0264M INTAKE EVALUATION IN-FACILITY, 15 MINUTES
0265M INTAKE EVALUATION OUT-FACILITY, 15 MINUTES
0266M SPECIAL POPULATION EVALUATION IN-FACILITY, 15 MINUTES
0267M SPECIAL POPULATION EVALUATION OUT-FACILITY, 15 MINUTES
0268M INTERDISCIPLINARY EVALUATION IN-FACILITY, 15 MINUTES
0269M INTERDISCIPLINARY EVALUATION OUT-FACILITY, 15 MINUTES
0270M PSYCHOLOGICAL ASSESSMENT IN-FACILITY, 15 MINUTES
0271M PSYCHOLOGICAL ASSESSMENT OUT-FACILITY, 15 MINUTES
0272M MEDICATION MANAGEMENT INDIVIDUAL, IN-FACILITY
0273M MEDICATION MANAGEMENT INDIVIDUAL, OUT-FACILITY
0274M MEDICATION MANAGEMENT GROUP, IN-FACILITY
0275M MEDICATION MANAGEMENT GROUP, OUT-FACILITY
0276M INDIVIDUAL THERAPY IN-FACILITY, 15 MINUTES
0278M GROUP THERAPY IN-FACILITY, 15 MINUTES
0279M GROUP THERAPY OUT-FACILITY, 15 MINUTES
0280M ADULT DAY TREATMENT IN-FACILITY, 15 MINUTES
0281M ADULT DAY TREATMENT OUT-FACILITY, 15 MINUTES
0282M ADULT ACUTE DIVERSION IN-FACILITY, 15 MINUTES
0283M ADULT ACUTE DIVERSION OUT-FACILITY, 15 MINUTES
0284M CHILD & ADOLESCENT DAY TREATMENT IN-FACILITY, 15 MINUTES
0285M CHILD & ADOLESCENT DAY TREATMENT OUT-FACILITY, 15 MINUTES
0286M CHILD & ADOLESCENT ACUTE DIVERSION IN-FACILITY, 15 MINUTES
0287M CHILD & ADOLESCENT ACUTE DIVERSION OUT-FACILITY, 15 MINUTES

NURSE DELEGATION
8900N INITIAL NURSE ASSESSMENT
8901N REASSESSMENT
8902N TEACHING OF A TASK
8903N SUPERVISORY REVIEW

- DUMMY DIAGNOSIS CODES

SERVICE	CODE
ANESTHESIA	V709
APPLIANCES AND/OR PHARMACIST	V589
BLOOD	V582
CASE MGT (CHILDREN/MATERNITY)	V61.22
COMMUNITY MENTAL HEALTH	3009
DAY HEALTH CARE	V950
DETOX	3035
SUBSTANCE ABUSE	303.9 (ALCOHOL) 304.9 (DRUG)
HEALTHY KIDS	V960 OR V20.2
FAMILY PLANNING	V999
HEARING AIDS	V532
HMO ADJUSTMENTS	V990
ICF-MR-DD	V930
INCAPACITY REVIEW (GAU)	V72.99
INTERPRETATIVE SERVICES	V65.19
LAB	V726
NUTRITIONAL COUNSELING	V653
OPTICIAN	V531
OPTOMETRIST	V720

OXYGEN & RESPIRATORY THERAPY	V814
PHARMACIST AND/OR APPLIANCES	V589
TRANSPORTATION	V900
X-OVER AND X-OVER IH	V980
X-RAY	V728

- HCFA 1500 PLACE OF SERVICE CONVERSIONS

MEDICARE / MEDICAID		MEDICARE / MEDICAID		MEDICARE / MEDICAID	
IH	1	NCF	1	IL	3
OH	2	NH	8	OMS	3
O	3	SNF	8	RIC	3
H	4	AMB	3	STF	3
DCF	3	OL	9		

- PATIENT STATUS CODES

NURSING HOMES

0 DISCHARGE-ON-SAME-DAY-AS-ADMIT	
1 TRANSFER TO HOSPITAL	6 - NOT DISCHARGED
2 DISCHARGE TO ANOTHER SNF	7 - TRANSFER TO STATE HOSPITAL
3 TRANSFER TO NURSING HOME	8 - LEAVE OF ABSENCE
4 DEATH	9 - TRANSFER TO CONGREGATE CARE
5 DISCHARGE TO HOME, HOSPICE, PRIVATE PAY, OR OTHER	

UB - 92

01 DISCHARGED TO HOME	06 - DISCHARGED TO HOME HEALTH
02 TRANSFER TO ANOTHER HOSPITAL	07 - LEFT AGAINST MEDICAL ADVICE
03 DISCHARGE TO SNF	08 - DISCHARGE TO HOME W/IV THRPY
04 DISCHARGE TO ICF	20 - EXPIRED
05 TRANSFER TO EXEMPT UNIT/HOSP	30 - STILL PATIENT

- MAIL STOPS

OFFICE	MAIL STOP	CONTACT
AGING & ADULT SERVICES	QG-16/5600	
ALCOHOL & SUBSTANCE ABUSE	OB 21-W/5330	
CHILDRENS' COORDINATED SERVICES (CCS)	LC 11-B	
DDD/MEDICAL ASSISTANCE LIASON	OB 42-C/5310	WALT BOWEN
DISABILITY INSURANCE	LN - 11/5550	
DISBURSEMENTS	OB 24-B/5845	
DIVISION OF MENTAL HEALTH	OB 42-F/5320	
LABOR AND INDUSTRIES	HC - 271	
LICENSING	PB - 01	
MEDICAID FRAUD SECTION (SCAN 462-2154)	WT - 32	
MEDICAID QUALITY CONTROL	OB 31-H	
MEDICAL REVIEW SECTION (OAMR)	HB-13/5510	
MEDICALLY INTENSIVE COMMITTEE (DDD)	OB 42-C	CHUCK HOWARD
REGIONAL MEDICAL UNIT	N 56-5	
SERVICES FOR THE BLIND	BOX 18379	SEATTLE, WA 98118
THIRD PARTY LIABILITY - CASUALTY	45561	SHARON BLACK
THIRD PARTY LIABILITY -HEALTH/CLAIMS	45565	

VENDOR REVIEW OB - 33/5804 MEL HILL
VOC REHAB OB 21-C/5340

- BORDER AREAS

ASTORIA, OR	PORTLAND, OR	LEWISTON, ID
HERMISTON, OR	RANIER, OR	MOSCOW, ID
HOOD RIVER, OR	THE DALLES, OR	PRIEST RIVER, ID
MILTON-FREEWATER, OR	COEUR D ALENE, ID	SANDPOINT, ID

- METRIC CONVERSION CHART

1 INCH - 2.54 CM	6 INCHES - 15.24 CM
2 INCHES - 5.08 CM	7 INCHES - 17.78 CM
3 INCHES - 7.62 CM	8 INCHES - 20.32 CM
4 INCHES - 10.16 CM	9 INCHES - 22.86 CM
5 INCHES - 12.70 CM	10 INCHES - 25.40 CM
1 CENTIMETER - .3937 INCH	30 CENTIMETERS - 11.81 INCHES

- COMMUNITY SERVICE ORGANIZATIONS (CSO'S)

CTY #	NAME	MAIL STOP	CTY #	NAME	MAIL STOP
01	OTHELLO	B13-2	5-8	NEAH BAY	L5-8
02	CLARKSTON/ASOTIN	B2-1	06	VANCOUVER	S6-1
03	PASCO/BENTON	B11-1	07	DAYTON	S7-1
04	WENATCHEE/CHELAN	B4-1	08	KELSO	S8-1
05	PORT ANGELES	B5-1	09	WENATCHEE/DOUGLAS	B4-1
10	REPUBLIC	B10-01	23	SHELTON	B23-1
11	PASCO	B11-1	24	OKANOGAN	B24-01
11-3	RICHLAND	B11-1	25	SOUTH BEND	B25-1
	KENNEWICK	B03-04	26	NEW PORT	B26-1
13	MOSES LAKE	B13-1	27	TACOMA	N27-5
			28	FRIDAY HARBOR	B29-10
13-2	RITZVILLE	B1-1	29	MOUNT VERNON	B29-1
14	ABERDEEN	B14-1	30	STEVENSON	B30-1
14-2	ELMA	B14-2	31	EVERETT	N31-1
15	OAK HARBOR	B15-1	32	SPOKANE/CENTRAL	B32-3
16	PORT TOWNSEND	B16-1	33	COLVILLE	B33-1
17	PUYALLUP HCS CSO	N51-2	34	OLYMPIA	KR-11
18	BREMERTON	B18-1	35	CATHLAMET	B32-1
19	ELLENSBURG	B19-1	36	WALLA WALLA	B36-1
20	WHITE SLAMON	B20-1	37	BELLINGHAM	B37-1
21	CHEHALIS	S21-1	38	COLFAX	B38-1
22	DAVENPORT	B22-1	38-2	PULLMAN	B38-2
22-1	LINCOLN	B22-1	39	YAKIMA	B39-1
40	KING EASTSIDE	N40-1	58	SPOKANE EAST	B32-1
41	RAINIER	N41-1	59	SPOKANE NORTH	B32-4
42	KING/NORTH/BALLARD	N42-1	60	SPOKANE SOUTHWEST	B32-2
43	KING SOUTH	N43-01	61	ELMA	B14-2
44	BURIEN	N44-1	62	GOLDENDALE	B20-2
45	FEDERAL WAY	N45-1	64	FORKS	B64-01
46	CAPITOL HILL	N46-1	65	SMOKEY POINT	B65-1
47	BELLTOWN	N47-1	66	PIERCE LTC	N66-1

48	PIERCE SOUTH	N48-1	67	PIERCE WEST	N67-1
49	PIERCE NORTH	N49-1	68	SKYKOMISH VALLEY	N68-1
50	TOPPENISH	B50-1	69	YAKIMA/KITTITAS	B39-2
51	PUYALLUP VALLEY	N51-1	70	GRANDVIEW/SPOKANE DCYFS IF FOSTER CARE (PROG D)	
52	MOUNTAINLAKE TERR	N52-1	71	LONG BEACH	B25-5
53	ORCHARDS	S53-1	72	CHILD & FAMILY SVCS.	OB-41
54	SUNNYSIDE	B54-1	73	REFUGEE ASSISTANCE	OB-318
55	WEST SEATTLE	B55-1	74	KING NORTH/LAKE CITY	N74-1
56	KING LTC	B56-1	75	WAPATO	B75-1
57	PROSSER	45531	76	MEDS	45531
		B57-1	80	HOLGATE/RENTON	N95-1

- MEDICAL CONSULTANTS

NAME	CITY/OFFICE	MAIL STOP
BAUMGARTNER, JOAN, MD (MAC)	MAA/OLYMPIA	5506
COOLEN, PHYLLIS, RN (NCC)	MAA/OLYMPIA	5506
HUTCHINSON, JAMES DDS (MAC)	MAA/OLYMPIA	5506
BRUNSKILL, ANDREW, M.D. (HCA)	MAA/OLYMPIA	5506
ROGERS,JOHN ORTHODONTIC (MAC)	MAA/OLYMPIA	5506
HOUGHTON, ERIC MD (MAA)	MAA/OLYMPIA	5506
SALAMA, SAMUEL MD (MAC)	MAA/OLYMPIA	5506

- ADJUSTMENT RETURN GUIDELINES

THE FOLLOWING ARE THE ONLY INSTANCES WHICH AN ADJUSTMENT REQUEST (FORM 525-109) IS TO BE RETURNED TO THE PROVIDER.

1. ALL ADJUSTMENTS
   A. IMPROPER COMPLETION-RETURN FOR THESE REASONS UNLESS RA ATTACHED:
      1) ICN MISSING, INCOMPLETE, OR MORE THAN ONE ON THE ADJUSTMENT REQUEST FORM.
      2) PIC MISSING OR INCOMPLETE.
      3) DATE(S) OF SERVICE MISSING.
      4) INFORMATION ON ADJUSTMENT REQUEST IS NOT CONSISTENT WITH INFORMATION ON REMITTANCE ADVICE.
      5) INSUFFICIENT INFORMATION GIVEN (I.E. CORRECTION NOT MADE AND/OR UNCLEAR).
      6) ADJUSTMENT OR CORRECTION HAS ALREADY BEEN MADE.
      7) MULTIPLE ADJUSTMENT REQUESTS SUBMITTED FOR SAME CLAIM #. (MAY BE REQUESTING THE SAME OR DIFFERENT CORRECTIONS.)
      8) PROVIDER INQUIRY.

   B. CONFLICT WITH BILLING INSTRUCTIONS - RETURN FOR THE FOLLOWING:
      1) ADJUSTMENT SUBMITTED FOR CLAIM DENIED WITH EOB 015 OR 010.
      2) RA DATE OVER 12 MONTHS OLD. (EXCEPT: EXCEPTIONS TO POLICY BY STATE OFFICE, I.E., MEDICAL CONSULTANT, ETC.)
      3) ADJUSTMENT SUBMITTED FOR A CLAIM IN SUSPENSE STATUS
      4) ORIGINAL CLAIM WAS RETURNED ON A RETURN LETTER. IF ADJUSTMENT REQUEST CONTAINS ALL NECESSARY INFORMATION AND THAN RETURNING IT TO PROVIDER. EXCEPTION: HOSPITAL CLAIM TYPES (M,R,S) - CAN PROCESS A RETURNED CLAIM AS AN ADJUSTMENT.

C. ADDITIONAL INFORMATION REQUIRED - INFORMATION ON THE REMITTANCE REPORT & ITEM(S) TO BE CORRECTED MUST BE SUFFICIENTLY STATED TO ENTER PROPERLY INTO THE SYSTEM. PERTINENT SUPPORTING DOCUMENTS MUST BE ATTACHED PRIOR TO MICROFILMING (I.E. MEDICAL CONSULTANT PRICING, AUTH, ETC.).

2. HOSPITAL ADJUSTMENT ONLY MAY BE RETURNED FOR:
   A. INCOMPLETE, MISSING OR IMPROPER PROVIDER NUMBER.
   B. DOLLAR AMOUNTS NOT INDICATED FOR PROCEDURE CODE BREAKDOWN.
   C. REQUEST TO RECOUP PORTION OF PAYMENT BUT REVENUE/PROCEDURE CODE(S) AND/OR DOLLAR AMOUNT(S) NOT GIVEN.

3. TPL ONLY - TPL ADJUSTMENT REQUESTS MAY BE RETURNED FOR THE FOLLOWING:
   A. ADJUSTMENT IS A DUPLICATE OF AN ADJUSTMENT ALREADY PROCESSED.
   B. THE DSHS EOB ON THE RA SHOWS 147 BUT THE CLAIM WAS ACTUALLY DENIED FOR A CLAIMS PROCESSING REASON, RETURN THE ADJUSTMENT TO THE PROVIDER ADVISING THEM OF THE CORRECT DENIAL.
   C. WRONG INSURANCE EOB ATTACHED; I.E. WRONG INSURANCE CO., DIFFERENT DATE(S) OF SERVICE, OR DIFFERENT PATIENT.

4. V & W CLAIM TYPE - HOSPITAL CROSSOVER CLAIMS MAY BE RETURNED FOR THE FOLLOWING:
   A. WRONG CLAIM FORM USED - MUST BE BILLED ON UB-82.
   B. SUBMITTED MEDICARE RA DOES NOT MATCH CLAIM.
   C. MEDICARE RA INDICATES NO PAYMENT DUE FROM DSHS.
   D. NO RA ATTACHED - PROVIDER INDICATES AMOUNT BUT CANNOT VERIFY IF IT'S CO-INSURANCE OR MEDICARE PAYMENT.
   E. AMOUNT OWED IS GREATER THAN BILLED AMOUNT - NO RA ATTACHED

- MEDICAL VENDOR NONCOVERED MEDICAL EQUIPMENT AND SUPPLIES

MAA SHALL SPECIFICALLY EXCLUDE FROM THE FEE-FOR-SERVICE SCOPE OF COVERAGE THE FOLLOWING SVS,EQUIPMENT AND SUPPLIES UNLESS: 1) PRESCRIBED BY A EPSDT/HEALTH KIDS PROVIDER, 2) INCLUDED AS PART OF A MANAGED CARE PLAN SV PACKAGE, 3) INCLUDED IN A WAIVERED PROGRAM, OR 4) PART OF ONE OF THE MCARE PROGRAMS OF QUALIFIED MCARE BENEFICIARIES.

1. SVS,PROCEDURES,TREATMENT,DEVICES,DRUGS OR APPLICATION OF ASSOCIATED SVS WHICH THE DEPARTMENT OR HCFA CONSIDERS INVESTIGATIVE OR EXPERIMENTAL ON THE DOS PROVIDED.
2. MORE COSTLY SVS OR EQUIPMENT WHEN LESS COSTLY,EQUALLY EFFECTIVE SVS OR EQUIPMENT, AS DETERMINED BY THE DEPARTMENT, ARE AVAILABLE.
3. ANY SVS SPECIFICALL EXCLUDED BY STATUTE.
4. NONMEDICAL EQUIPMENT, SUPPLIES & RELATED SERVICES INCLUDING, BUT NOT LIMITED TO:
   A. ENVIRONMENTAL CONTROL DEVICES, SUCH AS:AIR CONDITIONERS, AIR CLEANERS/PURIFIERS, DEHUMIDIFIERS, PORTABLE RM HEATERS OR FANS, AND HEATING OR COOLING PADS.
   B. EXERCISE EQUIP SUCH AS THERAPY MATS, BICYCLES, TRICYCLES, STAIR STEPPERS, WEIGHTS, AND TRAMPOLINES.
   C. MUSCLE STIMULATORS
   D. ERGONIMIC EQUIPMENT

E. RACING STROLLERS/WHEELCHAIRS
F. WHEELED POSITIONING, LOUNGE OR RECLINING CHAIRS, AND/OR LIFT CHAIRS
G. ENURESIS(BED WETTING) TRAINING EQUIPMENT
H. BEDS (OTHER THAN HOSPITAL), BED BOARDS/CONVERSION KITS, AND BED LIFTERS
I. INFLATABLE BED BATHS, SITZ BATH, PARAFFIN BATH UNITS & SHAMPOO RINGS
J. COMMUNICATION EQUIPMENT & SVS INCLUDING, BUT NOT LIMITED TO: 2-WAY RADIOS,EMERGENCY RESPONSE SYST SVS, DEVICES INTENDED TO AMPLIFY OR REDUCE BACKGROUND NOISE, AND RENTAL OF RELATED EQUIPMENT OR SVS.
K. COMPUTERS, COMPUTER SOFTWARE, COMPUTER ACCESSORIES (E.G. ANTI-GLARE SHIELDS, BACKUP MEMORY CARDS), COMPUTER EQUIPMENT OTHER THAN SPECIFIED IN WAC 388-543-2900, AND AUGMENTATIVE COMMUNICATION DEVICES.
L. DIATHERMY AND DIAPULSE MACHINES
M. VACUUM CLEANERS,CARPET CLEANERS/DEODORIZERS,AND/OR INSECTICIDES
N. ROOM FRESHENERS/DEODORIZERS
O. CLEANING BRUSHES AND SUPPLIES, EXCEPT FOR OSTOMY-RELATED CLEANERS/SUPPLIES AS PROVIDED UNDER WAC 388-543-1800,REIMBURSE-MENT METHODOLOGY FOR MEDICAL SUPPLIES AND NONDURABLE EQUIPMENT
P. IDENTIFICATION BRACELETS
Q. CAR SEATS FOR CHILDREN UNDER 5, EXCEPT FOR POSITIONING CAR SEATS THAT ARE PRIOR AUTHORIZED, AS PROVIDED UNDER WAC 388-543-2200, ITEMS & SVS REQUIRING PRIOR AUTHORIZATION.
R. GENERATORS AND
S. INSTRUCTION MATERIALS, SUCH AS PAMPHLETS AND VIDEOSTAPES.
T. POUCHES, BAGS, BASKETS OR OTHER CARRYING CONTAINERS FOR USE WITH WHEELCHAIRS, WALKERS

5. WHEELCHAIR FEATURES AND OPTIONS ARE NOT CONSIDERED BY THE DEPT TO BE MEDICALLY NECESSARY OR ESSENTIAL FOR WHEELCHAIR USE. THESE FEATURES AND OPTIONS INCLUDE, BUT ARE NOT LIMITED TO:
SPEED CONVERSIONS KITS, TIE-DOWN RESTRAINTS, LIGHTING SYSTEMS, WARNING DEVICES (HORNS, BACKUP SIGNALS), CANOPIES, INCLUDING THOSE FOR STROLLERS & OTHER EQUIP. CLOTHING GUARDS, ID DEVICES AND ATTENDANT CONTROLS (REMOTE CONTROL DEVICES).

6. PERSONAL AND COMFORT ITEMS INCLUDING, BUT NOT LIMITED TO:
RADIO & TV, TELEPHONES, TELEPHONE ARMS, CELL PHONES, ELECTRONIC BEEPERS & OTHER PHONE MESSAGING SVS. BEDDING ITEMS,SUCH AS SHEETS, PILLOWS, BLANKETS, MATTRESS COVERS/BAGS, (REUSABLE) BED PADS, TOOTHETTES & TOOTHBRUSHES, WATERPICS, OR PERIODONTAL DEVICES WHETHER MANUAL, BATTERY OPERATED OR ELECTRIC. BEDSIDE ITEMS SUCH AS CARAFES, BED TRAYS OR OVER THE BED TRAYS, EATING/FEEDING UTENSILS, HOT OR COLD TEMP FOOD & DRINK CONTAINER/HOLDER EMESIS BASINS, ENEMA BAGS, DIAPER WIPES,IMPOTENCE DEVICES, HOT WATER BOTTLES AND COLD/HOT PACKS OR PADS,DIVERTER VALVES FOR BATHTUB.BATHRM ITEMS SUCH AS:WEIGHT SCALES,TOWELS,SHOWER CURTAINS,SHOWER CAP,SOAP,SHAMPOO,CONDITIONER,SOAP,BATH GEL MOISTURIZER,ASTRINGENT,TOOTHPASTE,DEODORANT,ANTIPERSPIRANT, MOUTHWASH,SHAVING CREAM,POWDER,COSMETICS,INCLUDING CORRECTIVE FORMULATIONS,TANNING,SUNSCREEN PRODUCTS,INSECT REPELLENTS,

MEDICINE CABINET & FIRST AID ITEMS SUCH AS:THERMOMETERS, BANDAIDS,TONGUE DEPRESSORS,MEDICINE CUPS,COTTON-TIPPED SWABS, COTTON BALLS & SCISSORS,MEDICATION DISPENSERS,SUCH AS:MED-COLLATORS & COUNT-A-DOSE,PAGE TURNERS,REACHERS,MASSAGE EQUIP, HEALTH CLUB MEMBERSHIPS,CLOTHING & ACCESSORIES SUCH AS:COATS, HATS,SCARVES,GLOVES (INCLUDING WC GLOVES)SOCKS/SLIPPERS, CLOTHING PROTECTORS & OTHER PROTECTIVE COVERING AGAINST INCONTINENCE.

7. HOME IMPROVEMENTS SUCH AS:
SECURITY SYST,BURGLAR ALARMS,CALL BUTTONS,LIGHTS,LIGHT DIMMERS AND SIMILAR DEVICES,AUTOMATIC DOOR OPENERS FOR THE HOUSE OR GARAGE,TIMERS OR ELECTRONIC DEVICES (ON/OFF),WHIRLPOOL SYST SUCH AS JACUZZI,HOT TUB OR SPA,SWIMMING POOLS,SAUNAS, WC LIFTS OR RAMPS FOR THE HOME,ELEVATOR SYST AND/OR STAIR LIFTS, ELECTRICAL WIRING FOR ANY REASON AND ANY STRUCTURAL MODIFICATION TO THE HOME

8. BILIRUBIN LIGHTS, EXCEPT AS RENTALS, FOR AT-HOME NEWBORNS WITH JAUNDICE.

9. SUPPLIES AND EQUIP USED DURING A PHYSICIAN OFFICE VISIT, SUCH AS TONGUE DEPRESSORS & SURGICAL GLOVES.

10. SUPPLIES & EQUIP OBTAINABLE FROM OR PROVIDED FOR FREE BY COMMUNITY SVS ORGANIZATION

11. MATERIALS OR SVS COVERED UNDER MANUFACTURERS' WARRANTIES

12. REPLACEMENT BATTERIES FOR HEARING AID & OTHER EQUIP, EXCEPT AS STATED IN WAC 388-543-1200(5).

13. PROCEDURES,PROSTHETICS,OR SUPPLIES RELATED TO GENDER DYSPHORIA SURGERY,EXCEPT WHEN RECOMMENDED UNANIMOUSLY BY A MULTI-DISCIPLINARY TEAM OF SPECIALISTS IN SEXUAL REASSIGNMENT SURGERY AFTER EVAL OF THE CLIENT

14. HAIR PIECES,WIGS

15. CLIENTS' UTILITY BILLS, EVEN IF THE OPERATION OR MAINTENANCE OF MEDICAL EQUIP PURCHASED OR RENTED BY MAA FOR THE CLIENT CONTRIBUTES TO THE UTILITY BILL.

-PAYMENT MODE CODES FOR HOSP & NH ON PROVIDER CHARGE FILE (SCREEN 06)

01 RCC - RATIO TO COST TO CHRG	08 LOW OUTLIER PERCENTAGE
02 PER DIEM	09 OUTPATIENT PERCENTAGE
03 DRG CONVERSION FACTOR	10 STATE ONLY PERCENTAGE (GAU) - RCC
04 HIGHT OUTLIER PERCENTAGE	
05 NO LONGER USED	11 STATE ONLY DRG CONVERSION FACTOR (GAU)
06 CONTRACT DRG CONVERSION FACTOR	
07 CONTRACT MATERNITY CONVERSION FACTOR	12 STATE ONLY HIGH OUTLIER PERCENTAGE (GAU) - DRG

NURSING HOME CLASS CODES
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20 - SKILLED NURSING
23 - INSTITUTION FOR MENTALLY RETARDED
24 - MEDICARE/MEDICAID
25 - EXCEPTIONAL CARE
26 - SWING BED
27 - INTERMEDIATE MENTAL RETARDATION SERVICES
29 - FULL MEDICARE
40 - EXCEPTIONAL THERAPY CARE
50 - BEHAVIOR SUPPORT
99 - MEDICARE INTERIM RATE (USED ON 6 SCREEN)

- MATCH CODES

A = LCP-MN-SD
B = LCP-MN-NO-SD
C = MA-CN-ABPRC-PROG
D = MEDICARE QMB ONLY
E = E-SLMB OR FOSTER KIDS
E = MA-CN-H-PROG-INDEP
E = W/CXU-PROG-INCAPACITY REVIEW EFFECTIVE 6/1/94
F = V PROG-OTHER THAN ALIENS
G = LCP-MI-MU-PROG
H = LCP-MN-INST-ABP-PROG
H = U PROG-INCAPACITATED 18 YEAR OLDS
I = TITLE IV-E-FOSTER-CARE
J = MA-CN-ABP-PROG
K = LCP-MN-INST-CHR-PART EFFECTIVE 1/1/93 IS SLMB
L = LCP-MN-INST-CHR
M = MEDICAL ONLY, TAKE CHARGE FAMILY PLANNING PROGRAM
N = MA-CN-INST-ABCHPR

P = INST-M-OR-U
Q = TANF REIMBURSEMENTS
R = DETOX
S = MA-CN-ABPC-PROG
S = N PROG-CHIP
T = ADOPT-SUPPORT-MED-PROG, TAKE CHARGE FAMILY PLANNING PROGRAM
U = GA-C (GEN. ASSIST. CONTINUING)
W = NOT ELIG FOR MEDICAL CARE (ONLY MEDICARE COVERAGE)
X = FIP-04-MONTH-EXT
Y = FIP-12-MONTH-EXT
Z = V PROG-UNDOCUMENTED ALIEN
1 = ABP-PROG-OR-AFDC-REL
2 = DEP-ADULT-ABP-PROG
4 = MEDICAL-ONLY-ELIG & BHP
5 = GA-N

- PROGRAM CODES

SPACE = UNKNOWN
A = AGED
B = BLIND

C = AFDC - REGULAR/TANF
D = CHILD WELFARE SERVICES (FOSTER CARE)
E = AFDC EMPLOYABLE/TANF
F = FOOD STAMPS - NO MEDICAL
G = FIP PROGRAM/OLD GAU PROGRAM/TAKE CHARGE FAMILY PLANNING
H = OTHER CHILD NOT ELIGIBLE AFDC
I = BASIC HEALTH PLAN (NOT MEDICAID)
J = FIP PROGRAM/AFDC REGULAR OLD AFDC REGULAR
K = FEDERAL EMERGENCY ASSISTANCE (NO MEDICAL)
M = MEDICALLY INDIGENT
N = GA-N. NO MEDICAL BEFORE 7/81. MATCH S-CHIP
O = FIP PROGRAM/AFDC-E - OLD AFDC-E PROGRAM
P = DISABLED
Q = ITA PROGRAM
R = REFUGEE
S = GAU $ FOR PREGNANT WOMEN
T = OLD AGE - PSYCHIATRIC
U = CONTINUING GENERAL ASSISTANCE
V = CHILDREN'S HLTH PROGRAM (SAME SCOPE OF CARE AS CNP, STATE
W = SUBSTANCE ABUSE FUNDED PRO)
X = MEDICAID EXPEDITED DISABILITY

- ELIGIBILITY CODES

A = NA-SOUND HEALTH PLAN
B = GROUP HEALTH NORTHWEST (SPOKANE)
E = KITSAP PHYSICIAN SERVICE
F = MSC SPOKANE
G = MSC COLVILLE
H = HMOO (WAS COLUMBIA HLTH)
I = BHP GROUP HEALTH SPOKANE
J = SSI FOSTER CARE CHILD
K = K-PROG-NOT ELIGIBLE
M = TRANSITIONING TO MSC - PAY AS A "0"
N = MEDICARE RESIDENCY VERIFIC
O = BHP MSC SPOKANE
P = FAMILY PLANNING ONLY PROGRAM
T = BHP PLUS ELIGIBLE (WAS KITSAP HMO)
X = RESIDENT ALIENS
Z = FAMILY PLANNING ONLY PROGRAM
0 = REGULAR MEDICAL CARE
1 = MEDICARE PART B BUY-IN
2 = UNDOCUMENTED ALIEN SUSP & REVIEW
3 = LEGAL ALIEN - USED TO BE GROUP HEALTH PUGET SOUND
4 = NA - GROUP HEALTH
5 = SLMB DUAL ELIGIBLE
6 = NOT ELIGIBLE FOR MEDICAL CARE
7 = MEDICARE QMB DUAL COVERAGE
8 = MEDICARE COVERAGE
9 = KAISER PLAN

- RECIPIENT RACE CODES

1 - CAUCASIAN

2 - AFRICAN AMERICAN
3 - ASIAN AMERICAN
4 - NATIVE AMERICAN
5 - HISPANIC
6 - OTHER (CWS INC. 3 & 5 HERE)
7 - REFUGEE, NOT RESIDENT 36 MOS
8 - REFUGEE, RESIDENT 36 MOS, MORE
9 - UNKNOWN

- AGED REPORT GUIDELINES

1. CLAIMS THAT ARE 15 DAYS OLD IN SYSTEM LOCATION WILL APPEAR ON REPORT.

2. SYSTEM CYCLES ON SATURDAY, LOCATION REPORTS PRINT ON MONDAY.

3. AGED REPORT INFORMATION INCLUDES:
   ICN DAYS IN LOCATION
   PIC CLAIM AGE
   DOS EXCEPTIONS, BOTH ADJUDICATED AND SUSPENDING
   PROVIDER

4. WORKING AGED REPORT:
   A.REPORT IS SEPARATED BY LOCATION & DISTRIBUTED TO APPROPRIATE AREAS.
   B.CLAIMS EXAMINERS CALL UP EACH ICN ON SYSTEM
   C.DETERMINATION OF APPROPRIATE HANDLING TAKES PLACE IN ONE OF THE
     FOLLOWING WAYS;
     - REVIEW AND WORK, IF POSSIBLE
     - 0 TO 7 DAYS IN LOCATION; WAIT FOR WORKSHEET TO PRINT ON
       SAME CYCLE AS AGED REPORT
     - 7 DAYS OR MORE IN LOCATION; CHECK AREA FOR WORKSHEET; IF
       NOT AVAILABLE, CYCLE TO PRINT WORKSHEET (CP ONLY)
   D.ADJUDICATION STATUS IS NOTED BY EACH ICN AND AGE REPORT IS HELD TO
     COMPARE TO REPORT THE FOLLOWING WEEK.

- HCPC PREFIX/SUFFIX INTERPRETATION (E.G. 1600L, OR V5050, ETC.)

A TRANSP, CHIRO, DME MED SUPP
B TPEN AND IV THERAPY
D DENTAL
E DME, OXYGN & VENTIL THERAPY
L ORTHOTICS & PROSTHETICS
M MEDICAL SERVICES
R RADIOLOGY SERVICES
V VISION, GLASSES SVS & HEARING

- TPL TYPE OF INSURANCE CODES

A = CASUALTY - HOMEOWNERS
B = CASUALTY - AUTOMOBILE
C = CASUALTY - MALPRACTICE
D = CASUALTY - PRODUCTS LIABILITY
E = CASUALTY - OTHER
F = VETERANS
G = PATERNITY

H = L & I
I = REVENUE - HEALTH
J = CRIME VICTIMS
K = VICTIM ASSISTANCE
L = NURSING HOME
N = HEALTH INSURANCE
P = MEDICARE
Q = MEDICARE/SUR
R = REVENUE CASUALTY
S = OSE
T = PROBATE
U = SUPPORT

- CATEGORY OF SERVICE

01	INPATIENT HOSP - PHYCHIATRIC
02	INPATIENT HOSP - OTHER
03	DIAGNOSIS RELATED GRP (DRG)
11	OUTPATIENT HOSP PSYCHIATRIC
12	OUTPATIENT HOSP - OTHER
20	PHYSICIAN GEN PRACTICE
21	PHYSICIAN GEN SURGERY
22	PHYSICIAN ANESTHESIOLOGY
23	PHYSICIAN INTERNAL MEDICINE
24	PHYSICIAN OB/GYN
25	PHYSICIAN ORTHOPEDIC SURGERY
26	PHYSICIAN PSYCHIATRY
27	PHYSICIAN RADIOLOGY
28	PHYSICIAN PEDIATRICS
29	PHYSICIAN EMERGENCY ROOM
30	PHYSICIAN OTHER
40	DENTAL UNDER 21
41	DENTAL 21 AND OVER
48	CAPITATION - DISPENSING FEE
49	CAPITATION - SUBSTANCE FEE
50	DRUGS - FORMULARY
51	DRUGS - NON-FORMULARY
61	LABORATORY & RADIOLOGY
62	HOME HEALTH AGENCIES
63	EPSDT/HEALTHY KIDS
64	HEALTH MAINTENANCE ORGANIZATION (HMO)
70	OPTOMOTRIST/OPTICIAN
71	EYEGLASSES/CONTACTS
72	CHIROPRACTOR
73	PODIATRIST
74	DURABLE MEDICAL EQUIP
75	OTHER PRACTIONERS
76	AMBULANCE
77	CABULANCE
78	TAXI
79	OTHER MEDICAL TRANSPORTATION
81	OXYGEN
82	HEARING AIDS
83	RURAL HEALTH FACILITIES

84 INDIAN HEALTH FACILITIES
85 OTHER
90 SKILLED NURSING/EXTENDED CARE
91 INTERMEDICATE CARE FACILITIES
94 CONGREGATE CARE
95 INVOLUNTARY TREATMENT
96 ALCOHOL DETOXIFICATION
97 FAMILY PLANNING
98 ALL OTHER SERVICES

- CATEGORIES AND SUB-CATEGORIES FOR DUS-MAS/MEDAU

----HHIU-HMU-PAU-SSU----

01-INFECTIONS & PARASITIC DIS.
01-AA VIRAL ENTERITIS NEC.
01-AB HEPATITIS W/O COMA
01-AC VIRAL INFECTION
01-ZZ OTHER

02-NEOPLASMS
02-BA UTERINE LEIOMYOMA NOS.
02-ZZ OTHER

03 ENDOCRINE/DISEASES OF BLOOD
03-CA DIABETES
03-CB HYPOVOLEMIA
03-CC OBESITY/HYTPERALIMENT
03-CD ANEMIA NOS
03-ZZ OTHER

06 DISEASE OF CIRCUL. SYSTEM
06-FA HYPERTENSION
06-FB ATRIAL
06-ZZ OTHER

07-DISEASE OF RESPIR. SYSTEM
07-GA BRONCHITIS
07-GB EMPHYSEMA
07-ZZ OTHER

08 DISEASE OF DIGESTIVE SYSTEM
08-HA GASTRITIS 12-ZZ OTHER
08-HB INTESTINE/IMPACTION
08-HC LIVER
08-HD CHRONIC PANCREATITIS
08-ZZ OTHER

09 DISEASE OF GENITOURINARY SYST.
09-IA FEM. PELV. INFLAM. DIS.
09-IB UTI
09-IC CHRONIC RENAL FAILURE

04-MENTAL DISORDERS
04-DA SENILE DEMENTIA UNCOMP
04-DB ALCOHOLIC DEMENTIA
04-DC ORGANIC AFFECTIVE SYND.
04-DD ANXIETY STATE
04-DE MULTIPLE PERSONALITY
04-DF NEUROTIC DEPRESSION
04-DG ALCOHOL DEPENDENCE SYND
04-DH DRUG DEPENDENCE
04-DI STRESS REACT.
04-DJ DEPRESSSIVE DISORDER
04-DK CONDUCT DISTURBANCE
04-ZZ OTHER

05-DISEASE OF NERVOUS SYSTEM
05-EA MIGRANE
05-ZZ OTHER

10 DISEASES OF SKIN
10-SA CELLULITIS
10-SB INFECTED ULCER OF SKIN
10-ZZ OTHER
11 DISEASE OF MUSCULOSKELETAL SYST
11-ZZ OTHER

12 SYMPTOMS, SIGNS & ILL-DEF. COND
12-JA HEADACHE
12-JB PAINFUL RESPIRATION
12-JC NAUSEA & VOMITING
12-JD ABDOMINAL PAIN
12-JE RESP ANORMALITY

13 INJURY AND POISONING
13-KA BACK SPRAIN
13-KB TOXIC AFFECTS OF ALCOHOL
13-ZZ OTHER

09-ZZ OTHER

14 ORGAN TRANSPLANTS
14-LA HEART
14-LB HEAR/LUNG
14-LC KIDNEY
14-LD LIVER
14-LE PANCREAS
14-LF BONE MARROW
14-LG BONE MARROW HARVESTING
14-LH BONE MARROW SEARCH
14-LI TRANSPLANT EVALUATION
14-LJ LUNG
14-LK CORNEA
14-LL PSC-T HARVEST
14-LM PSC-T
14-ZZ OTHER

15 REPAIR/RECONSTRUCTION SURGERY
15-MA REDUCTION MAMMAPLASTY
15-MB RHINOPLASTY
15-MC GRAFT/SKIN
15-MD TENDON REPAIR HAND
15-ME RECONSTRUCTION PATELLA
15-MF ABDOMINOPLASTY
15-ZZ OTHER

19 CARDIOVASCULAR SURGERY
19-QA AICD
19-QB CABG
19-ZZ OTHER

20 OTHER SURGERY PROCEDURES
20-RA UNLISTED PROCEDURE
20-ZZ OTHER

21 CRITICAL CARE
21-SA CRITICAL CARE 1ST HOUR
21-SB CRITICAL CARE ADD'L. 1/2 HR

22 RADIOLOGY/MRI
22-TA MRI/MRA BRAIN
22-TB MRI/CHEST
22-TC MRI/SPINAL CANAL
22-TD MRI/THORACIC
22-TE MRI/LUMBAR

24 P M & R
24-WE DECONDITIONING
24-ZZ OTHER

25 EYE

16 MUSCULOSKELETAL SYSTEM SURGERY
16-NA ARTHROPLASTY

16-NB LAMINECTOMY
16-NC ARTHRODESIS-SPINAL INSTR.
16-ND ELECTRONIC BONE STIMULATION
16-NE ARTHROSCOPY/REPAIR/KNEE
16-ZZ OTHER

17 DIGESTIVE SYSTEM SURGERY
17-OA COLECTOMY
17-OB ESOPHAGOGASTRIC
17-OC CHOLECYSTECTOMY
17-OD LAPAROTOMY, EXPLORATORY
17-OE GASTROPLASTY
17-ZZ OTHER

18 FEMALE GENITAL SYSTEM SURGERY
18-PA HYSTERECTOMY
18-PB STRESS INCONT
18-ZZ OTHER

22-TF MRI/PELVIS
22-TG MRI/TMJ
22-TH MRI/UPPER EXTREMITY
22-TI MRI/JOINT OF UPPER EXTREM.
22-TJ MRI/LOWER EXTREMITY
22-TK MRI/JOINT OF LOWER EXTREM.
22-TL MRI/ABDOMEN
22-TM MRI/BONE MARROW BLOOD
22-TN MRA OTHER
22-TO MRI SOFT TISSUE NECK/FACE
22-ZZ OTHER

23 HOME HEALTH
23-UA SKILLED NURSING VISIT
23-UB HOME HEALTH AIDE VISIT
23-UC SPEECH THERAPY
23-UD PHYSICAL THERAPY
23-UE OCCUPATIONAL THERAPY
23-UF BRIEF RN VISIT
23-ZZ OTHER

EXCEPTION CODE NOTES (TYPE-E)

25-VA CATARACT
25-VB BLEPOHAROPLASTY
25-VC VITRECTOMY
25-VD STRABISMUS
25-VE OTHER

26 PAS EXTENSION
26 XA MEDICAL
26 XB NEONATES
26 XC PSYCH
26 XD SURGICAL
26 XE TRANSPLANTS
26 ZZ OTHER

27 SLEEP STUDY
27 YA INITIAL
27 YB WITH C-PAP
27 YC WITH BI-PAP
27 YD NARCOLEPSY-MSLT

28 PAIN CLINIC
28 ZA OUTPATIENT
28 ZB INPATIENT

35 LTC ACUTE HOSPITAL REHAB
35-AA 9 HR NSG; VENT WEAN
35-AB 9/NSG; CMC
35-AC 9/NSG; CMC; WDS/DNG
35-AD 9/NSG; CMC; BURNS/3RD
35-AE 9/NSG; CMC; THPY
35-AF 9/NSG; CMC; WDS/DR; THPY
35-AG 9/NSG; CMC; BNS/3RD; THPY
35-AH 9/NSG; CMC; THPY
35-AI 4-7 HR NSG; SV/CMC; THPY
35-AJ 4-7 HR NSG; CT/CMC-WEAN; THPY
35-ZZ OTHER

-----MEDAU-----

35 ALLERGY TESTING
35 RAST TESTING
36 SKIN TESTING
10 MISCELLANEOUS

36 BATH BENCH
01 RENTAL
02 PURCHASE
03 REPAIRS

37 BATH EQUIP. MISC.
01 RENTAL
02 PURCHASE
03 REPAIRS

38 BEDS
01 RENTAL
02 PURCHASE
03 REPAIRS
16 MATTRESS

39 BEDS, SPECIAL
01 RENTAL
02 PURCHASE
03 REPAIRS

40 BILIRUBIN LITE THERAPY
10 MISC.

41 BLOOD GLUCOSE MONIT
01 RENTAL
02 PURCHASE
03 REPAIRS
04 SUPPLIES

42 BONE STIMULATOR
01 RENTAL

45 COMMODE
01 RENTAL
02 PURCHASE
03 REPAIRS

46 COMMODE/SHOWER CHAIR
01 RENTAL
02 PURCHASE
03 REPAIRS

47 COMMUNICATION EQUIP
10 MISC.
61 COMPUTERIZED
62 VIBRATOR
63 PRINTER

51 DENTAL
10 MISC.
16 CROWNS
40 DENTURES
41 PARTIAL
42 RELINES
43 ORTHODONTIC
44 SHORT STAY
45 REBASES

52 DRUGS
10 MISC.

56 EYE SURGERY
10 MISC.

60 HEARING AIDS
10 MISC.

61 HYPERBARIC OXYGEN
10 MISC.

62 IRRIGATION SUPPLIES

50 DECUBITUS CARE PROD.
10 MISCELLANEOUS
11 AIR CUSHION
12 GEL CUSHION
13 FOAM CUSHION
14 GEL/AIR MATTRESS
15 AIR FLUID. FLOAT SYS.

64 LIFTS, PATIENT
01 RENTAL
02 PURCHASE
03 REPAIRS

70 POSITIONING DEVICES
01 RENTAL
02 PURCHASE
03 REPAIRS

71 OCCUPATIONAL THERAPY
10 MISCELLANEOUS

72 ORTHOPEDIC SHOES
02 PURCHASE
03 REPAIRS

73 ORTHOTIC
02 PURCHASE

81 SPEECH THERAPY
10 MISC.

82 TENS UNITS
01 RENTAL
02 PURCHASE
03 REPAIR

83 TPEN THERAPY
37 ENTERAL
38 PARENTERAL

84 TRANSPORTATION
10 MISCELLANEOUS
40 AIR AMBULANCE
41 NON-EMERGENT AMB.
42 BUS
43 CABULANCE
44 COMMERCIAL AIR
45 PRIVATE

98-06 MODIFICATIONS

99 SYSTEM DEFAULT
10 MISCELLANEOUS
99 SYSTEM DEFAULT

55 EYE CARE
10 MISC.
21 FRAMES
22 LENS
23 COMPLETE
24 CONTRACT LENS
26 EXAMS

73-03 REPIAR

71 OSTOMY SUPPLIES
10 MISC.

75 PHYSICAL THERAPY
10 MISC.
30 MODALITIES
31 PROCEDURE
32 COMBINATION
33 TESTS & MEASUR.
34 MUSCLE TESTING

76 PROSTHETICS
02 PURCHASE
03 REPAIR

77 RESP./VENT/OXY
01 RENTAL

84-46 TAXI

85 URINARY SUPPLIES
10 MISC.

86 WHEELCHAIR LIFTS
02 PURCHASE
03 REPIAR

87 WHEELCHAIR,MANUAL
01 RENTAL
02 PURCHASE
03 REPAIR
05 ACCESSORIES
06 MODIFICATION

88 WHEELCHAIR,POWER
01 RENTAL
02 PURCHASE
03 REPAIRS
10 MISC.

63 IV THERAPY EQUIP.
01 RENTAL
02 PURCHASE
03 REPAIR

77-02 PURCHASE
03 REPAIR
04 SUPPLIES
51 OXYGEN
52 VENTILATOR EQUIP
53 THERAPY

78 ROOM EQUIPMENT
01 RENTAL
02 PURCHASE
03 REPAIR

80 SHOWER CHAIRS
01 RENTAL
02 PURCHASE
03 REPAIR
10 MISCELLANEOUS

88-05 ACCESSORIES
06 MODIFICATION

89 WHEELCHAIR RAMPS
02 PURCHASE
03 REPAIR

90 CHIROPRACTIC
90 SUBLUXATION
91 X-RAY

91 STERILIZATION
10 MISCELLANEOUS

98 MISC. DME
01 RENTAL
02 PURCHASE
03 REPAIR
04 SUPPLIES
05 ACCESSORIES

- PCOP TYPE FIELD

1 MEDICAL REASONS (INCLUDES PLAN/PROVIDER REQUEST)
2 PREGNANT
3 TRAVEL
4 TPL
5 HOMELESS
6 INDIAN
7 PENDING DECISION
C CAPITATED MANAGED HEALTHCARE
F FAIR HEARING
M REFUND FOR DUAL COVERAGE
0 OTHER
P PCCM
R RECOUP FOR DUAL COVERAGE
S STATE PAID PREMIUM PAYMENT
X PREMIUM RECOUPMENT
Z 1-DAY SEGMENT (NOT COVERED BY MHC)

- FIRST PCOP-INFO FIELD

A = ASSIGNMENT
AE = ASSIGNMENT ERROR
AL = ALIEN NOT ELIGIBLE FOR HEALTHY OPTIONS
AR = ASSIGNMENT RETRACTED
AT = TELEPHONE CALL WAS REC'D CONFIRMING ASSIGNMENT/DOCTOR REQUEST
BI = RECOUPED DUE TO INPATIENT TREATMENT FACILITY (BHP+)
BP = BAD PROGRAM
BT = CHANGE OF BHP PLAN BY TELEPHONE REQUEST
C = CORRESPONDENCE
CH = FEE FOR SERVICE SEGMENT FOR CHIP CLIENT
CI = 1998 CONTRACT ISSUE
CS = EXEMPTION GRANTED AT CSO
C1 = CHIP ENROLLMENT
D = DISENROLLMENT
DC = DUAL COVERAGE (INFO FROM PLANS ONLY)
DP = DUPLICATE PIC THAT'S BEEN COMBINED
DX = INFORMATION RECEIVED FROM SDX THAT CLIENT IS SSI ELIGIBLE
E = ANY OTHER ENROLLMENT FORM (NOT BUFF, GREEN, BLUE, PINK, YELLOW)
EB = BUFF ENROLLMENT FORM
EC = ENROLLMENT CONVERSION
EE = ENROLLMENT ERROR
EG = GREEN ENROLLMENT FORM
E1 = ENROLLED BY ENROLLMENT FORM - CONFIRMATION LETTER GENERATED
EM = BLUE ENROLLMENT FORM FROM PACKET MAILING
EP = PINK ENROLLMENT FORM; SSI ENROLLMENT
EW = ENROLLMENT FORM FROM WALLA WALLA CLINIC
EY = YELLOW ENROLLMENT FORM FROM CSO
FC = EXEMPTION DUE TO CLIENT BEING IN FOSTER CARE
FF = PAYING FEE FOR SERVICE & PREMIUM NOT RECOUPED
FH = FAIR HEARING
FI = ENROLLMENT FORM RETURNED FOR FUTHER INFORMATION
GH = SSI ENROLLMENT FORM - RETURNED FOR UNAVAILABLE PLAN CHOICE-GHNW
HP = BHP CLIENT WITH HEALTHPLAN SVCS. FLORIDA

EXCEPTION CODE NOTES (TYPE-E)

I = INSURANCE
IE = INDEFINITE EXEMPTION
IF = INVALID FQHC FOR THE CLIENT'S CSO
IT = INTERNAL TRANSFER
L1 = ASSIGNMENT LETTER CONNECTING FAMILY MEMBERS
L2 = ASSIGNMENT LETTER BREAK IN ELIGIBILITY
L3 = ASSIGNMENT LETTER MOVED
L4 = ASSIGNMENT LETTER NEW CLIENT
L5 = RE-ENROLLED TO PREVIOUS PLAN WITH LESS THAN 2 MO BREAK IN SERVICE
L6 = ASSIGNMENT LETTER PREGNANT CLIENT
LL = CLIENT NOTICE/ASSIGNMENT LETTER FOR UNSUCCESSFUL BIDDER
MD = MOM IN DIFFERENT PLAN
ME = MEDICAL/CLINICAL EVALUATION
MF = MOM FEE FOR SERVICE
MM = BHP+ MISMATCH REPORT
MP = MULTIPLAN PROJECT
MX = MEDICAL CONSULTANT EXCEPTION TO POLICY
NB = ENROLLED BASED ON NEWBORN REPORT
NE = NOT ELIGIBLE (THIS IS TO BE USED WHEN AN ENROLLMENT IS ENTERED AT THE TIME THE ELIGIBILITY FILE REFLECTS THE CLIENT NOT ELIGIBLE)
NS = SYSTEM GENERATED RETRO PROCESS FOR NEWBORN CLAIMS 0351M DONE
NV = EXEMPTION ENDED, NO LONGER VALID
PB = PREGNANCY EXEMPT AS CLIENT IS BASIC HEALTH ENROLLEE
PC = PLAN CORRESPONDENCE
PE = PREGNANCY EXEMPTION
PG = EXEMPTED PER ASSIGNMENT REPORT
PI = TPL UPDATED PCOP SEGMENT (4)
PM = PROGRAM MANAGER REQUEST
RC = REENROLLED TO PREVIOUS PLAN (CORRESPONDENCE)
RE = REENROLLED TO PREVIOUS PLAN (ENROLLMENT FORM)
RF = RETROENROLLMENT INTO FQHC/RHC FOR BILLING RETROACTIVE RATES
RM = REENROLLED PER ARCHIVED MICROFILM
RN = RETROENROLL NEWBORN BASED ON MOTHER'S PLAN
RP = PREMIUM PAID RETROACTIVELY
RR = PREMIUM RECOUPED AND REPAID
RT = REENROLLED TO PREVIOUS PLAN (TELEPHONE)
RS = PREMIUM RECOUP PULLED PRIOR TO PROCESSING
RV = REENROLLED TO PREVIOUS PLAN (VOICE MAIL)
SA = STAFF APPROVAL
SD = STAFF DENIAL
SE = SYSTEM ENHANCEMENT TO GENERATE RETRO CLAIMS FOR FQHC/RHC 0357M
SG = SYSTEM GENERATED RETRO PROCESS FOR FQHC/RHC 0357M DONE
SI = RETRO SSI RECOUPMENT
SS = RECOUPED DUE TO CLIENT COVERED BY MEDICARE (SOCIAL SECURITY)
T = TELEPHONE
T1 = ENROLLED BY TELEPHONE FORM - CONFIRMATION LETTER GENERATED
TC = TRANSFERRED CLIENT
TE = TELEPHONE REQUEST ERROR
TT = TRANSLATED TELEPHONE CALL
V = VOICE MAIL
V1 = ENROLLED BY VOICE MAIL - CONFIRMATION LETTER GENERATED
VC = EXEMPTION OR DISENROLLMENT REQUESTED IN A VOLUNTARY AREA OR COUNTY

VD = VOLUNTARY DISENROLLMENT
WD = WITHDRAWN EXEMPTION/DISENROLLMENT REQUEST
ZA = SYSTEM GENERATED RECOUPMENT FOR MEDICAL REASON (EDC)
ZC = SYSTEM GENERATED RECOUPMENT FOR DUAL COVERAGE
ZI = SYSTEM GENERATED RECOUPMENT FOR RETRO SSI ELIGIBLE
ZX = SYSTEM GENERATED RECOUPMENT FOR SSI ELIGIBLE
X = RECOUPED
# = CLIENT REQUESTED EXEMPTION OR DISENROLLMENT
& = CLIENTS IN CSOR'S 08 & 35 THAT RECEIVED "LL" NOTICE
? = HEALTHY OPTIONS COMPLAINT HAS BEEN RECEIVED

- SECOND PCOP INFO FIELD

AD = ADAMS
AS = ASOTIN
BF = BENTON-FRANKLIN
CD = CHELAN-DOUGLAS
CH = CHEHALIS TRIBE
CL = CLALLAM
CO = COLUMBIA
CW = COWLITZ
DH = WA STATE DEPT. OF HEALTH
E4 = ENDING A TPL EXEMPT SEGMENT (4), CONTACT WITH CLIENT
E5 = ENDING A TPL EXEMPT SEGMENT (4), NO CONTACT WITH CLIENT
GR = GRANT
IS = ISLAND
JF = JEFFERSON
KI = KITTITAS
KT = KITSAP
LU = LUMMI TRIBE
ME = MEDICAL EXEMPTION
MM = CLIENT APPEARED ON BASIC HEALTH MISMATCH REPORT
NS = NISQUALLY TRIBE
NC = FQHC DOESN'T HAVE SIGNED CONTRACT
NG = NEWBORN PREMIUM SYSTEM GENERATED RETRO-ACTIVELY
NR = NEWBORN PREMIUM TO BE RETRO-ACTIVE
NS = NOOKSACK TRIBE
NT = NORTHEAST TRI-COUNTY
OK = OKANOGAN
OR = ORIGINAL SEGMENT WAS RECOUPED
PA = PACIFIC
PO = PORT GAMBLE S'KLALLAM TRIBE
PU = PUYALLUP TRIBE
QL = QUILEUTE TRIBE
SC = SKAGIT
SK = KING
SN = SNOHOMISH
SO = SKOKOMISH TRIBE
SP = SPOKANE
ST = SPOKANE TRIBE
SW = SOUTHWEST WASHINGTON
TP = TACOMA-PIERCE
WH = WHATCOM
WK = WAHKIAKUM

WT = WHITMAN
YK = YAKIMA
YN = YAKAMA INDIAN NATION
02 = SSI RECOUP PER THE 2002 CONTRACT

- PLAN RECORD PROGRAM CODE INDICATORS

1 = AFDC-R, AFDC-E, GA-S, S, H PROGRAMS, U PROGRAM WITH H MATCH
2 = SSI PROGRAMS A,B,P,X WITH MATCH CODES 1,2,C,I,J,N,S,U
3 = SSI PROGRAMS FOR FQHC/RHC DELIVERY CASE RATE ENHANCEMENT
4 = DELIVERY CASE RATE
Y = PROGRAM S KICKER FQHC/RHC ENHANCEMENT
Z = DELIVERY FQHC/RHC ENHANCEMENT

- ACRONYMS

AASA - AGING & ADULT SERVICES ADMINISTRATION
ACES - AUTOMATED CLIENT ELIGIBILITY SYSTEMS
ACS - AFFILIATED COMPUTER SERVICES
AFO - ANKLE FOOT ORTHOTICS
ARNP - ADVANCED REGISTERED NURSE PRACTITIONER
ASC - AMBULATORY SURGERY CENTER
ASU - AUTHORIZATION SERVICES UNIT
BAU - BASE ANESTHESIA UNITS
CASA - COMMUNITY AIDS SERVICE ALTERNATIVE PROGRAM
CBC - COMPLETE BLOOD COUNT
CCI - CORRECT CODING INITIATIVE
CCF - CONGREGATE CARE FACILITY
CDC - CENTER FOR DISEASE CONTROL
CMN - CERTIFICATE OF MEDICAL NEED
CF - CONVERSION FACTOR
CFR - CODE OF FEDERAL REGULATIONS
CHAMPUS - CIVILIAN HEALTH & MEDICAL PROGRAM OF THE UNIFORMED SERVICES
CLIA - CLINICAL LABORATORY IMPROVEMENT ACT
CMEU - CENTRAL MEDICAL ENROLLMENT UNIT
CMHC - COMMUNITY MENTAL HEALTH CENTER
CNP - CATERGORICALLY NEEDY PROGRAM
CNS - CENTRAL NERVOUS SYSTEM
COPES - COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM
COS - CATEGORY OF SERVICE
CPAS - CLAIMS PROCESSING ASSESSMENT SYSTEM
CPS - CHILD PROTECTIVE SERVICES
CPT - CURRENT PROCEDURAL TERMINOLOGY
CQ - CLASSIFICATION QUESTIONNAIRE
CRNA - CERTIFIED REGISTERED NURSE ANESTHETIST
CRT - CATHODE RAY TUBE
CSF - CEREBRO-SPINAL FLUID
CSO - COMMUNITY SERVICE OFFICE
CSR - CHANGE SERVICE REQUEST
CUP - CHEMICALLY USING PREGNANT
CVA - CORONARY VASCULAR ACCIDENT (STROKE)
DASA - DIVISION OF ALCOHOL & SUBSTANCE ABUSE
DAW - DISPENSE AS WRITTEN
DCS - DIVISION OF CLIENT SERVICES

DDD - DIVISION OF DEVELOPMENTAL DISABILITIES
DDDS - DIVISION OF DISABILITY DETERMINATION SERVICES
DEERS - DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM
DMBS - DIVISION OF MANAGEMENT & BUDGET SERVICES
DME - DURABLE MEDICAL EQUIPMENT
DMERC - DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER
DOB - DATE OF BIRTH
DOD - DATE OF DEATH
DOS - DATE OF SERVICE
DPS - DIVISION OF PROVIDER SERVICES
DRG - DIAGNOSIS RELATED GROUPING
DUS - DIVISION OF UTILIZATION SERVICES
EAC - ESTIMATED ACQUISITION COST
EAS - EMPLOYEE ADVISIORY SERVICE
ECF - EXTENDED CARE FACILITY
ECG - ELECTROCARDIOGRAM
ECT - ELECTROCONVULSIVE THERAPY
EDC - EXPECTED DATE OF CONFINEMENT/DELIVERY
EMC - ELECTRONIC MEDIA CLAIMS
ENT - EAR, NOSE, & THROAT
EOB - EXPLANATION OF BENEFITS
EPSDT - EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
ESLMB - EXPANDED SPECIAL LOW-INCOME MEDICARE BENEFICIARY
ESRD - END STAGE RENAL DISEASE
FECA - FEDERAL EMPLOYEE COMPENSATION ACT
FPL - FEDERAL POVERTY LEVEL
FQHC - FEDERALLY QUALIFIED HEALTH CENTER
FSU - FIELD SERVICE UNIT
FUO - FEVER OF UNKNOWN ORIGIN
GAS - GENERAL AUTHORIZATION SERVICES
GAU - GENERAL ASSISTANCE - UNEMPLOYABLE
GHC - GROUP HEALTH COOPERATIVE
HCFA - HEALTH CARE FINANCING AUTHORITY
HCPCS - HEALTHCARE COMMON PROCEDURE CODING SYSTEM
HIC - HEALTH IDENTIFICATION CODE
HMO - HEALTH MAINTENANCE ORGANIZATION
ICD-9 - INTERNATIONAL CLASSIFICATION OF DISEASES - 9TH REVISION
ICF - INTERMEDIATE CARE FACILITY
ICN - INTERNAL CONTROL NUMBER
IDDM - INSULIN DEPENDENT DIABETES MELLITUS
IDG - INTER-DISCIPLINARY GROUP
IHS - INDIAN HEALTH SERVICES
IMR - INSTITUTION FOR THE MENTALLY RETARDED
ISSD - INFORMATION SYSTEMS SERVICES DIVISION
ITA - INVOLUNTARY TREATMENT ACT
ITIS- INTERACTIVE TERMINAL INPUT SYSTEM
KPS - KITSAP PHYSICIAN SERVICE
LAN - LOCAL AREA NETWORK
LCP - LIMITED CASUALLTY PROGRAM
LMC - LOCAL MEDICAL CONSULTANT
LTAC- LONG TERM ACUTE CARE
MAA - MEDICAL ASSISTANCE ADMINISTRATION
MACSC - MEDICAL ASSISTANCE CUSTOMER SERVICE CENTER FORMERLY (RAIS)
MAID - MEDICAL ASSISTANCE IDENTIFICATION CARD

MAS - MEDICAL AUTHORIZAION SECTION
MCM - MATERNITY CASE MANAGEMENT
MEDAU - MEDICAL EQUIPMENT & DEVICES AUTHRORIZATION UNIT
MIHCP - MEDICALLY INTENSIVE HOME CARE PROGRAM
MIP - MEDICALLY INDIGENT PROGRAM
MNP - MEDICALLY NEEDY PROGRAM
MEV - MEDICAL ELIGIBLITY VERIFICATION
MCH(P) - MANAGED HEALTH CARE (PLAN)
MFS - MEDICARE FEE SCHEDULE
MHCRA - MEDICAL AND HOME CARE REVIEW AND AUTHORIZATION
MMIS - MEDICAID MANAGEMENT INFORMATION SYSTEM FORMERLY (MPAS)
MMISSS - MEDICAID MANAGEMENT INFORMATION SYSTEM SERVICES SECTION
MPAS - MEDICAL POLICY AND SYSTEMS
MPMU - MEDICAL PROGRAM MANAGEMENT UNIT
MRS - MEDICAL REVIEW SECTION
MSAS - MMIS SECURITY ACCESS SYSTEM
MSP - MEDICARE SECONDARY PAYOR
MVA - MOTOR VEHICLE ACCIDENT
NABP - NATIONAL ASSOCIATION BOARD OF PHARMACY
NAD - NO APPARENT DISTRESS OR NO APPRECIABLE DISEASE
NEC - NOT ELSEWHERE CLASSIFIED
NOS - NOT OTHERWISE SPECIFIED
OMC - OFFICE OF MANAGED CARE
OMIS - OFFICE MANAGEMENT INFORMATION SYSTEM
OMD - OFFICE OF THE MEDICAL DIRECTOR
OPS - OFFICE OR PROVIDER SERVICES
PA - PRIOR AUTHORIZATION OR PHYSICIAN'S ASSISTANT OR PUBLIC ASSISTANCE
PCCM - PRIMARY CARE CASE MANAGER/MANAGEMENT
PCHES - PARENT CHILD HEALTH SERVICES
PCOP - PRIMARY CARE OPTIONS PROGRAM
PDDD - PROCEDURE, DIAGNOSIS, DRUG, AND DRG FILE
PEU - PROVIDER ENROLLMENT UNIT
PIC - PATIENT IDENTIFICATION CODE
PIU - PROVIDER INQUIRY UNIT AKA (PRU) PROVIDER RELATIONS UNIT
PM&R - PHYSICAL MEDICINE & REHABLILITATION
POC - PLAN OF CARE
POS - PLACE OF SERVICE -OR- POINT OF SALE
POT - PLAN OF TREATMENT
PRS - PROVIDER RELATIONS SECTION
PTCA - PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY
QC - QUALITY CONTROL
QDWI - QUALIFIED DISABLED WORKING INDIVIDUAL
QI-1 - QUALIFIED INDIVIDUAL
QI-2 - QUALIFIED INDIVIDUAL
QMB - QUALIFIED MEDICARE BENEFICIARY
RAIS - REFERRAL AND INFORMATION SERVICE
RBRVS - RESOURCE BASED RELATIVE VALUE SCALE
RCC - RATIO OF COSTS TO CHARGE
RCW - REVISED CODE OF WASHINGTION
RVS - RELATIVE VALUE SYSTEM
RVU - RELATIVE VALUE UNITS
SCA - SELECTIVE CONTRACTING AREA
SCAN - STATE CONTROLLED AREA NETWORK
SLIAG - STATE LEGALIZED IMPACT ASSISTANCE GRANT

SLMB - SPECIAL LOW INCOME MEDICARE BENEFICIARY
SMAPD - SCHEDULE OF MAXIMUM ALLOWANCES AND PROGRAM DISCRIPTIONS
SMIB - SUPPLEMENTARY MEDICAL INSURANCE BENEFIT = MEDICARE PART "B"
SNF - SKILLED NURSING FACILITY
SOS - SITE OF SERVICE (FACILITY/NON-FACILITY)
SPR - SYSTEMS PERFORMANCE REVIEW
SSPS - SOCIAL SECURITY PAYMENT SYSTEM
SUR - SURVEILLANCE AND UTILIZATION REVIEW
TAD - TURN AROUND DOCUMENT
TCS - THERAPEUTIC CONSULATION SERVICE
TOP - TERMINATION OF PREGNANCY
TOS - TYPE OF SERVICE
TPEN - TOTAL PERENTERAL ENTERAL NUTRITION
TPL/R - THIRD PARTY LIABILITY/RECOVERY
YVFWC - YAKIMA VALLEY FARMWORKERS CLINIC
WAC - WASHINGTON ADMINISTRATIVE CODE

- ITA INDICATOR

A - ELDERLY
B - BABY ON MOMS PIC
C - BYPASS COPAY FOR ADJUSTMENTS
D - DEVELOPEMENTAL DISABILITY
E - EMERGENCY
F - MEDICAL NUTRITION - PROVIDER NOT USING WIC
G - TPR BYPASS
H - CHILDREN W/SPECIAL NEEDS
I - ITA
K - NOT RELATED TO TERMINAL ILLNESS (HOSPICE CLIENT)
L - MEDICAL NUTRITION - 3 MONTH TRANSITION PERIOD EXCEEDED
M - MENTAL HEALTH PROBLEMS
P - PREGNANCY
S - SUICIDAL RISK
T - THERAPIES
U - UNABLE TO COLLECT COPAY
V - VOLUNTARY
W - STATE FUNDS ONLY
X - MNCP PRESCRIPTION
Z - AIDS
1 - PREVIOUS IN HOUSE UNIT DOSE
2 - COMPOUND DRUG
3 - IN HOUSE UNIT DOSE

- EXPEDITED/LIMIT EXTENSION AUTHORIZATION NUMBER RANGES

850000000 - PHARMACY

870000101 - 870000230
HYSTERECTOMIES & HYSTERECTOMIES W/OTHER SURGERIES IN COMBO

870000241 - 870000250
MAMMOPLASTIES

870000301 - 870000390

MRI'S

870000401 - 870000420
MEDICAL ADMITS

870000421 - 870000599
OPEN

870000600 - 870000699

MISCELLANEOUS-SEE BELOW

870000610 - 870000627
VISUAL/DISPENSING/FITTING FEES

870000630 - 870000631
MISC SURGERIES (BLEPHAROPLASTIES/STRABISMUS)

870000640 - 870000645
THERAPIES (PHYSICAL/OCCUPATIONAL)

870000700 - 870000849
DME (INCLUDES PHYS ORTHOTICS 781 - 785)

870000850 - 870000899
MEDICAL SUPPLIES/ALSO INFUSION SUPPLIES

870000900 - 870000929
OXYGEN/RESPIRATORY THERAPY/ALS/VENT & TRACH PROGRAM

870000930 - 870000949
OPEN

870000950 - 870000999
DENTAL

870001000 - 870001099 (DINEEN KILMER)

870001100 - 870001200 (DEBBIE COVERDELL)

870001201 - 870001201 (SA,NEUROPSYCHOLOGICAL EVAL TESTING, DR. H)

870001202 - 870001202 (SA,PEDIATRIC INTENSIVISTS, DR. M BUCHOLZ)

870001203 - 870001250 (SA,PEDIATRIC INTENSIVISTS,UNASSIGNED, DR. BAUM)

870001251 - 870001251 (ALLON P. HIV AIDS X WALK)

870001252 - 870001999 (OPEN, SEE SANDY A.)

- MMIS LOCATION CROSS-REFERENCE "OLD TO NEW"

IF A LOCATION X-REFERENCES TO MULTIPLE LOCATIONS & YOU ARE UNSURE OF
WHICH IS APPLICABLE - SEE YOUR SUPERVISOR FOR REVIEW. IF ANY CHANGES

OR QUESTIONS - SUPERVISORS SHOULD SEE MMIS SERVICES SECTION FOR REVIEW
AND POSSIBLE UPDATE TO THIS LIST.

OLD = NEW

01	01
02	55
03	86
04	05,29
06	06,30
08	10,42
10	82
11	
12	78
13	
14	14
15	78
16	31
17	49
20	17
24	86
25	25
26	18
27	36
28	07,12,24,26,27,32,34,36,42,46,48,87
30	09,10,16,24,26,27,32,36,38,42,43,44,46,48,50,52,54,56,58,68, 71,73,74,80,87,89
31	02,09,10,16,18,22,24,27,32,36,38,42,46,48,50,52,54,56,58,60, 62,68,69,73,74,76,80,89
32	26,35,36
33	10,22,23,35,46,50,54
34	47
35	01,83
36	
40	10,71,73,74,77
41	71,73,74
44	09
45	09,27
50	59
51	
52	
53	37
59	81
80	79
81	84
85	
88	52

- POS FORMULARY COVERAGE CODE INDICATORS

C - COVERED
E - EXPEDITED PRIOR AUTHORIZATION REQUIRED
H - COVERED, BUT NOT COVERED IN NURSING HOME (REQUIRES AUTH IN NH)

N - NOT COVERED
P - PRIOR AUTHORIZATION REQUIRED
X - TCS NON-PREFERRED DRUG (REQUIRES A TCS CONSULTATION FOR APPROVAL)

- POS ELIGIBILITY PLAN FILE DESCRIPTIONS

250 - REGULAR MEDICAID
251 - NURSING HOME
252 - MANAGED CARE
253 - HOSPICE
254 - FAMILY PLANNING & TAKE CHARGE FAMILY PLANNING
255 - MEDICARE DUAL ELIGIBLES (EXCLUDES SLMB & ESLMB)
256 - MEDICALLY INDIGENT (NO DRUG COVERAGE)
257 - PCCM

- POS AUTHORIZATION TYPE INDICATORS

DO - REFILL TOO SOON
GC - GENERIC CODE NUMBER
ND - NATIONAL DRUG CODE (NDC)
PC - NON-CONTRACT DRUG
PM - 3RD OR 5TH FILL OF THE MONTH
PP - WAIVE MAC PRICE
TC - THERAPEUTIC CLASS CODE

- ADJUSTMENT REASON CODES

CODE	SHORT DESCR	LONG DESCR
A	AUDIT	AUDIT
B	RATE CHG	RATE CHANGE
C	COST SETL	COST SETTLEMENT
D	TPL PROV	THIRD PARTY RECOVER PROVIDER
E	CLAIM ERR	CLAIM ERROR
F	RETRO-ELI	RETROCACTIVE ELIGIBILITY CHANGE
G	TPL STATE	THIRD PARTY RECOVERY STATE
H	INACT-PRV	INACTIVE PROVIDER
I	TPL-ADJ	TPL-ADJUSTMENT (AFF PROV PYMT)
J	WALK-THRU	WALKTHROUGH (A-19)
K	TPL CONTR	THIRD PARTY RECOVERY CONTRACT
L	HIST-ACCT	REASSIGN ACCOUNT CODE ONLY
M	GME-PAYMNT	GME PAYMENT
N	BYPASS1099	HISTORY ONLY BYPASS 1099
O	TRAU ENHAN	PRE HOSPITAL TRAUMA ENHANCEMENT
P	PIP-PROJEC	PIP PROJECT
Q	QRS-PROJEC	QRS PROJECT
S	STOP LOSS	STOP LOSS GROSS ADJ PAYMENT
X	DISP-SHARE	DISP SHARE PAYMENT
Y	MI TPL REC	MI DISP SHARE TPL REC STATE

TEXT KEY	TEXT DESC
3	ONLY ONE PRENATAL LAB (8000M,8001M,80055) COVERED IN NINE MONTH SPAN. SAME OR DIFFERENT PROVIDER - DENY. PAY THE OLDEST DATE OF SERVICE FIRST. DENY AND/OR RECOUP AS NECESSARY. EXCEPTIONS: IF ONE PHYSICIAN HAS BILLED A PRENATAL LAB WITH TRIMESTER CARE AND ANOTHER PHYSICIAN IS BILLING A PRENATAL LAB WITH A DELIVERY OR C-SECTION - FORCE. IN RARE INSTANCES IT MIGHT BE THE PATIENTS SECOND DELIVERY IN A NINE MONTH SPAN (EXAMPLE: PREMATURE BIRTH) - FORCE. IN RARE INSTANCES IT MIGHT BE THE PATIENT SECOND PREGNANCY (EXAMPLE: PATIENT MISCARRIED, ABORTED, TERMINATED) - FORCE. IF PRENATAL LAB IS BILLED FOR THE SAME PATIENT IN TWO DIFFERENT COUNTIES - FORCE. NOTE:8000M/8001M ENDED 6/30/99, 80055 REPLACED EFF 7/1/99.

TEXT KEY TEXT DESC

6 PAYMENT FOR PHYSICIAN CALLS FOR ROUTINE CONDITIONS IN A SKILLED NURSING HOME AND/OR INTERMEDIATE CARE FACILITY IS LIMITED TO TWO CALLS PER MONTH, PER CLIENT. DENY ALL OTHERS UNLESS AUTHORIZATION ON THE CLAIM FOR SERVICES OVER THE LIMIT OR EXCEPTION LISTED BELOW.

EXCEPTION: EFFECTIVE RETRO BACK TO 7/1/03 DOS ALLOW 5 VISITS FOR THE FOLLOWING PROVIDERS BILLING FOR CLIENTS IN ALS FACILITIES. DO

BEL AIR IN TACOMA, WA (ALS)
PROVIDER # 7098841 W/PP 1100791
PROVIDER # 7088800 W/PP 1002294
PROVIDER # 1116136

SEATTLE MEDICAL IN SEATTLE, WA (ALS)
PROVIDER # 7098841 W/PP 1100791
PROVIDER # 7101801 W/PP 8246431

RAINER VISTA CARE CENTER IN PUYALLUP, WA (ALS)
PROVIDER # 7109499 W/PP 1665702
PROVIDER # 7109499 W/PP 1093731
REGENCY @ NORTHPOINTE (ALS)
PROVIDER # 7088974 W/PP 8118697
PROVIDER # 7114242 W/PP 8249740

PACIFIC SPECIALTY (ALS)
PROVIDER # 7835705 W/PP 8179749

ANY QUESTIONS ON THE ABOVE - SEE SANDY A.

(EFFECTIVE 11/10/02, THE FOLLOWING TEXT IS NOT APPLICABLE, PER EDWINA DORSEY/DEPUTY DIRECTOR/DMM. SERVICES OVER THE MAX WILL BE DENIED)

NOTE: EFFECTIVE 10/21/98 PER PHYLLIS COOLEN ALLOW CLAIMS BILLED FOR ADDITIONAL SERVICES OVER 2 ONLY FOR THE NOTED PERFORMING PROVIDER #'S BELOW. DENY ALL ELSE. IF ADJUSTMENT OR CLAIM INDICATES A REQUEST FOR REVIEW - ROUTE TO THE PHYLLIS COOLEN, DHSQS/MS 45506 FOR TRIAGE. INDICATE ON ROUTING SLIP, PLEASE REVIEW OVER 2 NURSING HOME CALLS PER MONTH.
1002294 (DR. J. REGIMBAL)
1015429 (DR. K. ADAMS)
1024496 (DR. W. ROES)
1037084 (DR. FRANKEL)
1073923 (DR. DENTLER)
1093731 (DR. MANN) IF PATIENT RESIDES IN RAINER VISTA
1097476 (DR. MOZAFFARIAN)
1259605 (DR. HANING)
1309509 (DR. ROSS)
1611706 (DR. FISHER)
1665702 (DR. NESSAN) IF PATIENT RESIDES IN RAINER VISTA
8118697 (DR. GREEN)
8133415 (DR. VILLA)

8133963 (DR. MANN) IF PATIENT RESIDES IN RAINER VISTA
8458101 (DR. FOWLER)
7023328 (KITSAP MENTAL HEALTH)
7086598 (DR.'S CAROL TALLMAN, STEVE TAYLOR, KATHY HETTEL, THOMAS SEIB, TERRI PARSONS)

TEXT KEY	TEXT DESC
8	J AND P CLAIMS

PARAMETER (1036)
CLOZARIL COORDINATION (0857J) - ALLOW 1 IN EACH CALENDAR WEEK (SUNDAY THRU SATURDAY), SAME OR DIFFERENT PROVIDER. TRY TO PAY THE OLDEST DOS FIRST.

PARAMETER (1037)
CLOZARIL COORDINATION (90862 W/DX 295 - 295.5) - ALLOW 1 IN EACH CALENDAR WEEK (SUNDAY THRU SATURDAY), SAME OR DIFFERENT PROVIDER. TRY TO PAY THE OLDEST DOS FIRST.

TEXT KEY TEXT DESC
9

PHYSICIANS (J)

SPECIAL AGREEMENT CODE POSTING MORE THAN ONCE IN THREE MONTHS FOR THE SAME PROVIDER AND CLIENT.

1. IF PROVIDER NUMBER 7017122 - FORCE
2. IF PROVIDER IS BILLING A FACILITY CHARGE FOR BABY - DENY WITH EOB 350.
3. ALL ELSE - OVERLOC TO 83.

TEXT KEY	TEXT DESC
12	K CLAIMS PARAMETER 1022:3 FLOURIDES IN 12 MONTHS. DENY ANY FLOURIDES ON CURRENT CLAIM IF OVER 3 IN A 12 MONTH PERIOD. DO NOT RECOUP PAID HISTORY CLAIMS WITH DATES OF SERVICE PRIOR TO 11/01/02 IF OVER THE LIMIT. P CLAIMS PARAMETER 1033: 5 GASTRO/JEJUNOS TUBES (B4086) PER MONTH. IF 6 OR MORE UNITS BILLED ON A LINE - DENY. IF 6 OR MORE UNITS BILLED IN A 31 DAY TIME PERIOD - DENY. PROVIDER MAY BILL WITH DATE SPANS - AS LONG AS SPANS DO NOT OVERLAP, ALLOW UP TO 5 UNITS PER 31 DAYS. ANY QUESTIONS - OL TO 83 OR SEE CHRISTINE IN MMIS SERVICES.

TEXT KEY TEXT DESC
13 CLAIM TYPES J,L,M

AUTOMATED/NON AUTOMATED LAB. CONSULTEC SYSTEM CANNOT PRICE LAB PANELS WHEN MULTIPLE CLAIMS ARE INVOLVED. THIS AUDIT WILL NOT POST WHEN ONLY ONE CLAIM IS INVOLVED. AUDIT POSTS ON 2 OR MORE CLAIMS IN SUSPENSE OR IN PAID HISTORY.

NOTE: PROCEDURES INCLUDED OR EXCLUDE FROM AUDIT BY EFF DOS BELOW.
82250 - EXCLUDE 4/1/99
82251 - EXCLUDE 1/1/99
82247,82374,82248 - INCLUDE 1/1/99
86705,86709 - INCLUDE 1/1/00
84436,84479 - EXCLUDE 1/1/00

BABY ON MOM'S PIC VS MOM -- FORCE 013. OTHERWISE EXAMINER WILL REVIEW AND MANUAL PRICE PER MEDICARE GUIDELINES AS FOLLOWS:

NOTE: BUNDLED/UNBUNDLED PRICING APPLIES TO ALL SERVICES ON SAME DATE FOR SAME CLIENT, SAME PROVIDER, PER MDCR, TIMES OF DAY DONE DOES NOT MATTER.

1. 013 IS POSTING ON THE LINE IN SUSPENSE OR PAID HISTORY.
2. COUNT ALL THE LINES WITH AUTOMATED LAB "2" IN ALLOWED SOURCE.
3. FIND THE INTERNAL CODE THAT HAS THE # OF TESTS MATCHING YOUR CLAIMS. (SEE NEXT PAGE FOR INTERNAL CHART)
4. DIVIDE THE # OF TESTS INTO THE TOTAL ALLOWED SUM OF THE INTERNAL CODE = PRICE FOR EACH TEST. (IF THE PDDD ALLWD IS LESS THAN INTERNAL CODE ALLWD FOR 1 TEST - LET SYSTEM PRICE AT PDDD ALLWD FOR THE 1 TEST)
5. MANUAL PRICE EACH LINE WITH A "2" IN THE SOURCE AND FORCE 013.
6. LINES WITH A "C" IN THE SOURCE - FORCE THE 013.
7. LINES POSTING AGAINST HX CLAIM & HX DETAIL LINE HAS A "C" IN THE SOURCE CODE - FORCE IF THIS IS THE ONLY HX, OTHERWISE APPLY AUDIT.
8. LINES WITH A "G" IN THE SOURCE WOULD BE A "C" SOURCE, EXCEPT THE BILLED AMT IS LESS THAN THE PDDD ALLOWED - FORCE.
9. LINES WITH A "1" IN THE SOURCE - SEE YOUR TRAINER.
10. MULTIPLES OF THE SAME TEST - DENY W/EOB 910, UNLESS MOD QR OR 91 ON LINE, THEN FORCE THE DUPE AND TREAT AS 2 TESTS.
11. WHEN REVIEWING PAID HX - IF THE PAID CLAIM IS HARD COPY W/AT LEAST 6 LINES & THE CURRENT CLAIM STATES ADDITIONAL SERVICES - DO AN ADJ IF NECESSARY.
IF HX REVEALS MEDIA 1,2 OR 3 AND LINES ON CLAIM DO NOT EXCEED THE MAX - DENY CURRENT CLAIM (LINES POSTING 013 ONLY) W/EOB 189, UNLESS THERE IS NO MANUAL PRICINGON CURRENT CLAIM - THEN FORCE.
EXCEPTION: IF ADJ CREATES AN OVER MAX ON THE LINES - TREAT AS HARDCOPY.

NOTE: IT MAY BE NECESSARY TO ADJUST CLAIMS FOR APPROPRIATE PAYMENT, BUT MOST CLAIMS WILL BE BACK TO BACK.

NOTE: IF HARDCOPY PD HX VS CURRENT HARDCOPY AND PD VS CURRENT EQUALS THE SAME INTERNAL CODE $ - IT MAY BE APPROPRIATE TO DENY CURRENT AUTOMATED LAB "2" IN SOURCE W/EOB 380.

NOTE: IF MANUALLY PRICING A LINE AT MAX ALLOWED FOR INTERNAL CODE,
USE INFO EOB 380.

SEE NEXT PAGE FOR INTERNAL CODE PRICING CHART

INTERNAL CODE	# TESTS	7/00	7/01	7/02	1/03	7/03
8002M	1-2	$5.00	$5.18	$5.18	$5.83	$5.90
8003M	3	6.13	6.36	6.35	7.15	7.23
8004M	4	6.13	6.36	6.35	7.15	7.23
8005M	5	6.13	6.36	6.35	7.15	7.23
8006M	6	6.13	6.36	6.35	7.15	7.23
8007M	7	6.13	6.36	6.35	7.15	7.23
8008M	8	6.13	6.36	6.35	7.15	7.23
8009M	9	6.13	6.36	6.35	7.15	7.23
8010M	10	6.13	6.36	6.35	7.15	7.23
8011M	11	6.13	6.36	6.35	7.15	7.23
8012M	12	6.13	6.36	6.35	7.15	7.23
8016M	13-1	8.18	8.49	8.48	9.55	9.66
8018M	17-	9.17	9.51	9.50	10.70	10.82
8019M	199	10.60	11.00	10.99	12.38	12.51
8058M	20	10.95	11.36	11.35	12.78	12.92
8059M	21	11.29	11.71	11.70	13.18	13.32
8060M	22	11.64	12.07	12.06	13.58	13.73

TEXT KEY	TEXT DESC
14	

TEXT KEY	TEXT DESC
15	ONE PSYCH SERVICE PER DAY. 1. BOTH CLAIMS SUSPENDING - PAY THE HIGHER & DENY THE LOWER, 2. OTHERWISE, DENY THE CURRENT CLAIM. NOTE: 015 AND 066 FAILING ON THE SAME SERVICES: IF THERE IS A PSYCHOTHERAPY (I.E. 90819) AND AN EVALUATION (90801,90802) POSTING 015 AND 066 - WORK THE 066 FIRST. IF DENYING THE EVALUATION PAY THE PSYCH CALL. IF THE PSYCH WOULD GET DENIED - PAY THE EVALUTION. ---------- AUDIT CRITERIA CHANGED TO INCLUDE BOTH INPT/OUTPT SERVICES ON 7/02.

TEXT KEY TEXT DESC
17

THE FOLLOWING TEXT INFORMATION REFERS TO PAIN MANAGEMENT AFTER SURGERY AND DURING THE FOLLOWUP PERIOD.

NOTE: PROCEDURE CODE CHANGE ON 4-LINE PER DR. BAUMGARTNER 11/19/01

ALLOW 2 PAIN MANAGEMENT PROCEDURES, PAYING THE OLDEST DOS FIRST. DENY OR RECOUP AND DENY ALL OTHERS, SEE BELOW.

NOTE: IF 2 PAIN MANAGEMENT OF SAME PROCEDURE ON SAME DAY INDICATING LT/RT, MOD 50 OR BILATERAL - TREAT AS 1 OF THE ALLOWANCE OF 2.

1. IF HX SHOWS PAIN MANAGEMENT PAID AT 5B AND YOU ARE INCLUDING IN YOUR ALLOWANCE OF 2 - RECOUP AND REPAY AT 100 %.
2. IF MULTIPLES ON 1 LINE - CUT TO 1 UNIT W/INFO EOB 538.
3. ANYTHING UNUSUAL - SEE YOUR TRAINER.

ADJUSTMENTS ONLY: IF AFTER READING BACKUP, RESEARCHING HISTORY, ETC YOU FIND THAT NO INITIAL SURGERY WAS PERFORMED - YOU MAY FORCE THE 017 EXCEPTION AND USE INFO EOB 589. NOTE: IF POS 1,2,21,22,51,52 - REVIEW EACH CASE INDIVIDUALLY BEFORE YOU MAKE A DECISION TO %. ANY QUESTIONS - SEE YOUR SUPERVISIOR.

TEXT KEY	TEXT DESC
18	1 IN 2 YEARS ORTHO BANDING OR 1 IN 2 YEARS OCCLUSAL ORTHOTIC APPLIANCE (NIGHT GUARD)

1. 07880 OR D7880 VS 08--- CODES - FORCE.
2. 07880 OR D7880 VS 07880 OR D7880 - DENY WITH EOB 339.

TEXT KEY TEXT DESC

26

SPEECH THERAPY IS LIMITED TO 12 SESSIONS PER CALENDAR YEAR UNLESS DIAGNOSIS ON LIST 1017. IF AUTH PRESENT, REVIEW FOR POSSIBLE PAYMENT. DO NOT RECOUP CLAIMS IN HISTORY WITH DIAGNOSIS FROM LIST 1017, BUT USE THEM IN ADDING UP TO THE 12 LIMIT. THIS AUDIT DOES NOT APPLY TO AGE 20 & UNDER.

CLAIM TYPE M (OUTPATIENT) - REV CODE 420/430 - FORCE.
NOTE: IF PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY W/EOBS 968/365 AT HEADER.

ALL CLAIM TYPES:
IF OVER MAX - CUT TO MAX WITH INFO EOB 101, ALL ELSE DENY.

CLAIM TYPE J/P:
PROVIDER TYPE 36, 40, OR ANY UNUSUAL SITUATIONS, OVERLOC TO 75.

TEXT KEY TEXT DESC

27 ONE UPPER DENTURE ALLOWED IN 10 YEARS

DOS PRIOR TO 11-1-02:
1. IF NO JUSTIFICATION - DENY
2. IF JUSTIFICATION - FORCE.

DOS 11-1-02 TO 7-31-03:
1. IF DATES OF SERVICE ARE LESS THAN 1 YEAR APART:
   A. IF AUTHORIZATION - FORCE
   B. IF NO AUTHORIZATION - DENY W/EOB 023 IN SECOND SLOT.
2. IF DATES OF SERVICE ARE MORE THAN 1 YEAR APART:
   A. IF AUTHORIZATION - FORCE
   B. IF NO JUSTIFICATION - DENY
   C. IF JUSTIFICATION IS "NO LONGER SERVICEABLE", OR DAMAGED BEYOND REPAIR" - FORCE
   D. IF JUSTIFICATION SAYS "LOST" - ALLOW 1 REPLACEMENT WITHIN THE 10 YEAR PERIOD. IF MORE THAN 1 SET WITH THE JUSTIFICATION OF LOST - DENY WITH EOB 339.

DOS 8-1-03 AND AFTER:
1. AGE 21 AND OVER:
   A. IF AUTHORIZATION - FORCE.
   B. IF NO AUTHORIZATION - DENY
2. AGE 20 OR UNDER - FOLLOW DIRECTIONS UNDER DOS 11-1-02 - 7-31-03.

0515D VS 05110, D5110, OR 5110D AND THE SAME PROVIDER:
1. DATES OF SERVICE ARE MORE THAN A YEAR APART - FORCE.
2. DATES OF SERVICE ARE WITHIN A YEAR OF EACH OTHER - STAGE TO DETERMINE IF THE 0515D IS BEING BILLED FOR THE SAME SERVICE
   A. IF THE SERVICES ARE THE SAME - DENY WITH EOB 189.
   B. IF THE SERVICES ARE DIFFERENT - FORCE.

TEXT KEY TEXT DESC

28 TOTAL OF 4 BITEWINGS (ANY COMBO) EVERY 12 MONTHS.

00270/D0270 VS 00272/D0272
1. DOS PRIOR TO 7-1-02 - FORCE
2. DOS 7-1-02 OR AFTER:
   A. DIFFERENT DOS - FORCE
   B. SAME DOS (THE PAYMENT FOR THE TWO CODES SHOULD BE SAME AS D0274):
      1. AGES 18 AND UNDER MANUAL PRICE D0272 AT $4.80 W/EOB 954.
      2. AGES 19 AND OVER MANUAL PRICE D0272 AT $3.00 W/EOB 954.

00272/D0272 VS 00272/D0272 - FORCE.

IF 00272/D0272 HAS ALREADY BEEN PAID FOR ANOTHER DOS AND PROVIDER IS NOW BILLING 00274/D0274 THEN MANUALLY PRICE THE 00274/D0274 AT THE ALLOWABLE FEE FOR CODE 00272/D0272:
1. AGES 18 AND UNDER:
   A. DOS 7-1-97 TO 6-30-01 MANUAL PRICE AT $8.08 WITH EOB 954.
   B. DOS 7-1-01 TO 6-30-02 MANUAL PRICE AT $8.50 WITH EOB 954.
   C. DOS 7-1-02 OR AFTER MANUAL PRICE AT $10.40 WITH EOB 954.
2. AGES 19 AND OVER:
   A. DOS 7-1-97 TO 6-30-99 MANUAL PRICE AT $6.16 WITH EOB 954.
   B. DOS 7-1-99 TO 6-30-01 MANUAL PRICE AT $6.28 WITH EOB 954.
   C. DOS 7-1-01 OR AFTER MANUAL PRICE AT $7.00 WITH EOB 954.

IF 00270/D0270 HAS ALREADY BEEN PAID FOR ANOTHER DOS AND THE PROVIDER IS NOW BILLING 00274/D0274, THEN MANUALLY PRICE THE 00274/D0274 USING EOB 954 AT:
1. AGES 18 AND UNDER:
   A. DOS 1-1-99 TO 6-30-02 $9.00
   B. DOS 7-1-02 OR AFTER $11.60
2. AGES 19 AND OVER: $7.30

IF THREE BITEWINGS HAVE BEEN PAID FOR ANOTHER DOS AND THE PROVIDER IS BILLING 00272/D0272 OR 00274/D0274, PAY AT THE ALLOWABLE FEE FOR 00270/D0270:
1. AGES 18 AND UNDER:
   A. DOS 7-1-97 TO 6-30-01 MANUAL PRICE AT $6.06 WITH EOB 954.
   B. DOS 7-1-01 TO 6-30-02 MANUAL PRICE AT $7.00 WITH EOB 954.
   C. DOS 7-1-02 OR AFTER MANUAL PRICE AT $8.00 WITH EOB 954.
2. AGES 19 AND OVER:
   A. DOS 7-1-97 TO 6-30-99 MANUAL PRICE AT $5.15 WITH EOB 954
   B. DOS 7-1-99 TO 6-30-01 MANUAL PRICE AT $5.25 WITH EOB 954.
   C. DOS 7-1-01 OR AFTER - MANUAL PRICE AT $6.00 WITH EOB 954.

IF ANY COMBINATION OF 4 HAVE ALREADY BEEN PAID - DENY.

TEXT KEY	TEXT DESC
29	AMBULANCE ALS (0001A, A0426, A0427, A0433, A0434) VS BLS (A0428, A0429)
	IF DIFFERENT MODIFIER OR IF MILEAGE IS DIFFERENT-FORCE
	IF SAME MODIFIER AND PROVIDER INDICATES SECOND TRIP-FORCE
	IF SAME MODIFIER AND NO INDICATION FROM PROVIDER OF SECOND TRIP-DENY

TEXT KEY	TEXT DESC
32	IF THE THIS PROVIDER HAS A SPECIAL AGREEMENT - FOLLOW THE INSTURCTIONS ON THE AGREEMENT.

TEXT KEY	TEXT DESC
35	ONE REFRACTION ALLOWED IN A TWO YEAR PERIOD

IF PATIENT IS A DDD CLIENT, INDICATED BY EXCEPTION 498 POSTING - FORCE.

IF CLIENT IS CURRENTLY 21 OR OLDER AND WAS UNDER AGE 21 AT ANY TIME DURING HX CLAIMS - FORCE.

IF AUTHORIZATION ON THE CLAIM AND:
1. AUTH IS FOR SERVICES BILLED - FORCE.
2. SERVICES BILLED ARE NOT LISTED ON THE AUTH FILE - DENY (ADDING INFO EOB 251)

PAY THE OLDEST DATE OF SERVICE FIRST. DENY AND/OR RECOUP AS NECESSARY.

TEXT KEY TEXT DESC

40 MULTIPLE OPERATIVE PROCEDURES PERFORMED ON THE SAME PT AT THE SAME OPERATIVE SESSION SHALL BE PAID IN DECLINING PERCENTAGES WITH EOB 823. (SAME OR DIFFERENT PROVIDER.) DENY AND/OR RECOUP IF NECESSARY. IF YOU SEE A SUBSEQUENT SURGERY THAT IS OBVIOUSLY DUE TO COMPLICATIONS RESULTING FROM A PREVIOUS SURGERY - MANUAL PRICE AT 80% OF THE ALLOWED AMOUNT WITH EOB 805, SAME OR DIFFERENT PROVIDER.

MULTIPLE OPERATIVE PROCEDURES AT DIFFERENT OPERATIVE SESSIONS MUST BE DOCUMENTED IN THE REPORTS (I.E. 2 DIFFERENT START/STOP TIMES, MOVING PATIENT TO DIFFERENT TABLE OR ROOM). DO NOT %.

11100 - ALLOW 1
20605 - ALLOW 2
21031 - ALLOW 1 PER QUADRANT, BUT PERCENT AS USUAL.
29800, 29804 ALLOW 2 OF EACH CODE
41828 - ALLOW UP TO 4
41830 - ALLOW 1 PER QUADRANT, BUT PERCENT AS USUAL.
41874 - ALLOW 1 PER QUADRANT, BUT PERCENT AS USUAL.

FOR CLAIMS WITH DOS 5-1-95 AND AFTER:

HIGHEST ALLOWED AMOUNT = 100 PER CENT
2ND HIGHEST AND ALL OTHERS = 50 PER CENT OF THE ALLOWED AMOUNT
FOR DATES OF SERVICE 7-1-00 AND AFTER, USE THE PLACE OF SERVICE TO DETERMINE WHICH PRICING SEGMENT TO USE:
1. PLACE OF SERVICE IS 1,2,5,7,8,21,22,23,31,32,51,52,54 - USE THE "F" (FACILITY) SEGMENT.
2. PLACE OF SERVICE IS 3,4,6,9,11,12,24,25,60,71,81,99 - USE THE "N" (NON-FACILITY) PRICING SEGMENT.

ASSISTANT SURGEON -
IF DIFFERENT ORAL SURGEONS AND ONE IS ASSISTING AT SURGERY, CHECK THE PDD FILE TO MAKE SURE THE PROCEDURE ALLOWS AN ASSIST BY CHECKING THE "SURG ASST" FIELD. IF "Y" PAY THE ASSIST 20% OF THE MAX ALLOWABLE ON THE PDD FILE (UNLESS PROCEDURE IS "BY REPORT" WHICH WILL BE ON PDD FILE TO PAY AT 45% - PAY ASSIST AT 45% OF BILLED AMOUNT). IF "N" IN "SURG ASST" FIELD - DENY WITH EOB 702. IF ASSISTING AT MULTIPLE SURGICAL PROCEDURES PRICE THE SECONDARY AND ALL OTHER PROCEDURES AT 10% OF MAX ALLOWABLE

CO-SURGERY -
1. ADDITIONAL ASSIST BY A THIRD PARTY WILL NOT BE ALLOWED - DENY 366.
2. CO-SURGEONS RECEIVE A PERCENTAGE OF OUR ALLOWED AMOUNT FOR EACH PROCEDURE. PROCEDURES WILL BE PRICED AS FOLLOWS:

1ST PROCEDURE = 62.50 PERCENT
2ND AND ALL OTHERS = 31.25 PERCENT

TEXT KEY TEXT DESC

44 OUR RECORDS SHOW THIS IS AN ESTABLISHED PATIENT, FEE REDUCED ACCORDINGLY
ONLY ONE NEW PATIENT CODE IS ALLOWED PER PROVIDER IN ALL HISTORY.
CHANGE CODE AND/OR RECOUP AND CHANGE AS NECESSARY USING INFO EOB 354,
OR EFF 10/01/03 DOS - DENY W/EOB 354 ON "J" OR "L" UNLESS ADDRESSED
BELOW.

DEFINITION OF NEW PATIENT - ONE WHO IS NEW TO PHYSICIAN & NEEDS
ADMINISTRATIVE RECORDS ESTABLISHED. CLINICAL CORPORATIONS, PARTNERSHIPS,
OR SIMILAR ARRANGEMENTS WILL BE TREATED AS A SINGLE PHYSICIAN.

1. SAME PERFORMING PROVIDER - SEE BELOW.
2. DIFFERENT PERFORMING PROVIDER:
   NOTE: DIFFERENT PERFORMING PROV & CLAIM LOOKS LIKE A BILLING ERROR,
   (ALL LINES PD ON ORIGINAL, CLERK REBILLED W/DIFFERENT PP) -
   DENY W/EOB 'S 041/280.
   A. SAME SPECIALTY - SEE BELOW
   B. DIFFERENT SPECIALTY - FORCE.
   C. DUMMY PROVIDER # - TREAT AS IF SAME PROVIDERS - SEE BELOW.

POLICY NOTE: BEFORE YOU SEE BELOW, IF AN ADMIT (99221-99223) IS THE
ONLY INITIAL CALL IN HX & THE DOS IS AFTER THE INITIAL
CALL THAT IS POSTING 044 - FORCE THE INITIAL CALL.
(REASONING: ADMITS ARE ONLY IN HX OF THE 044 AUDIT TO
SHOW AN ESTABLISHED PATIENT. IF THE ADMIT WERE TO PAY
ON THE EARLIEST DOS, & THEN AN INITIAL CALL WERE BILLED,
THEN WE WOULD CUT THE INTIAL CALL BACK). PLEASE SEE
YOUR TRAINER IF THIS IS NOT CLEAR.

NOTE:

(J) VS (J) OR (L) VS (L):
1. TWO PROCEDURES ON THE SAME DAY BOTH IN SUSPENSE - PAY THE HIGHER,
   AND REDUCE THE LESSER W/INFO EOB 354. EFF 10/01/03 DOS - DENY.
2. INITIAL PAID IN HX VS INITIAL SUSPENDING ON SAME DAY - REDUCE
   ACCORDINGLY W/INFO EOB 354. EFF 10/01/03 DOS - DENY.

(L) VS (J) OR (J) VS (L):
1. TWO INITIALS ON THE SAME DAY IN SUSPENSE - PAY THE PROCEDURE THAT
   PAYS THE HIGHEST AND THE OTHER PROCEDURE WILL BE REDUCED ACCORDINGLY
   OR EFF 10/01/03 DOS - DENIED ACCORDINGLY.
2. INITIAL PAID IN HX VS INITIAL SUSPENDING ON SAME DAY - REDUCE
   ACCORDINGLY W/INFO EOB 354. EFF 10/01/03 DOS - DENY.

(J) VS (J) OR (L), (L) VS (L) OR (J)
TWO INITIALS ON DIFFERENT DOS:
1. BOTH IN SUSPENSE - PAY EARLIEST DOS AND REDUCE THE 2ND ACCORDINGLY
   W/INFO EOB 354. EFF 10/01/03 DOS - DENY.
2. ONE PAID IN HX VS ONE SUSPENDING - REDUCE SUSPENDING ACCORDINGLY
   W/INFO EOB 354. EFF 10/01/03 DOS - DENY.

CONTINUE TO APPLY THE EDIT ON THE FOLLOWING LIST AS STATED ABOVE,
HOWEVER, TREAT AN ADMIT (99221,99222,99223) SAME AS NEW PATIENT
(INITIAL) CALL.

99201----------99212 99381----------99391
99202 -------- 99212 99382----------99392
99203 -------- 99213 99383----------99393
99204 -------- 99214 99384----------99394
99205 -------- 99215 99385----------99395
99321 -------- 99331
99322 -------- 99332
99323 -------- 99333
99341 -------- 99351
99341 -------- 99347 (FOR DOS 1/1/98 & AFTER
99342 -------- 99352
99342 -------- 99348 (FOR DOS 1/1/98 & AFTER)
99343 -------- 99353
99343 -------- 99349 (FOR DOS 1/1/98 & AFTER)
99344 -------- 99350
99345 -------- 99350

(D) DENTAL:

00150 - CHG TO - 00120
D0150 - CHG TO - D0120
4413D - CHG TO - 4410D
4414D - CHG TO - 4411D
4415D - CHG TO - 4412D

TEXT KEY	TEXT DESC
48	MAXIMUM OF 3 HOURS OF SUBSTANCE ABUSE GROUP THERAPY IS ALLOWED PER DAY (12 1/4 HOUR CODES)

1. IF BILLING SPANS OF DATES ON ONE LINE:
   A. IF UNITS CAN BE DIVIDED EVENLY SO THAT THERE ARE 12 UNITS PER DATE OF SERVICE - FORCE.
   B. IF UNITS DO NOT DIVIDE BY 12 EVENLY - DENY WITH EOB 417.

2. IF BILLING DIFFERENT CATEGORIES OF GROUP THERAPY (EXAMPLE: 2149M TANF VS 0169M YOUTH) - DENY WITH EOBS 102 & 189.

3. 0159M - THIS TEXT ONLY APPLIES FOR DATES OF SERVICE ON OR BEFORE 6/30/01. FOR DATES OF SERVICE AFTER, HIT ENTER & 048 WILL DROP.

4. ALL ELSE - DENY OR CUT BACK TO 12 UNITS PER DAY USING EOB 101.

TEXT KEY	TEXT DESC
50	TRIMESTER CARE (5944M, 5945M, 5946M, 5951M, 5952M) OR TOTAL TRIMESTER CARE (59420,5950M) OR POST PARTUM CARE (59430) IS INCLUDED IN TOTAL OB CARE (59400) OR C-SECTION (59501,59521,59510,59515,59618) OR POST PARTUM CARE AND ASSIST AT C-SECTION (5947M) 1. IF THE TRIMESTER CARE IS FOR A NEW PREGNANCY FOLLOWING A PREVIOUS DELIVERY - FORCE. 2. CHECK TO IDENTIFY WHETHER OR NOT THE PROCEDURE YOU HAVE POSTING IS INDEED INCLUDED IN THE OB CODE IT'S POSTING AGAINST. A. IF IT'S NOT (I.E. 5946M VS 59515) - FORCE. B. IF IT IS - DENY.

TEXT KEY TEXT DESC

51 ONE DELIVERY PAID IN A NINE MONTH PERIOD.

NOTE: ASSIST VS ANES VS SURGEON, DO NOT BE CONCERNED ABOUT DOS NOT MATCHING FOR SAME PREGNANCY (IE) 01/01 VS 01/03 - FORCE.

NOTE: IF IT IS OBVIOUS AFTER REVIEWING CLAIM, HISTORY OR BACKUP THAT PROVIDER IS PRE-BILLING FOR THE DELIVERY - DENY W/EOB'S 076/589. ANY QUESTIONS - SEE YOUR SUP.

NOTE: ANESTHESIA VS ANESTHESIA & C-SECTION ANESTHESIA POLICY - O'LOC TO 12. LOC 12 REVIEW EXCEPTION 087 FOR PROPER ADJUDICATION.

NOTE: ANESTHESIA ONLY - IF 01968/01969 BILLED WITHOUT 01967 DENY W/EOB 757.

NOTE: 5947M VS 59510/59618 - DENY THE CURRENT W/EOB 302.

NOTE: DELIVERY CODES W/MOD TG (HIGH RISK) REPLACES HIGH RISK CODES 5941M/5959M. ONLY 1 DELIVERY W/THE (TG) ENHANCEMENT IS ALLOWED AND MUST BE BILLED ON ONE LINE. (IT PAYS AN ADDITIONAL FEE FOR HIGH RISK).
NOTE: DO NOT ALLOW AN ADDITIONAL HIGH RISK FEE TO ASSIST.

NOTE: WHEN DENYING 2ND DELIVERY ALSO, DENY HIGH RISK
1. PRIOR TO 07/01/03 DOS - ALSO DENY 5941M & 5959M (HIGH RISK DELIVERY ADD ON) WITH EOB 473.
2. 07/01/03 AND AFTER DOS:
A. 2 LINES BILLED - 1 WITH MOD TG & 1 WITHOUT TG BOTH DEL CODES.
1. DENY THE LINE WITHOUT THE MOD TG W/EOB 562.
2. DENY THE LINE WITH THE MOD TG W/EOB 818.
B. IF ONLY 1 LINE OF DELIVERY W/MOD TG - DENY.

EXCEPTIONS -

1. IF 2ND DELIVERY IS JUSTIFIED ON THE CLAIM, ADJUSTMENT OR BACKUP (E.G. 2ND BABY BORN PREMATURE) - FORCE.

2. TWINS/TRIPLETTS
A. PAY ONLY ONE CESAREAN DELIVERY - DENY 2ND,3RD W/EOB 324.
B. PAY CESAREAN DELIVERY AND VAGINAL DELIVERY/DELIVERIES EACH AT 100%.
PAY ONLY ONE WITH TRIMESTER CARE, MANUAL PRICE 2ND/3RD DELIVERY AT DELIVERY ONLY FEE IF NECESSARY.
C. PAY MULTIPLE VAGINAL DELIVERIES:
(1) DOS PRIOR TO 1/1/94 - MANUAL PRICE 2ND/3RD DELIVERY AT 50% OF PROCEDURE (59410) USING EOB 373.
(2) DOS 1/1/94 AND AFTER - MANUAL PRICE 2ND/3RD DELIVERY AT 50% OF PROCEDURE (59409) USING EOB 373.
D. PAY ONLY 1 5941M/5959M OR EFF 7/1/03 DOS, ONLY 1 OF ANY DELIVERY CODE W/HIGH RISK DELIVERY ADD ON MOD (TG), DENY W/EOB 339.

EXCEPTION: IF A VAG & C SECT - FORCE BOTH DELIVERIES, BUT MOVE THE (TG) MOD FROM THE VAG DELIVERY TO ONE OF THE OTHER MOD FIELDS ON THE LINE W/INFO EOB 359.

E. 59409 W/MODIFIER SU (FACILITY FEE FOR A BIRTHING CENTER):

1. SU MODIFIER VS. SU MODIFIER - DENY
   ONLY 1 FACILITY FEE IS ALLOWED PER PREGNANCY. DO NOT ALLOW MULTIPLES FOR TWIN OR TRIPLET BIRTHS.
   EXCEPTION: DIFFERENT PREGNANCY - FORCE. MORE...
2. SU MODIFIER VS. ANY OTHER MODIFIER OR BLANK MOD - FORCE.

TEXT KEY	TEXT DESC
52	

TEXT KEY TEXT DESC
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WORK THE INCLUSIVE/INCIDENTAL CRITERIA PRIOR TO 053 CRITERIA

1. INTENT:
SPECIFIC SITUATIONS MAY NOT BE ADDRESSED AND YOU MAY NEED TO ASK YOUR SUPERVISOR.

THE INTENT OF THIS EXCEPTION IS TO PAY MULTIPLE OPERATIVE PROCEDURES PERFORMED AT THE SAME OPERATIVE SESSION IN DECREASING PERCENTAGES. SINCE ALL PROCEDURES IN ALL POSSIBLE COMBINATIONS CANNOT POSSIBLY BE LISTED, THE FOLLOWING GUIDELINES AND EXAMPLES SHOULD BE THE BASIS FOR ANY DECISION MADE ON CIRCUMSTANCES NOT ADDRESSED. IF IN DOUBT, ASK YOUR SUPERVISOR.

NOTE: ORAL SURGEONS BILLING CPT CODES HITTING AGAINST HISTORY CLAIMS FOR EXTRACTIONS (D7140-D7240) - IGNORE THE EXTRACTION CODES AND APPLY THE REGULAR POLICY TO THE CPT CODES.

NOTE: EFFECTIVE ON 9/2/03, MODIFIERS U1/U2 ARE NOW VALID FOR DOS 7/1/03 DOS & AFTER. HOWEVER, WE DID EXTEND THE 5A/5B MODS UNTIL 7/31/03 DOS. THUS IF PT 22 BILLS W/EITHER MOD DURING THIS TIME PERIOD, PAY. OTHERWISE, IF THIS TEXT INSTRUCTS YOU TO PRICE A CLAIM WITH EITHER 5A/5B OR U1/U2, USE 5A/5B ONLY PRIOR TO 7/1/03 DOS. DOS AFTER 7/1/03 - USE U1/U2.

EXCEPTION: IF THIS TEXT INDICATES A DENIAL FOR SOME OTHER REASON - DENY. ANY QUESTIONS SEE TRAINER/MMIS.

12. POLICY & PROCEDURE

A. GENERAL

1. BEFORE APPLYING AUDIT 053 POLICY YOU WILL NEED TO LOOK AT THE MULTIPLE SURGERY, BILATERAL SURGERY, TEAM SURGERY, AND CO-SURGERY INDICATORS ON THE PDDD FILE TO SEE HOW YOU WOULD WORK

THE AUDIT.

2. GLOBAL DEFINITIONS:
   A. GLOBAL SURGERY DEFINITION INCLUDES: (PREVIOUSLY CONSIDERED FLAT FEE)
      1. THE OPERATION
      2. PRE-OPERATIVE VISITS, IN OR OUT OF THE HOSPITAL, BEGINNING ON THE DAY PRIOR TO SURGERY.
      3. SERVICES BY PRIMARY SURGEON, IN OR OUT OF THE HOSPITAL, DURING A STANDARD 90-DAY POST OPERATIVE PERIOD (0 TO 10 DAYS FOR MINOR SURGERY).
      4. DRESSING CHANGES; LOCAL INCISIONAL CARE & REMOVAL OF OPERATIVE PACKS, REMOVAL OF CUTANEOUS SUTURES, STAPLES, LINES, WIRES, TUBES, DRAINS AND SPLINTS, INSERTION, IRRIGATION AND REMOVAL OF URINARY CATHETERS. ROUTINE PERIPHERAL IV LINES, NASOGASTRIC AND RECTAL TUBES; AND CHANGE AND REMOVAL OF TRACHEOSTOMY TUBES. ALL ADDITIONAL MEDICAL OR SURGICAL SERVICES REQUIRED BECAUSE OF COMPLICATIONS THAT DO NOT REQUIRE ADDITIONAL TRIPS TO THE OPERATION ROOM.

   B. CCI GLOBAL DEFINITION:
      DURING THE SAME OPERATIVE SESSION THESE SERVICES ARE INCLUDED INTO THE MAJOR PROCEDURES PERFORMED. DENY AS INCLUSIVE WHEN BILLED BY THE SAME SURGEON AS THE MAJOR PROCEDURE.

      1. CLEANSING, SHAVING AND PREPPING OF SKIN
      2. DRAPING OF PATIENT, POSITIONING OF PATIENT
      3. SEDATIVE ADMINISTRATION BY SURGEON PERFORMING THE PROCEDURE
      4. LOCAL, TOPICAL OR REGIONAL ANESTHETIC ADMINISTERED BY THE SURGEON PERFORMING THE PROCEDURE
      5. SURGICAL APPROACH, INCLUDING IDENTIFICATION OF ANATOMICAL LANDMARKS, INCISION, EVALUATION (EXPLORATION) OF THE SURGICAL FIELD, LYSIS OF SIMPLE ADHESIONS, ISOLATION OF NEUROVASCULAR, MUSCULAR (INCLUDING STIMULATION FOR IDENTIFICATION), BONY OR OTHER STRUCTURES LIMITING ACCESS TO THE SURGICAL FIELD.
      6. SURGICAL SUTURES/STAPLES/STERI-STRIPS
      7. WOUND IRRIGATION
      8. INSERTION AND REMOVAL OF DRAINS, SUCTION DEVICES, DRESSINGS, PUMPS INTO SAME SITE
      9. APPLICATION, MANAGEMENT, AND REMOVAL OF POST-OPERATIVE DRESSINGS INCLUDING DEVICES (PERI-INCISIONAL TENS UNIT, INSTITUTION OF PATIENT CONTROLLED ANALGESIA)
      10. PREOPERATIVE, INTRAOPERATIVE AND POSTOPERATIVE DOCUMENTATION, INCLUDING PHOTOGRAPHS, DRAWINGS, DICTATION, TRANSCRIPTION
      11. SURGICAL SUPPLIES, UNLESS EXCEPTED BY EXISTING POLICY

3. EXCEPTION TO POLICY CLAIMS THAT HAVE BEEN REVIEWED AND PRICED BY A MEDICAL CONSULTANT SHOULD BE PAID BY CLAIMS PROCESSING AS PRICED. NOTE: YOU MUST STILL APPLY ALL POLICY AS WRITTEN

(I.E. BILATERAL(S), ENDOSCOPIES, ETC. IN COMBINATION W/OTHER SURGICAL PROCEDURES). ALL RELATED SURGICAL CLAIMS SHOULD BE SENT FOR REVIEW STATING ON THE ROUTING SLIP THAT THESE SURGERIES WERE DONE AT THE SAME OP SESSION AS SURGERIES PREVIOUSLY PRICED. ALWAYS USE EOB 383 ON THE LINE/LINES IF THE MEDICAL CONSULTANT ADJUSTS THE FEE. USE EOB 373 AT HEADER. ANY QUESTIONS SHOULD DO THROUGH YOUR SUPERVISOR.

4. MULTIPLE OPERATIVE PROCEDURES AT DIFFERENT OPERATIVE SESSIONS MUST BE DOCUMENTED IN THE REPORTS (I.E. 2 DIFFERENT START/STOP TIMES, MOVING PATIENT TO DIFFERENT TABLE OR ROOM). DO NOT %.

5. IF IT IS NECESSARY TO DENY ONE OR MORE OF THE SURGERIES ON A CLAIM OF MULTIPLE SURGERIES W/AN EOB SUCH AS (190) AND AN ADJUSTMENT WILL BE NECESSARY TO FINALIZE THE REBILL, ADD EOB 189 TO THE DENIED LINE. (THIS POLICY IS COVERAGE FOR EXAMINERS WITH SURGICAL POLICY TRAINING ONLY)

6. INCIDENTAL INSTRUCTIONS HAVE BEEN MOVED TO THE PAGE 37. WORK ALL INCIDENTAL INSTRUCTIONS PRIOR TO WORKING THE 053 CRITERIA.

7. FORCE IF TWO DIFFERENT SURGEONS ARE OPERATING AT THE SAME OP SESSION IN DIFFERENT AREAS (HEAD VS LEG, LEFT LEG VS RIGHT LEG, ETC.) OR DIFFERENT INCISIONS OR APPROACHES.

8. IF TWO DIFFERENT SURGEONS OF THE SAME SPECIALITY PERFORM SEPARATE SURGERIES IN THE SAME INCISION, PERCENT. IF DIFFERENT APPROACHES TREAT AS IF THEY WERE ALONE. IF DIFFERENT SPECIALTIES, TREAT EACH SURGEON AS IF THEY WERE ALONE.

9. TWO PHYSICIANS "ASSISTING" AT THE SAME SESSION- DENY THE CURRENT W/EOB 366. (IF BOTH SUSPENDING OR REPORT AVAILABLE, CHECK REPORT TO DETERMINE FIRST ASSIST AND PAY APPROPRIATELY).

10. PHYSICIAN AND P.A. "ASSISTING" AT THE SAME SESSION-DENY THE P.A. W/EOB 366.

11. CLAIM INDICATES THE SURGEON PERFORMED HIS OWN ANESTHESIA- HE SHOULD BE BILLING W/MOD 47. IF NO MOD OR MOD OTHER THAN THAN (47) IS USED-DENY W/EOB 036. EFF 7/1/00 DOS - NO LONGER ACCEPTS SURGEON.
NOTE: EFF 7/1/00 DOS - MAA NO LONGER ACCEPTS SURGEONS PERFORMING HIS OWN ANESTHESIA (MOD 47).

12. IF ASSISTANT OR CO-SURGEON BILLING WITHOUT MODIFIER 62,66,80, 81,82-DENY W/EOB 562.

13. IF PROV IS USING BY REPORT OR UNLISTED CODES (SHOWN AS "TYPE 4 PERCENT ON THE PDDD FILE) YOU WILL SEE THE SYSTEM HAS APPLIED THE PDDD FILE PERCENTAGE UNDER THE ALLOWED AMOUNT. DETERMINE THE MULTIPLE SURGERY PERCENTAGE BY USING 5A/5B OR EFF 7/1/03 DOS U1/U2.
NOTE: IF UNLISTED PROCEDURE CODE IS IDENTIFIED BY DESCRIPTION OR REPORT, YOU MAY NEED TO DENY 190, TO MAKE A DETERMINATION

WHETHER THE PROCEDURE DONE IS INCLUSIVE, NONCOVERED, OR NEEDS TO BE REVIEWED BY THE MEDICAL CONSULTANT. IF THE PROCEDURE DOES NEED TO BE REVIEWED, ROUTE TO DHSQS, DR. ANDERSON, MS 45506, WITH DETAILED QUESTION.

14. IF PROCEDURE ON PDDD FILE DOES NOT ALLOW CO-SURGERY OR SURGICAL TEAM- DENY W/EOB 702.

15. IF PROCEDURE ON PDDD FILE INDICATES (SINGLE OR 1) & PROVIDER IS BILLING FOR (RT & LT,MULTIPLE UNITS, MULTIPLE LINES) & A CODE INDICATING (MULTIPLES, SECOND THRU ?, EACH ADDITIONAL, ECT)IS AVAILABLE - DENY W/EOB 302.

B. SPECIFIC

1. RN ASSISTS-DENY W/EOB 325 THRU DOS 12/31/99.

2. IF THIS EXCEPTION IS FAILING AND ANOTHER CLAIMS INDICATES DIAGNOSIS V59-V59.9 (DONORS) - FORCE.

3. ORGAN DONOR VS ORGAN RECIPIENT ONLY-FORCE. IF IN DOUBT, SEE YOUR SUP/TRAINER.

4. ANESTHESIOLOGISTS (PT 20,48,49,OR 95) SEE 087 TEXT IF MAJOR ANESTHESIA PROCEDURE IS ON THE CLAIM OR IN HISTORY. OTHERWISE, APPLY 053 AUDIT.

5. HEART CATHERIZATIONS ON THE SAME DAY AS HEART SURGERY - DO NOT PERCENT AGAINST EACH OTHER. (EXCEPTION: THIS DOES NOT APPLY TO ANGIOPLASTIES). DO NOT % THE MOD TC ON HEART CATHS VS ANY OTHER PROCEDURE.

6. WHEN BILLING FOR USE OF LASER/ENDOSCOPE INDEPENDENTLY - DENY W/EOB 324.

7. 17380 (ELECTROLYSIS) IF BILLED IN COMBINATION W/EACH OTHER - PAY AT 100% EACH, IF BILLED IN COMBINATION W/OTHER PROCEDURES, APPLY 053 POLICY.

8. PRIOR TO 1/1/98 DOS SINUSOTOMY CODE (31090) SHOULD NOT BE PAID BILATERALLY.

9. TRICHIASIS: EPILATION (67820-67825) PAY ONE FOR LEFT AND RIGHT. THIS MAY BE DISTINGUISHED BY (I.E.) REPORT, RT/LT, E2/E4, E1/E3 COMBINATION MODIFIERS. DO NOT PAY MULTIPLES FOR ONE EYE - OR DENY W/EOB 324.

10. MULTIPLE DELIVERIES-SEE 051 TEXT.

11. FORCE D & C (DILATION AND CURETTAGE) ON THE SAME DAY AS DELIVERY (POSTPARTUM HEMORRAGE IS COMMON AFTER DELIVERY AND IS GENERALLY A DIFFERENT OP SESSION).

12. 59412 (EXTERNAL CEPHALIC VERSION) CAN BE PAID IN ADDITION TO DELIVERY IF BILLED BY OB/GYN (SPECIALITY 16) PHYSICIAN. DENY

W/EOB 324/712 IF ANY OTHER SPECIALITY.

13. 59020 (FETAL CONTRACTION STRESS TEST) AND 59025 (FETAL NON-STRESS TEST)-PAY MULTIPLES OF EACH APPLYING THE 053 POLICY. IF ALL BILLED W/MOD 26-DO NOT %, PAY AT 100% FOR EACH ADDTL. IF EITHER OF THE ABOVE PROCEDURES BILLED IN COMBINATION W/OTHER PROCEDURES W/MULT SURGI INDICATOR OF (2)-APPLY 053 POLICY; DO NOT APPLY % CRITERIA TO THE (TC) MOD. DO APPLY % CRITERIA TO A 100% WHEN ADDTLS BILLED W/MOD 26.

14. PAY 17340 (CRYOTHERAPY) ONLY ONCE PER OP SESSION REGARDLESS OF HOW MANY LESIONS WERE DESTROYED.

15. 61795 (STEREOTACTIC CAV) PER DR. BAUMGARTNER,1/03, DO NOT PAY THIS PROCEDURE FOR DX 473.1/473.2, DENY W/EOB 800/373.

16. AMBULATORY SURGERY CENTERS (ASC-PT 22)
NOTE: DO NOT APPLY CCI CRITERIA TO ASC-PT22.

17. 59409 W/MODIFIER SU -(FACILITY FEE PAYMENT FOR BIRTHS IN BIRTHING CENTERS) - 59409 SU VS. 59400, 59409, 59410 OR 59430 WITHOUT A MODIFIER OR WITH A DIFFERENT MODIFIER - FORCE. *SR

NOTE: HIPAA CONVERSION MODIFIERS FOR 5A & 5B ARE U1 & U2, RESPECTIVELY, EFFECTIVE W/DOS 7/1/03 & AFTER.

A. (ASC) PROCEDURES SHOULD BE BILLED & PAID W/MODS 5A AND 5B. (EXCEPTION: 64830 AND 69990 DO NOT NEED A MODIFIER - DO NOT %.)

B. THE PRIMARY PROCEDURE (PROCEDURE WITH THE HIGHEST REIMBURSMENT RATE) SHOULD BE IDENTIFIED WITH MODIFIER 5A. THE SECONDARY PROCEDURE SHOULD BE IDENTIFIED WITH MODIFIER 5B. DO NOT USE MOD 50 IN MODIFIER FIELD, OVERCODE RT/LT IF APPLICABLE FOR TWO LINES BILLED FOR SAME PROCEDURE CODE.

C. MOD (SG) BILLED W/ONLY 1 PROCEDURE - FORCE. 2 PROCEDURES BILLED - DENY BOTH LINES W/EOB 822.

D. 2 OF SAME PROCEDURE CODES & MOD 5A/5B IS PRESENT: CHECK TOS 3 TO SEE IF A "Y" IN BILAT FIELD.
   1. IF NO "Y" - DENY SECOND PROCEDURE W/WOB 324 OR;
   2. IF A "Y" PRESENT OR YOU THINK PROCEDURE COULD BE DONE RT/LT FORCE. (MAA WILL PAY TIME & 1/2 PER MDCR)

E. MOD 50 IS BILLED FOR SAME CODE:
   1. ON 2 LINES- CHECK CODES PER D ABOVE & PROCESS APPROPRIATELY IF 5A/5B ALSO BILLED & O'CODE APPROPRIATELY. NO 5A/5B IS BILLED - DENY W/EOB 822.
   2. ON 1 LINE - CHECK CODE PER D ABOVE
      A. IF BILAT IS APPROPRIATE - DENY W/EOB'S 538/822.
      B. IF BILAT IS NOT APPROPRIATE - DENY W/EOB 700.

F. MICRODISSECTION (69990) SHOULD ONLY BE BILLED W/61304 - 61711, 62010 - 62100, 63081 - 63308, 63704 - 63710, 64831 - 64907 - BILLED W/ANY OTHER CODES DENY W/EOB 800. (EFF 7/1/01 69990 NO LONGER APPLICABLE TO ASC).

G. ASC BILLING MORE THAN 2 SURGERIES - DENY W/EOB 339. (EXCEPTION: 69990 MAY BE BILLED IN ADDITION TO 2 ALLOWABLE SURGERIES & AT LEAST 1 OF THEM IS (64831-64907)

THRU DOS 7/1/02.)

H. 2 DIFFERENT PROCEDURES ARE BILLED & NO MOD 5A/5B - DENY W/EOB 822. (EFFECTIVE 7/1/03 DOS MODS 5A/5B REPLACED WITH U1/U2.)

17. CHROMOTUBATION (58350) DO NOT PAY IF BILLED FOR INFERTILITY DX CODES (628 - 628.9) - DENY W/EOB 325/373.

18. CO-SURGERY (TWO SURGEONS-SAME AREA)(MOD-62)

A. ADDITIONAL ASSIST BY A THIRD PARTY WILL NOT BE ALLOWED-DENY W/EOB 366.

B. DETERMINE IF CO SURGERY IS/IS NOT ALLOWED. PF4 UNDER THE CODE & REVIEW THE CO SURG FIELD ON PDDD.
1. IF "Y" GO TO POLICY/PROCEDURE SECTION IN THIS TEXT.
2. IF "N": DENY W/EOB 702. (PER MEDICAL CONSULT DECISION, REQUESTS FOR ETR SHOULD COME THROUGH DMM)

C. CO-SURGEONS RECEIVE 62.5% OF OUR ALLOWED AMOUNT FOR THE MAJOR PROCEDURE. DECREASING PERCENTAGES WILL BE PRICED AS FOLLOWS:

PRIMARY PROCEDURE	62.5%
SECONDARY PROCEDURE	31.25%

19. SURGICAL TEAM (MOD-66)(MORE THAN 2 SURG, SAME OR DIFFERENT AREA).
THE FORMULA FOR PRICING IS - ALLOWED AMT + 25% = 125%, 125% DIVIDED BY THE NUMBER OF SURGEONS INVOLVED.

NOTE: IF PROCEDURE ON PDDD FILE DOES NOT ALLOW SURGICAL TEAM DENY W/EOB 702.

20. FOR CO-SURGEONS AND SURGICAL TEAMS ONLY: IF PROCEDURE IS BY REPORT OR UNLISTED, AND PAYS AT A PERCENT OF CHARGES (TYPE 4 ON PDDD FILE) AND BILLED AMOUNT IS OVER $1100.00 AND NO REPORT IS ATTACHED - DENY W/EOB 190. IF REPORT IS ATTACHED - OVERLOC TO LOC 14.

21. ENDOSCOPIES

NOTES FOR BOTH RELATED AND UNRELATED ENDOSCOPIES:

A. WHEN DENYING THE BASE PROCEDURE OR A PROCEDURE THAT SHOWS A NEGATIVE AMOUNT-USE EOB 561.

B. USE INFO EOB 561 ON ALL PROCEDURES YOU ARE APPLYING THE ENDOSCOPY RULE TO.

C. PAY ONLY ONE UNIT FOR REMOVAL OF POLYPS/BIOPSIES DURING AN ENDOSCOPIC SESSION. DENY ALL OTHERS W/EOB 324.

D. PHYSICIAN (J)VS MEDICARE X-OVER (O)- IF MEDICARE HAS DENIED SURGERY, STAGE PHYSICIANS CLAIM FOR MEDICARE BACKUP TO DETERMINE IF SURGERY NEEDS TO BE DENIED AS INCLUDED

IN MAJOR PROCEDURE. ANY QUESTIONS, SEE YOUR SUPERVISOR.

NOTE: FOR ENDOSCOPIC PROCEDURES AND MINOR SURGERY, FOR WHICH GLOBAL SURGICAL PAYMENT POLICY HAS NOT GENERALLY BEEN USED, PAYMENTS ARE NOT ALLOWED FOR A VISIT ON THE SAME DAY OF THE SURGICAL OR ENDOSCOPIC PROCEDURE UNLESS A DOCUMENTED, SEPARATELY IDENTIFIABLE SERVICE IS PROVIDED.

--RELATED ENDOSCOPIC PROCEDURES--

SPECIAL PRICING RULES APPLY TO MULTIPLE ENDOSCOPIC PROCEDURES BILLED ON THE SAME DATE OF SERVICE. THE PROCEDURE WHICH HAS THE HIGHEST VALUE IS PAID THE FULL GLOBAL AMOUNT. THE SECOND HIGHEST VALUE PROCEDURE, EXAMPLE, A PHYSICIAN BILLING PROCEDURE CODES 45385 (REMOVAL OF A POLYP) AND 45380 (BIOPSY OF A LESION) WOULD RECEIVE THE FULL GLOBAL AMOUNT FOR 45385 (THE HIGHEST VALUE PROCEDURE). IN ADDITION, THE SECONDARY PROCEDURE WOULD BE CALCULATED BY SUBTRACTING THE VALUE OF PROCEDURE CODE 45378 FROM THE VALUE OF 45380. PROCEDURE CODE 45378 IS CONSIDERED A COMPONENT OF BOTH THE BILLED CHARGES, AND IS THEREFORE DEDUCTED FROM THE SECOND AND SUBSEQUENT CHARGES RELATING TO THE COLONSCOPY. THE BASE PROCEDURE IS DETERMINED FROM THE PDDD FILE. LOOK AT THE PDDD FILE FOR 45385 AND NOTE THE BASE CODE (45378). CHECK THE PDDD FILE ON THE BASE CODE AND NOTE THE ALLOWABLE. SUBTRACT THE ALLOWABLE FOR THE BASE FROM THE ALLOWABLE FOR YOUR PROCEDURE.
ENDOSCOPIES SUBJECT TO THIS RULE ARE DISIGNATED W/A 3 IN THE MULTIPLE SURGERY FIELD ON THE PDDD FILE.

NOTE: IF BILLING BILATERAL ENDOSCOPIES APPLY THE ENDOSCOPY RULE FIRST, AND THEN THE BILATERAL RULE.

NOTE: ENDOSCOPY AND BILATERAL (MOD 50)- IF TWO OF SAME SURGERY, APPLY BILATERAL RULE ONLY AND NOT THE ENDOSCOPY RULE. IF TWO DIFFERENT SURGERIES, APPLY BOTH THE ENDOSCOPY RULE AND THE BILATERAL RULE.

NOTE: PER MEDICAL CONSULTANT-PAY ONLY ONE SCOPY IN THE URINARY AREA UNLESS THE PROCEDURE HAS A "Y" IN THE BILATERAL FIELD, THEN YOU WOULD EITHER PAY AS IN THE SCOPY FAMILY OR 5A/5B,U1/U2 IF NOT.

--UNRELATED ENDOSCOPIC PROCEDURES--

UNRELATED ENDOSCOPIC PROCEDURES PERFORMED ON THE SAME DAY I.E. 45380 (COLOSCOPY WITH BIOPSY OF LESION) AND 43234 (UPPER GASTROINTESTINAL ENDOSCOPY) WOULD BE SUBJECT TO THE MULTIPLE SURGERY RULE INSTEAD OF THE ENDOSCOPY RULE SINCE THE CODES ARE NOT IN THE SAME RANGE GROUP. IN THIS CASE (45380) WOULD BE PD IN FULL AND (43234) WOULD BE PD AT 50%. (5A/5B,U1/U2 IN ADDITION, IF MULTIPLE UPPER AND LOWER GI ENDOSCOPIES WERE PERFORMED ON THE SAME DAY, THE SPECIAL GROUP AND ENDOSCOPY RULES WOULD BE APPLIED SEPARATELY WITHIN EACH GROUP AND MULTIPLE SURGERY RULE WOULD BE APPLIED BETWEEN THE GROUPS.

22. SURGICAL PROCEDURE/PAYMENT REDUCTION(S)-CUTBACK POLICY SURGICAL PROCEDURES (OTHER THAN SURGI INDICATOR OF 3) THAT ARE LISTED IN CPT AS A BASE PROCEDURE SHOULD BE REVIEWED FOR POSSIBLE CUTBACK AND MANUAL PRICE. FOR EXAMPLE, PROVIDER IS BILLING 47610 (CHOLECYSTECTOMY W/EXPLORE OF COMMON DUCT) AND 47605 (CHOLECYSTECTOMY W/ANGIOGRAPHY). YOU WOULD NOT WANT TO PAY THE CHOLECYSTECTOMY TWICE. YOU DO NEED TO PAY IT ONCE AND BOTH OF THE OTHER PROCEDURES. PAY THE 47610 AT 100% AND SUBTRACT THE CHOLECYSTECTOMY BASE PRICE OF 47600 FROM THE LESSER PROCEDURE OF 47605 AND MANUAL PRICE AT THE BALANCE. THIS WAY, THE PROVIDER IS GETTING ONE CHOLECYSTECTOMY, ONE EXPLORATION OF COMMON DUCT, AND ONE ANGIOGRAPHY. DO NOT % THE CUT BACK PROCEDURES USE EOB 805.

ANOTHER EXAMPLE OF THE CUTBACK POLICY: A PROCEDURE THAT HAS A SURGERY INDICATOR OF (2) BILLED WITH A PROCEDURE(S) THAT HAVE SURGERY INDICATOR (3) AND THEY ARE UNDER THE SAME SUB HEADING IN THE CPT. LOOK AT THE BASE CODE FOR THE SURGI-INDICATOR (3), IF THE MONEY IS LESS THAN THE SURGERY INDICATOR (2) CODE, SUBTRACT THE VALUE OF THE BASE PROCEDURE WITH THE INDICATOR OF (2) AND USE EOB 805. DO NOT INCLUDE THE SURGERY INDICATOR (2) IN PERCENT POLICY. IF THE VALUE OF THE BASE PROCEDURE IS MORE THAN THE SURGI-INDICATOR (2) DO NOT CUT, APPLY PERCENT POLICY IF APPLICABLE.

23. 78306 AND 78320, 78802 AND 78803, 78806 AND 78807

A. THE MULTIPLE SURGERY RULE WILL BE APPLIED WHEN THE ABOVE COMBINATIONS ARE BILLED FOR THE SAME CLINET, ON THE SAME DAY, BY THE SAME PHYSICIAN, OR BY MORE THAN ONE PHYSICIAN OF THE SAME SPECIALITY IN THE SAME GROUP PRACTICE.

B. THE MULTIPLE SURGERY RULE WILL ALSO BE APPLIED WHENEVER THE ABOVE CODES ARE BILLED WITH OTHER CODES THAT ARE SUBJECT TO THE MULTIPLE SURGERY RULES, NOT JUST WHEN BILLED IN THE COMBINATIONS SPECIFIED ABOVE.

NOTE: FORCE MOD 26 VS TC FOR SAME PROCEDURE
NOTE: MOD 26 OR TC VS 100% SAME PROCEDURE- SEE SUPERVISOR.
NOTE: MOD 1M/SU(IF SPECIAL CONTRACT INDICATES TECHNICAL) VS MOD 26-FORCE

24. PAIN MANAGEMENT PROCEDURES (11981-11983, 20526, 61790, 62273-62283, 62298-62365, 63600, 63650-63655, 63660, 63685-63688 64400-64484, 64505-64595, 64600-64680, 64802-64818)

PAIN MANAGEMENT PROCEDURES BILLED IN COMBINATION W/EACH OTHER IN POS 1,21,51 - FORCE.

PAIN MANAGEMENT PROCEDURES (62310-62319) ARE UNILATERAL. THESE CODES MAY BE BILLED ONLY ONCE PER LEVEL, ONCE PER SIDE. IF BOTH SIDES OF SPINAL LEVEL ARE INJECTED - MOD 50 SHOULD BE USED TO AND PAID AS A BILATERAL PROCEDURE.

NOTE: DO NOT APPLY THE 053 AUDIT IF YOU ARE APPLYING THE ALLOWANCE OF TWO IN THE 017 AUDIT. (WORK THE 017 AUDIT FIRST).

NOTE: PROCEDURE CODE UPDATE PER DR. BAUMGARTNER 11/19/01

3. PDDD INDICATORS FOR SURGICAL ADJUDICATION (REVIEW BEFORE APPLYING POLICY)
   A. MULTI -SURGI INDICATOR:
      1. 0 INDICATES PAYMENT ADJUSTMENT RULES FOR MULTIPLE SURGERIES DO NOT APPLY.
      2. 2 STANDARD PAYMENT ADJUSTMENT RULE APPLIES (100%,50%).
      3. 3 SPECIAL RULE FOR MULTIPLE ENDOSCOPIC PROCEDURES APPLIES IF THIS SERVICE IS BILLED WITH ANOTHER ENDOSCOPY THAT HAS THE SAME BASE. IF THE SERVICE(S) IS BILLED WITH THE BASE PROCEDURE THE BASE PROCEDURE IS NOT PAID SEPARATELY. PAYMENT FOR THESE BASE PROCEDURES IS INCLUDED IN THE PAYMENT FOR THE OTHER ENDOSCOPY.

   B. DUP CHECK INDICATOR:
      1. BLANK - IF MULTIPLES MEDICALY JUSTIFIED, I.E. BODY PARTS, OR BY REPORT/WRITEN DESCRIPTION - APPLY 053 POLICY.
      2. 1 - MULTIPLES ALLOWED PER RBRVS/MEDICARE IN CONJUNCTION WITH WRITTEN DESCRIPTION OR BODY PARTS.

   C. BILATERAL INDICATOR FOR SURGERY MOD (50):
      1. N - PAYMENT ADJUSTMENT DOES NOT APPLY.
      2. Y - PAYMENT ADJUSTMENT FOR BILATERAL PROCEDURES APPLIES IF CODE IS BILLED WITH MOD 50.

   D. CO-SURGEON INDICATOR FOR MOD (62):
      1. N - CO SURGEONS NOT PERMITTED FOR THIS PROCEDURE.
      2. Y - CO SURGEONS COULD BE PAID.

   E. TEAM SURGERY INDICATOR FOR MOD (66):
      1. N - TEAM SURGEONS NOT PERMITTED FOR THIS PROCEDURE.
      2. Y - TEAM SURGEONS COULD BE PAID.

   F. MULTIPLE UNITS:
      1. MULTI SURGERY INDICATOR (0)
         A. DUP CHECK = BLANK:
            1. MULTIPLES MEDICALLY JUSTIFIED,IE BY BODY PARTS OR BY REPORT/ WRITTEN DESCRIPTION - FORCE.
            2. MULTIPLES NOT QUALIFIED - DENY W/EOB 538.

         B. DUP CHECK = 1
            1. MULTIPLES ARE ALLOWED PER MEDICARE/RBRVS - FORCE.
            2. MULTIPLES ARE QUESTIONABLE - SEE SUP TRAINER.

      2. MULTI SURGERY INDICATOR = 2 OR 3:
         NOTE: IF PER THE CPT AND ANATOMY A PROCEDURE CODE CAN BE BILLED MULTIPLY ON SEPARATE LINES, IF MULTIPLE UNITS ARE

BILLED ON THE SAME LINE & THE PROCEDURE IS THE 5B/U2 SECONDARY PROC ONLY OF AN OP SESSION, THEN MULTIPLE UNITS CAN BE PAID ON ONE LINE.
--ALWAYS USE THE PDDD FILE ALLOWANCE FOR DETERMINING 5A/5B, U1/U2 PLACEMENT FOR THE PROCEDURES IN SAME OP SESSION WHEN MULTIPLE UNITS HAVE BEEN BILLED ON ONE LINE.--

A. DUP CHECK = BLANK:
--MULTIPLES MEDICCALY JUSTIFIED BY(IE)BODY PARTS OR BY REPORT/ WRITTEN DESCRIPTION
1. IF PER 053 CRITERIA THE 5A/U1 PROC IS WITHIN THIS LINE - DENY W/EOB 538.
2. IF PER 053 CRITERIA ONLY 5B/U2 PROC ARE WITHIN THIS LINE - PLACE 5B/U2 PER 053 IF APPROPRIATE & FORCE 177.

B. DUP CHECK = 1:
--MULTIPLES ARE ALLOWED PER MEDICARE/RBRVS IF:
1. IF PER 053 CRITERIA THE 5A/U1 PROCEDURE IS WITHIN THIS LINE - DENY W/EOB 538.
2. PER 053 CRITERIA ONLY 5B/U2 PROCEDURES ARE WITHIN THIS LINE - PLACE 5B/U2 IF APPROPRIATE & FORCE 177.
NOTE: IF MULTIPLES ARE QUESTIONABLE - SEE SUP/TRAINER.

4. GENERAL PRICING:

A. THE FOLLOWING APPLIES TO SURGEONS, CO-SURGEONS, TEAMS AND ASSISTANTS

B. MULTIPLE OPERATIVE PROCEDURES AT THE SAME OPERATIVE SESSION ARE TO BE PAID WITH DECREASING PERCENTAGES USING THE ALLOWED AMOUNT AS THE PERCENTAGE CRITERIA - HIGHEST TO LOWEST.

C. THE MAJOR SURGERY OR HIGHEST PDDD ALLOWED AMOUNT IS PAID AT 100% OF THE ALLOWED

D. THE SECONDARY SURGERIES ARE ALL PAID AT 50% OF THE PDDD ALLOWED W/INFO EOB 823 ON AT LEAST ONE LINE OF THE SECONDARY SURGERIES.

E. SURGEONS: DETERMINE THE MODIFIER PLACEMENT OF 5A/U1 FOR 100% OR 5B/U2 FOR 50% SURGERIES. THIS IS CONSISTENT TO ENDOSCOPIES.

F. CO-SURGEONS/TEAMS: MANUAL PRICE AT 100% OF THE 62.5% (SYSTEM ALLOWED) FOR THE MAJOR SURGERY AND 50% OF THE 62.5% (SYSTEM ALLOWED) FOR SECONDARY SURGERIES.

G. ASSISTANTS: MANUAL PRICE AT 100% OF THE 20% (SYSTEM ALLOWED) FOR THE MAJOR SURGERY AND 50% OF THE 20% (SYSTEM ALLOWED) FOR THE SECONDARY SURGERIES.

H. IF UNABLE TO OVERIDE MODIFIERS - REFER TO THE 993 FOR APPROPRIATE OVERCODE PLACEMENT.

5. MODIFIERS:

NOTE: EFF W/DOS 7/1/03 MODIFIERS 5A/5B ARE BEING REPLACED W/MODS U1/U2. SEE UPDATE REFERENCE THROUGHOUT THIS TEXT.

MODIFIERS THAT CANNOT BE OVERIDDEN ARE: 26,54,55,56,62,66,78,80,81 82,9T,ST,TG OR 50 UNLESS BILATERAL INDICATOR = N.

A. MOD 47: ANESTHESIA BY SURGEON
WHEN REGIONAL OR GENERAL ANESTHESIA IS PROVIDE BY THE SURGEON, IT MAY BE REPORTED BY ADDING MODIFIER 47 TO THE BASIC SERVICE. THIS MODIFIER IS NOT APPROPRIATE FOR LOCAL OR DIGITAL ANESTHESIA, OR BIER BLOCK. PAYMENT ISS 50% OF THE LISTED ANESTHESIA VALUE. THIS MODIFIER CANNOT BE USED WITH NERVE BLOCKS, SPINAL PUNCTURES, ETC. HOWEVER, IT MAY BE USED IN CONJUNCTION WITH A DELIVERY OR C-SECT PROCEDURE CODE WHEN PHYSICIAN IS ALSO PERFORMING THE EPIDURAL.
NOTE: EFF 7/1/00 DOS MAA NO LONGER ALLOWS PHYSICIANS BILLING FOR THEIR OWN ANESTHESIA (MOD 47).

B. MOD 50:
1. BILATERAL PROCEDURE
A. UNLESS OTHERWISE IDENTIFIED AS BILATERAL IN THE LISTING, BILATERAL PROCEDURES THAT ARE PERFORMED AT THE SAME SESSION SHOULD BE IDENTIFIED BY THE MOD 50 AND THE APPROP-RIATE 5 DIGIT CODE DESCRIBING THE FIRST PROCEDURE.
B. FOR SURGICAL PROCEDURES TYPICALLY PERFORMED ON BOTH SIDES OF THE BODY, PAYMENT IS MADE BASED ON 100% OF THE VALUE FOR THE PROCEDURE CODE.
C. FOR SURGICAL PROCEDURES TYPICALLY PERFORMED ON ONE SIDE OF THE BODY, BUT PERFORMED BILATERALLY IN A SPECIFIC CASE, PAYMENT IS 150% OF THE GLOBAL SURGERY FEE FOR THE PROCEDURE.
D. MODIFIER 50 INDICATES BILATERAL. THE PROCEDURE MAY BE BIL-LED ON TWO LINES WITH THE MOD 50 ON THE SECOND LINE ONLY OR THE PROCEDURE MAY BE BILLED ON ONE LINE WITH MOD 50.
E. MODIFIERS LT/RT BILLED ON TWO LINES MAY ALSO INDICATE BILATERAL.
NOTE: RT/LT MOD CAN BE USE SAME AS MOD 50.

2. PRICING
NOTE: IF MULTIPLE SURGICAL PROCEDURES, APPLY ALL APPROPRIATE CRITERIA.

A. IF 1 LINE W/MOD 50, BILAT INDICATOR = N, AND IT IS APPROP-RIATE TO PAY RT & LT (IE LEGS,ARMS,BREASTS) - DENY W/EOB'S 036/538.OTHERWISE, MANUAL PRICE AT THE BILLED AMT OR SYSTEM ALLOWED FOR 1, WHICHEVER IS LOWER AND USE EOB 001/866.
B. IF 2 LINES W/MOD 50 ON SECOND LINE, BILAT INDICATOR = N AND ITS APPROPRIATE TO PAY RT & LT (IE LEGS,ARMS, BREASTS)-APPLY 053 OTHERWISE, MOVE MONIES TO LINE W/NO MOD 50 IF NECESSARY AND USE EOB 001. DENY LINE W/MOD 50 W/EOB 866.
C. IF 1 LINE W/MOD 50, BIALT INDICATOR = Y - MANUAL PRICE LINE AT 150% W/APPROPRIATE BILAT O'CODE.
D. IF 2 LINES W/MOD 50 ON SECOND LINE, BILAT INDICATOR=Y-ALLOW LINE ONE TO PAY AT 100% AND MANUAL PRICE LINE TWO AT 50% OF THE SYSTEM MAX ON PDDD FOR DOS USING BI-LATERAL O'CODE.

E. IF 2 LINES W/NO MOD 50, BILAT INDICATOR= Y - SEE (D) ABOVE AND PROCESS AS IF A MOD 50 ON THE SECOND LINE.
F. IF 1 LINE W/NO MOD 50, BILAT INDICATOR = Y - APPLY 053 CRITERIA.
G. IF BILAT INDICATOR = Y, NO MOD 50, MULTIPLES ARE ALLOWED - APPLY 053 CRITERIA.

NOTE: IT MAY BE APPROPRIATE TO APPLY % CRITERIA TO A PROCEDURE THAT HAS BEEN PRICED BIALATERALLY.

NOTE: IF PROCEDURE HAS A DUP CHECK "1" ON PDDD AND "N" IN BILATERAL FIELD - WE MAY PAY MULTIPLES - SEE INFO ON DUP CHECK IN DUP CHECK SECTION.

C. MOD 51: MULTIPLE PROCEDURES. WHEN MULTIPLE SURGERIES ARE PERFORMED ON THE SAME CLIENT AT THE SAME OPERATIVE SESSION TOTAL PAYMENT IS EQUAL TO THE SUM OF THE 100% OF THE GLOBAL FEE FOR THE HIGHEST FEE PROCEDURE; 50% OF THE GLOBAL FEE FOR THE SECOND THROUGH FIFTH PROCEDURES. PROCEDURES IN EXCESS OF FIVE REQUIRE SUBMISSION OF DOCUMENTATION AND INDIVIDUAL REVIEW TO DETERMINE THE PAYMENT AMT.

D. MOD 52: REDUCED SERVICES. UNDER CERTAIN CIRCUMSTANCES, A SERVICE OR PROCEDURE IS PARTIALLY REDUCED AT THE PHYSICIAN DIRECTION. UNDER THESE CIRCUMSTANCES, THE SERVICE PROVIDED CAN BE IDENTIFIED BY ITS USUAL PROCEDURE NUMBER AND THE ADDITION OF THE MOD 52 SIGNIFYING THAT THE SERVICE IS REDUCED. THIS PROVIDES A MEANS OF REPORTING REDUCED SERVICES WITHOUT DISTURBING THE IDENTIFICATION OF THE BASIC SERVICE. USING THIS MODIFIER WILL NOT REDUCE THE ALLOWANCE TO THE PROVIDER.

NOTE: MOD 52 MAY BE USED W/COMPUTERIZED TOMOGRAPHY NUMBERS FOR A LIMITED STUDY OR A FOLLOW-UP STUDY.

E. MOD 53: DISCONTINUED PROCEDURE. UNDER CERTAIN CIRCUMSTANCES, THE PHYSICIAN MAY ELECT TO TERMINATE A SURGICAL OR DIAGNOSTIC PROCEDURE. DUE TO EXTENUATING CIRCUMSTANCES, OR THOSE THAT THREATEN THE WELL BEING OF THE PATIENT, IT MAY BE NECESSARY TO INDICATE THAT A SURGICAL OR DIAGNOSTIC PROCEDURE WAS STARTED BUT DISCONTINED. USE OF MOD 53 IS ALLOWED FOR ALL SURGICAL PROCEDURES. MODIFIER 53 IS PAYMENT MOD WHEN USED WITH PROCEDURE CODE 45378 ONLY; DO NOT INCLUDE IN % CRITERIA. ALL ELSE, TREAT AS INFO MOD, APPLY 053 CRITERIA & PRICE ACCORDINGLY STARTING WITH PDDD FILE MAX FOR DOS. IF OVERIDING WITH ANOTHER MOD USE O'CODE 809.

NOTE: MOD 53 BILLED BY PT 22- SEE YOUR SUP/TRAINER. MOD 53 IS NOT APPLICABLE TO PT 22 AND CANNOT TAKE THE PLACE OF 5A/5B OR U1/U2. *S

F. MOD 54/55/56: INTRODUCTION. PROVIDERS PROVIDING LESS THAN GLOBAL SURGICAL PACKAGE SHOULD USE MODS 54,55, & 56. THE PAYMENT POLICY PAYS EACH PHYSICIAN DIRECTLY FOR HIS PORTION OF THE GLOBAL PKG.

INFO: MOD 54 VS 55 OR 56 SAME PROCEDURE - FORCE.
MOD 55 VS 54 OR 56 SAME PROCEDURE - FORCE.
MOD 56 VS 54 OR 55 SAME PROCEDURE - FORCE.
MOD 54,55,56, VS 100% OR VICE VERSA, SAME PROCEDURE - DENY W/EOB 587.

G. MOD 54: INTRA OP ONLY. ONE PHYSICIAN PROVIDES A SURGICAL PROCEDURE AND ANOTHER PROVIDES PRE/POST OP. IF MULTIPLE SURGERIES ARE BILLED ON 1 OR MORE LINES W/MOD 51, OVERIDE THE 51 MODS W/MOD 54, APPLY THE 053 POLICY IN DECREASING PERCENTAGES IF APPRO-PRIATE. MOD 54 VS SAME MOD- IF YOU HAVE MULTIPLE SURGICAL PROCE-DURES POSTING, APPLY 053 CRITERIA. PRICE SECOND, THIRD ETC AT 50% USE ALL APPROPRIATE OVERIDE CODES (IE 819,820). REFER TO ASSIST MODS & CO-SURG MODS.

H. MOD 55: POST OP ONLY. WHEN ONE PHYSICIAN PERFORMS THE POST OP MANAGEMENT & ANOTHER PHYSICIAN PERFORMS THE INTR/PRE OP. MOD 55 VS SAME MOD - IF YOU HAVE MULTIPLE SURGICAL PROCEDURES POSTING, APPLY 053 CRITERIA. PRICE SECOND,THIRD, ETC AT 50. USE ALL APPROPRIATE O'CODES (IE 819,820).

I. MOD 56:PRE OP ONLY. WHEN ONE PHYSICIAN PERFORMS THE PRE OP CARE AND EVAL AND ANOTHER PHYSICIAN PERFORMS THE SURGICAL PROCEDURE.

J. MOD 58: STAGED OR RELATED PROCEDURE OR SERVICE BY THE SAME PHYSICIAN DURING THE POSTOPERATIVE PERIOD.
NOTE: THIS MOD IS NOT USED TO REPORT THE TREATMENT OF A PROBLEM THAT REQUIRES A RETURN TO THE ORIGINAL ROOM. SEE MOD 78.

K. MOD 59/GB: DISTINCT PROCEDURAL SERVICE. % OR DENY AS INCLUDED IF APPROPRIATE, UNLESS CLAIM OR BACKUP INDICATES (DIFFERENT OP SES-SION, DIFFERENT SITE, SEPARATE LESON, OR SEPARATE INJURY) THEN YOU NEED TO TAKE OUR PROCEDURE AND POLICY INTO CONSIDERATION. IF OVERIDING THE GB/59 MOD USE OVERCODE 810.

L. MOD 62: CO-SURGEONS. THE SKILLS OF 2 SURGEONS MAY BE NECESSARY IN THE MANAGEMENT OF CERTAIN SURGICAL PROCEDURES. PAYMENT FOR THIS MOD IS 125% OF THE GLOBAL SURGICAL FEE IN THE RBRVS FEE SCHEDULE. THE PAYMENT IS DIVIDED EQUALLY BETWEEN THE 2 SURGEONS. NO PAYMENT IS MADE FOR AN ASSISTANT AT SURGERY IN THIS CASE.
NOTE: SEE SECTION 2.B TO DETERMINE IF CO SURG IS APPLICABLE
1. MOD 54 PAYS AT THE INTRA-OP FEE ONLY. CLAIMS FOR CO SURG (62,66) MANUAL PRICE AT 62.5% OF MAX FEE. IF SECONDARY MODS (62,66) BILLEDIN COMBINATION WITH MOD 54, USE THE SECONDARY MOD AND OVERCODE 811. ALSO, APPLY 053 DECREASING PERCENTAGE CRITERIA IF APPROPRIATE.
2. MOD 78 PAYS AT THE INTRA-OP FEE ONLY. CLAIMS FOR CO-SURGERY (62,66) MANUAL PRICE 62.5% OF INTRA OP FEE. IF NO INTRA-OP FEE, MANUAL PRICE AT 62.5% OF MAX IF. IF SECONDARY MODS (62, 66) BILLED IN COMB W/MOD 78, USE THE SECONDARY MOD & O'CODE 813. ALSO, FORCE 053/088 AUDITS ON ALL PROCEDURES THAT WERE BILLED W/MOD 78 & SECONDARY MOD.
NOTE: IF YOU SEE MOD 80 POSTING AGAINS THE SURGEONS BILL W/MOD 78 FOR THE SAME OP SESSION - FOLLOW THE PRECEDING PRICING FORMULA FOR THE ASSIST & USE INFO EOB 589.
3. MOD 79 PAYS AT MAX FEE. IF SECONDARY MODS (62,66) BILLED IN COMB W/MOD 79, USE THE SECONDARY MOD & O'CODE 812.

M. MOD 66: TEAM SURGERY.SEE CO-SURGERY FOR MOD 54/78/79 INFORMATION.

N. MOD 76: REPEAT PROCEDURE BY SAME PHYSICIAN. SHOULD ONLY BE ADDED TO THE REPEATED PROCEDURE. LET SYSTEM PRICE AT MAX. IF SURGERIES WERE DONE AT THE SAME OP SESSION YOU MAY OVERRIDE THE MOD 76 76 W/O'CODE 222 AND APPLY DECREASING PERCENTAGE IF APPROPRIATE.

O. MOD 77: REPEAT PROCEDURE BY ANOTHER PHYSICIAN. LET SYSTEM PRICE AT MAX. TREAT AS SEPARATE OP SESSIONS & IF NECESSARY TO OVERRIDE MOD 77 - O'CODE W/222.

P. MOD 78: RETURN TO THE OPERATING ROOM FOR A RELATED PROCEDURE DURING THE POSTOP PERIOD.
1. MOD 78 VS BLANK OR ANY OTHER MOD - SEE YOUR TRAINER FOR REVIEW OF CLAIMS, REPORTS AND HISTORY FOR DECISION ON PAYMENT.
2. MOD 78 - INTRA OP FEE ONLY. IF MULTIPLE SURGERIES ARE BILLED ON 1 OR MORE LINES W/MOD 51, & NO MOD 78, DO NOT CARRY DOWN THE MOD 78 (INTRA-OP). % OR INCLUDE IF APPLICABLE.
3. MOD 78 MAY BE ADDED TO THE LINE W/EOB 359 IF YOU NOTE THAT SURGERIES ARE BILLED DURING THE FOLLOW UP PERIOD OF THE ORIGINAL SURGERY. NOTE: MORE INFO UNDER MOD 62(CO-SURG) AND MOD 80/81/82 (ASSISTANT AT SURGERY).
4. MULTI SURG RULE DOES NOT APPLY. INCLUSIVE/CCI EDITING, BILAT/COSURG/ASSIST PRICING DO APPLY.

Q. MOD 79: UNRELATED PROCEDURE OR SERVICE BY THE SAME PHYSICIAN DURING THE POST OP PERIOD. THE MULTIPLE SURGERY RULE DOES NOT APPLY TO PROCEDURES BILLED W/MOD 79 POSTING AGAINST PROCEDURES BILLED DURING THE ORIGINAL OP SESSION. NOTE: IF MOD 51 IS USED IN COMBO W/LEAD MOD 79 FOR SAME SESSION, OVERRIDE MODS W/SURGERY PLACEMENT MODS. USE 812 O'CODE ON LINE(S) SUBMITTED W/MOD 79.

R. MODS 80/81/82: ASSISTANT/PHYSICIAN ASSISTANT. PAYMENT IS 20% OF THE MAX ALLOWANCE ON PDDD.
1. MOD 54 PAYS AT THE INTRA OP FEE ONLY. YOU MUST MANUAL PRICE CLAIMS FOR ASSIST (80,81,82) AT 20% OF THE INTRA OP FEE. IF NO INTRA OP FEE, MANUAL PRICE AT 20% OF MAX FEE.
IF SECONDARY MODS (80,81,82) BILLED IN COMBINATION W/MOD 54, USE THE SECONDARY MOD AND O'CODE 811. ALSO, APPLY 053/088 DECREASING PERCENTAGE CRITERIA IF APPROPRIATE.
2. MOD 78 PAYS AT THE INTRA OP FEE ONLY. YOU MUST MANUAL PRICE FOR ASSIST (80,81,82) AT 20% OF THE INTRA OP FEE. IF NO INTRA OP FEE, MANUAL PRICE AT 20% OF MAX FEE.
IF SECONDARY MODS (80,81,82) BILLED IN COMBO W/MOD 78, USE THE SECONDRY MOD AND O'CODE 813. ALSO, FOR 053/088 AUDITS ON ALL PROCEDURES THAT WERE BILLED W/MOD 78 & SECONDARY MOD.
NOTE: IF YOU SEE MOD 80 POSTING AGAINST THE SURGEONS BILL W/MOD 78 FOR THE SAME OP SESSION - FOLLOW THE PRECEDING PRICING FORMULA FOR THE ASSIST AND USE INFO EOB 589.
3. MOD 79 PAYS AT MAX FEE. IF SECONDARY MODS (80,81,82) BILLED IN COMBO W/MOD 79, USE THE SECONDARY MOD & O'CODE 812.

S. MOD SG: IF BILLED BY PROVIDER OTHER THAN A PT 22, DENY W/EOB 350.
NOTE: ASC(SURGICAL) PROCEDURES SHOULD BE BILLED & PD W/MODS 5A/5B OR U1/U2. IF MOD SG BILLED W/ONLY 1 (SURGICAL PROCEDURE)-FORCE. IF 2 (SURGICAL) PROCEDURES ARE BILLED - DENY W/EOB'S

822/158.
NOTE: THE ABOVE ONLY APPLIES TO A SURGICAL PROCEDURE, NOT SUPPLIES, IMPLANTS, PROSTHESIS, ETC. (SEE ASC PT 22 SECTION)

NOTE: DO NOT APPLY ANY MANUAL PRICING TO THE 9T MOD FOR TRAUMA, EFF 4/4/02 PROCESS DATE. IF OTHER PRICING MODS ON CLAIM, YOU MAY REMOVE 9T & ADD TO COMMENTS, USE INFO EOB 877 AT HEADER. SEE PAGE 23 IN 993 INFO TEXT.

T. MOD 9T/ST: MAJOR TRAUMA ENHANCEMENT. IF MOD 9T/ST IS ON A CLAIM, ALL OTHER POLICY & PROCEDURE SHOULD BE APPLIED BEFORE APPLYING THE 9T/ST PRICING OF:
1. PRIOR TO 1/1/99 DOS - ALLOW 173% OF PDDD ALLOWED.
2. 1/1/99 DOS TO 12/31/00 DOS - ALLOW 300% OF PDDD ALLOWED.
3. 1/1/01 DOS TO RA PD DATES OF 4/8/02 - ALLOW 400% OF PDDD ALLOWED.
4. 7/1/03 DOS & AFTER - ALLOW 250% OF PDDD ALLOWED.

HOWEVER, POLICY, PROCEDURE & ALL OTHER MODS SHOULD BE APPLIED BEFORE PRICING. REVIEW BELOW.
1. 2 PROCEDURES ON CLAIM W/MOD 80 & 9T HAVE BEEN BILLED
2. MANUALLY APPLY MOD 80 (20%) TO EACH
3. DETERMINE WHICH IS THE 5A & 5B OR U1 & U2.
4. MANUALLY APPLY THE ABOVE % FOR DOS TO EACH LINE.
5. IE: 61343 = $1369.04 X 20% = $273.81 X 173% = $473.69. 21431 = $290.59 X 20% = $58.12 X 50% = $29.06 X 173% = $50.27.

NOTE: MOD 9T/ST PRICING SHOULD ONLY BE APPLIED TO POS 1,2,3, 21,22,23,51,52 ALL OTHER POS SHOULD BE PAID AT PDDD MAX ALLOWED, APPLYING NO ADDITIONAL % FOR TRAUMA. REMOVE THE MOD 9T/ST & USE INFO EOB 036.
NOTE: 9T/ST MOD MUST BE RETAINED IN MOD FIELD IF THE APPRPRIATE POS HAS BEEN BILLED.
NOTE: SEE SUP/TRAINER OR MMIS IF NECESSARY.
NOTE: 9T/ST MOD IS VALID FOR PROVIDER TYPES (18,20,25,48,49,93) ONLY. IF ANY OTHER PROVIDER TYPE - PAY AT PDDD MAX ALLOWED AND APPLY 053 IF NECESSARY.

U. SU MODIFIER:
THE SU MODIFIER IS USED TO DENOTE THE USE OF FACILITY/EQUIPTMENT IN A BIRTHING CENTER SETTING. FORCE AGAINST THE ACTUAL DELIVERY & DO NOT APPLY PRICING MODIFIERS IN COMBO WITH MOD SU. *SR

V. U1, U2, U3, U4, U5, U6 - EFFECTIVE 07/01/03
1. U1 AND U2 ARE TO BE USED TO PRICE SURGERY CLAIMS INSTEAD OF 5A AND 5B.
2. U3, U4, U5, U6 ARE TO BE USED TO PRICE CLAIMS THAT HAVE THE ST TRAUMA ENHANCEMENT MODIFIER WHEN THERE ARE NO OTHER PRICING MODIFIERS ON THE LINE. IF THERE ARE OTHER PRICING MODIFIERS, CLAIM WILL NEED TO BE MANUALLY PRICED. IF USING THE U3-U6 MODIFERS, MOVE THE ST MODIFIER TO THE SECOND MOD FIELD. DIRECTIONS FOR USE:
A. U3 WOULD BE USED IN PLACE OF U1 FOR A SURGERY CLAIM. THIS MODIFIER WILL CAUSE THE LINE TO PRICE AT 100% PLUS THE

EXTRA % FOR THE TRAUMA ENHANCEMENT.
B. U4 WOULD BE USED IN PLACE OF U2. THIS MODIFER WILL CAUSE THE LINE TO PRICE AT 50% PLUS THE EXTRA % FOR THE TRAUMA ENHANCEMENT.
C. U5 IS TO BE USED FOR ASSIST. IT WILL PRICE AT 20% PLUS THE % FOR THE TRAUMA ENHANCEMENT.
D. IS FOR ASSIST & WILL PRICE AT 50% OF THE 20% PLUM THE TRAUMA ENHANCEMENT.
IF YOU HAVE ANY QUESTIONS, SEE BARBARA IN MMIS. *BJS

6. INCLUSIVE/INCIDENTAL AND CCI EDITING CRITERIA

NOTE: LISTS OR SPANS OF CODES WITHIN THIS TEXT ARE NOT ALL INCLUSIVE REFER TO THE CPT AND NOTIFY MMIS IF PROCEDURE CODES ARE NOT FAILING APPROPRIATELY. NOT ALL SITUATIONS ARE LISTED WITHIN THIS TEXT ONLY EXAMPLES ARE GIVEN.

A. INCLUSIVE/INCIDENTAL BY DEFINITION/COMPLEXITY EXISTING PRIOR TO CCI EDITING CRITERIA IMPLEMENTATION:

NOTE: AS OF 04/15/02 FOLLOW CCI EDITING FOR INCLUSIVE BEFORE APPLYING THIS SECTION OF THE INCLUSIVE/INCIDENTAL TEXT.

1. INCIDENTAL PROCEDURES ARE THOSE PROCEDURES THAT DO NOT ADD SIGNIFICANTLY TO THE COMPLEXITY OF THE SURGERY OR THE AFTER-CARE AND ARE TO BE DENIED WITH EOB 324, REGARDLESS OF THE BILLED OR ALLOWED AMOUNT.

EXAMPLE(S) OF INCIDENTAL:
A.LYSIS OF ADHESIONS, ENTEROLYSIS, SALPINGOLYSIS WHEN BILLED WITH A MORE COMPREHENSIVE SURGERY IN THE SAME AREA SHOULD BE DENIED AS INCLUSIVE W/EOB'S 324/373.
B.LARYNGOSCOPY, BRONCHOSCOPY & ESOPHAGOSCOPY - PAY IN DECREASING PERCENTAGES, UNLESS THE LARYNGOSCOPY CODE IS DIAGNOSTIC (31505,31520,31525,31575) - DENY THE LARYNGOSCOPY & PAY THE BRONCHOSCOPY & ESOPHAGOSCOPY IN DECREASING %. IF ONLY THE B AND E ARE BILLED - PAY IN DECREASING %, UNLESS THE B IS DIAGNOSTIC (31622) - DENY THE B INTO E. OVERRULES CCI (MOD 59 DOES NOT MAKE ALLOWABLE) PER DMM MEDICAL CONSULT DECISION.

C.TYPANOSTOMY BILLED WITH TYMPANOPLASTY ON THE SAME EAR, DENY TYMPANOSTOMY WITH EOB 324/373.

EXCEPTION DO NOT DENY ANYTHING INCIDENTAL THAT:
A.INVOLVES DIFFERENT APPROACHES
B.THERE IS SPECIFIC APPROVAL FOR THE INCIDENTAL PROCEDURE INDICATED IN THE NOTES OF THE PA NUMBER OR WRITTEN ON A HARD COPY CLAIM BY THE MEDICAL CONSULTANT. JUST BECAUSE A PROCEDURE APPEARS ON THE LINE OF AN AUTHORIZATION RECORD, IT DOES NOT MEAN IT IS EXEMPT FROM AUDIT POLICIES.
C.(44955) DO NOT CONSIDER INCIDENTAL - PAY AT 100%
D.(58300) INSERTION OF IUD - DO NOT CONSIDER INCIDENTAL TO A VAGINAL DELIVERY.

E.IS CONSIDERED THE MAJOR PROCEDURE (THE REASON THE SURGERY WAS DONE).

NOTE: SOME PROCEDURES ARE INCIDENTAL BY PROCEDURE DESCRIPTION (I.E. CHOLECYSTECTOMY WITH EXPLORATION OF THE COMMON DUCT VS CHOLECYSTECTOMY - YOU WOULD DENY THE CHOLECYSTECTOMY)

NOTE: A PROCEDURE WITH A DESCRIPTION THAT IS WITHIN THE WORDING OF ANOTHER PROCEDURE MAY BE DENIED WITH EOB 324.

2. SPECIFIC INCIDENTAL:

A. EXPLORATORY LAPAROTOMY BILLED W/OTHER ABDOMINAL SURGERIES - DENY W/EOB 324.

NOTE: DO NOT CONSIDER 43830/43831 (INSERTION OF GASTROSTOMY TUBES) AS AN ABDOMINAL SURGERY PRIOR TO 04/13/02 CYCLE. AFTER 04/13/02 CYCLE APPLY CCI EDITING "SEPARATE PROCEDURE"

NOTE: CHECK DESCRIPTIONS ON PROCEDURES THAT YOU WOULD BE DENYING THE LAP INTO. (I.E.) 44955 HAS BEEN CUT ALREADY IN ORDER TO BE BILLED W/ANOTHER PROCEDURE, SO YOU WOULD NOT DENY THE LAP AS INCLUDED IN IT.

B. DIAGNOSTIC LAPAROSCOPY BILLED W/LAPAROTOMY- DENY W/EOB 324.

C. MICRODISSECTION CODE 69990 CAN BE BILLED WITH (61304-61711, 62010-62100, 63081-63308, 63704-63710) NOTE EFF 7/1/02 DOS, 61548 CAN NO LONGER BE BILLED W/69990, DENY PER BELOW.

1. IF MICRO CODE BILLED W/ANY CODE OTHER THAN THE ABOVE - DENY W/EOB 800.
2. PAY ONLY 1 MICRODISSECTION CODE, IF MORE THAN 1 BILLED DENY OVER 1 W/EOB 800.
3. DO NOT % MICRODISSECTION CODE 69990 IN COMBINATION W/ANY OF THE BILLABLE CODES.

D. LASER SURG - DO NOT PAY LASER SURG PROCEDURE CODES WHEN BILLED IN COMBO WITH ANOTHER SURGERY OF SAME CATEGORY (I.E.) CAUTERIZATION OF CERVIX (57510) AND LASER SURGERY (57513) - DENY W/EOB 324.

E. SINUSOTOMY CODE (31090) SHOULD NOT BE PAID IN COMBINATION WITH PROCEDURE CODES (31020-31032, 31050-31087) - DENY 31090 W/EOB 324.

F. EPISIOTOMY (59300) BILLED BY THE DELIVERING PHYSICIAN - DENY W/EOB 324.

G. PUDENDAL NERVE BLOCK INJECTION - IF BILLED W/DELIVERY OR ABORTION - DENY W/EOB 324.

H. CASTING/STRAPPING/SPLINTING (29000 - 29799) BILLED W/PROCE-

DURES SUCH AS SURGICAL REPAIR, REDUCTION OF FRACTURES OR JOINT DISLOCATION ON THE SAME DAY, SAME OP SESSION, SAME PROVIDER - DENY W/EOB 324.

B. INCIDENTAL PER CCI EDITING:

NOTE: 053 PRE-CCI CRITERIA WILL BE LISTED ONCE WITHIN THE APPROPRIATE CCI EDITING CATEGORY WITH A NOTATION (PRE CCI).

NOTE: APPLY THE FOLLOWING CCI EDITING ONLY TO THE SAME SURGEON.

NOTE: ALL CCI EDITING IS BASED ON ALL PROCEDURES BEING PERFORMED AT THE SAME OP SESSION. ANY INDICATION THAT THE PROCE-DURES WERE PERFORMED AT A DIFFERENT OP SESSION, APPLY THE FOLLOWING CRITERIA SEPARATELY TO EACH OP SESSION.

NOTE: MODIFIERS 59, FA-F9, E1-E4, OR TA-T9 MAY BE USABLE TO PAY PER CCI INCLUSIVE CRITERIA PER DIFFERENT OPERATIVE SITE IF APPLICABLE PER ANATOMY AND PROCEDURE CODE DESCRIPTION. A DIAGNOSIS AND/OR AN OPERATIVE REPORT IS ALSO USABLE TO DEFINE A DIFFERENT OPERATIVE SITE.
--EXCEPT - "ADD-ON" PROCEDURE CODES BILLED WITHOUT THE PRIMARY PROCEDURE SPECIFIED BY THE CPT CODING MANUAL AND THE "SEQUEN-TIAL PROCEDURE" EDITING GUIDELINE ISSUES IN THE FOLLOWING TEXT-DENY PER THE FOLLOWING CRITERIA UNLESS A DIFFERENT OPERATIVE SESSION.

NOTE: MODIFIER 58 (STAGED PROCEDURE) IS USABLE IN CCI TO ALLOW PAYMENT FOR MOHS (17304-17310) BILLED TOGETHER AND DIAG-NOSTIC ENDOSCOPY PROCEDURES BILLED WITH MORE COMPREHENSI PROCEDURES WITHIN THE SAME AREA.
CCI STATEMENT - "IF A DIAGNOSTIC ENDOSCOPY IS PERFORMED, AND THIS RESULTS IN A DECISION TO PERFORM A (NON DIAG-NOSTIC) SURGICAL PROCEDURE, THEN THIS ENDOSCOPY WOULD BE BILLED WITH MOD 58. THE DIAGNOSTIC ENDOSCOPY AND THE NON ENDOSCOPIC SURGICAL PROCEDURE ARE STAGED AND PLANNED SER-VICES. THE DIAGNOSTIC ENDOSCOPY RESPRESENTS A DISTINCT DIAGNOSTIC SERVICE." THE DIAGNOSTIC ENDOSCOPY IS TO BE ALLOWED PER SURGICAL PRICING CRITERIA. (VA-2)

NOTE: A DIFFERENT OPERATIVE SESSION MUST BE MADE IN A COMMENT OR STATEMENT ON THE CLAIM OR IN BACKUP BY TIMES LISTED OR WORDING.

1. CCI EDITING CATEGORY "ADD-ON CODE" OR "SEPARATE PROCEDURE":

A. ADD-ON CODES SUPPLEMENTAL TO A PRINCIPAL PROCEDURE MAY BE IDENTIFIED IN THE CPT CODING MANUAL BY A + SIGN AND THE STATEMENT "LIST SEPARATELY IN ADDITION TO CODES(S) XXXXX" OR "LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCE-DURE" IN PARENTHESIS. THESE CODES ARE TO BE BILLED ONLY WHEN THE PRIMARY PROCEDURE IS ALSO BILLED. IF THE LISTED PROCEDURE CODE(S) OR PRIMARY PROCEDURE IS NOT BILLED - DENY THE SUPPLEMENTAL ADD-ON CODE W/EOBS 302/158 UNLESS OTHER-

WISE SPECIFIED IN THE FOLLOWING TEXT.

EXAMPLES:
1. + 44139 (USE 44139 IN CONJUNCTION WITH 44140-44147)
(PRE CCI)
DO NOT PAY 44139 (MOBILIZATION OF SPLENIC FLEXURE) IN COMBINATION W/ANY PROCEDURE EXCEPT 44140-44147. IF BILLED W/ANY OTHER PROCEDURE - DENY 44139. OTHERWISE APPLY 053 POLICY.

2. + 22328 (USE 22328 IN CONJUNCTION WITH 22325, 22326, 22327). IF BILLED WITH THE CORRECT PROCEDURE CODES - APPLY 053 POLICY, OTHERWISE - DENY W/EOB 302/158.

3. + 49568 (LIST SEPARATELY IN ADDITION TO CODE FOR THE INCISIONAL OR VENTRAL HERNIA REPAIR)
(PRE CCI)
IMPLANTATION OF MESH/OTHER PROSTHESIS (49568) - PER CPT IF BILLED W/INCISIONAL OR VENTRAL HERNIA REPAIR CODES (49560-49566) - APPLY 053 POLICY, OTHERWISE - DENY W/EOB 324.

B. SEPARATE PROCEDURE - THE NARRATIVE FOR MANY CPT CODES INCLUDES A STATEMENT "SEPARATE PROCEDURE" WITHIN THE DESCRIPTION. THE INCLUSION OF THIS STATEMENT INDICATES THAT THE PROCEDURE, WHILE IT CAN BE PERFORMED SEPARATELY, IS GENERALLY INCLUDED IN A MORE COMPREHENSIVE PROCEDURE AND THE SERVICE IS NOT TO BE BILLED WHEN A RELATED, MORE COMPREHENSIVE, SERVICE IS PERFORMED. WHEN A RELATED PROCEDURE IS PERFORMED, A CODE WITH THE DESIGNATION OF "SEPARATE PROCEDURE" IS NOT TO BE PAID.

IF BILLED TOGETHER, DENY THE "SEPARATE PROCEDURE" AS INCLUDED WITH EOB 019.

NOTE: WHEN A LARYNGOSCOPY (31505, 31520, 31525 OR 31575) IS BILLED WITH A BRONCHOSCOPIC OR ESOPHAGOSCOPIC PROCEDURE - DENY THE LARYNGOSCOPY & PAY THE BRONCHOSCOPY &/OR ESOPHAGOSCOPY PROCEDURE. IF ONLY BRONCHOSCOPY AND ESOPHAGOSCOPY BILLED & THE "B" IS DIAGNOSTIC (31622) - DENY THE "B" INTO THE "E". OTHERWISE, APPLY DECREASING PERCENTAGE CRITERIA.

NOTE: THIS SEPARATE PROCEDURE SECTION WILL SUPERCEDE ANY OTHER CCI EDITING SECTION FOLLOWING THESE INSTRUCTIONS.

EXAMPLES:
1. 59414 (SEPARATE PROCEDURE) BILLED WITH ANY DELIVERY. PAY THE DELIVERY AND DENY THE 59414 W/EOB 324.

2. 49255 (SEPARATE PROCEDURE) BILLED WITH ANY ABDOMINAL PROCEDURE. PAY THE ABDOMINAL PROCEDURE AND DENY 49255 W/EOB 324.

2. CCI EDITING CATEGORY "MOST EXTENSIVE PROCEDURE":

WHEN PROCEDURES ARE PERFORMED TOGETHER THAT ARE BASICALLY THE SAME, OR PERFORMED ON THE SAME SITE BUT ARE QUALIFIED BY AN INCREASED LEVEL OF COMPLEXITY, THE LESS EXTENSIVE PROCEDURE IS INCLUDED INTO THE MORE EXTENSIVE PROCEDURE. IN THE FOLLOWING SITUATIONS, THE PROCEDURE VIEWED AS THE MOST COMPLEX WOULD BE PAID.

NOTE: THE FOLLOWING CRITERIA IS DETERMINED BY DEFINITION WITHIN THE CPT OR OP SITE ACCESS BY ANATOMY.

DENY THE LESS EXTENSIVE PROCEDURE W/EOB 324.

A. SIMPLE VS COMPLEX BILLED AT THE SAME OP SESSION THEN THE SIMPLE PROCEDURE IS INCLUDED IN THE COMPLEX PROCEDURE ON THE SAME OP SITE.

EXAMPLE:

1. 12001 (SIMPLE REAPIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES) BILLED WITH 12031 (INTERMEDIATE - LAYER CLOSURE OF WOUNDS OF SCALP, AXIALLAE, TRUNK AND/OR EXTREMITIES) AT THE SAME OP SESSION AT THE SAME OP SITE. PAY 12031, DENY 12001 W/EOB 324.
   NOTE: IF MORE THAN ONE OF THE LEAST COMPREHENSIVE PROCEDURES ARE BILLED AT THE SAME OP SESSION PAY THE MOST COMPREHENSIVE PROCEDURE BY DEFINITION AND CPT SECTION TITLE, DENYING ALL OTHERS AT THE SAME OP SITE W/EOB 324.

2. 40845 INCLUDES 40842, 40843 AND 40844. PAY 40845 AND DENY PROCEDURE CODE(S) 40842, 40843, AND/OR 40844 W/EOB 324.

B. LIMITED VS COMPLETE BILLED AT THE SAME OP SESSION THEN THE LIMITED PROCEDURE IS INCLUDED INTO THE COMPLETE PROCEDURE ON THE SAME OP SITE.

EXAMPLE:
40844 INCLUDES 40842 AND 40843.

C. SIMPLE VS COMPLICATED BILLED AT THE SAME OP SESSION THEN THE SIMPLE PROCEDURE IS INCLUDED INTO THE COMPLICATED PROCEDURE ON THE SAME OP SITE.

EXAMPLE:
10080 (INCISION AND DRAINAGE OF PILONDIAL CYST, SIMPLE) BILLED WITH 10081 (INCISION AND DRAINAGE OF PILONDIAL CYST, COMPLICATED) AT THE SAME OP SESSION, PAY 10081 AND DENY 10080 W/EOB 324.

D. INTERMEDIATE VS COMPREHENSIVE (COMPLEX OR COMPLETE) BILLED AT THE SAME OP SESSION THEN THE INTERMEDIATE PROCEDURE IS

INCLUDED INTO THE COMPREHENSIVE (COMPLEX OR COMPLETE) PRO-CEDURE ON THE SAME OP SITE.

EXAMPLE:
1. 12031 (INTERMEDIATE REPAIR - LAYER CLOSURE WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES) BILLED WITH 13120 (REPAIR COMPLEX, SCALP, ARMS AND/OR LEGS) AT THE SAME OP SESSION ON THE SAME OP SITE. PAY 13120 AND DENY 12031 W/EOB 324.

2. 13160 INCLUDES 12020 AND 12021. PAY 13160 AND DENY 12020 AND/OR 12021 W/EOB 324.

E. INCOMPLETE VS COMPLETE BILLED AT THE SAME OP SESSION THEN THE INCOMPLETE PROCEDURE IS INCLUDED IN THE COMPLETE PRO-CEDURE ON THE SAME OP SITE.
EXAMPLE:
40844 INCLUDES 40842 AND 40843. PAY 40844 AND DENY 40842 AND/OR 40843 W/EOB 324.

F. EXTERNAL VS INTERNAL BILLED AT THE SAME OP SESSION THEN THE EXTERNAL PROCEDURE IS INCLUDED INTO THE INTERNAL PROCEDURE AT THE SAME OP SITE.

NOTE: THIS SECTION DOES NOT APPLY TO "FIXATION SYSTEMS" (20690-20694) SEE SECTION FOR "PROCEDURE CODE DEFINITION" FOR RULES.
EXAMPLES:
1. PERCUTANEOUS VS OPEN SURGICAL REPAIR:
A. 26776 (PERCUTANEOUS) VS 26785 (OPEN SURGICAL)
B. 26040 (PERCUTANEOUS) VS 26045 (OPEN SURGICAL)
2. CLOSED VS OPEN REPAIR:
A. 25622 (CLOSED) VS 25628 (OPEN)
B. 25500 (CLOSED) VS 25515 (OPEN)

G. SINGLE VS MULTIPLE BILLED AT THE SAME OP SESSION THEN THE SINGLE PROCEDURE IS INCLUDED INTO THE MULTIPLE PROCEDURE.
EXAMPLE:
10060 (INCISION AND DRAINAGE OF ABCESS, SIMPLE OR SINGLE) BILLED WITH 10061 (INCISION AND DRAINAGE OF ABCESS, COMPLEX OR MULTIPLE) AT THE SAME OP SESSION NO MATTER OF THE SITE BY CPT DEFINITION. PAY THE 10061 AND DENY 10060 W/EOB 324.

H. PARTIAL VS FULL BILLED AT THE SAME OP SESSION THEN THE PAR-TIAL PROCEDURE IS INCLUDED INTO THE FULL PROCEDURE AT THE SAME OP SITE.

I. UNILATERAL VS BILATERAL BILLED AT THE SAME OP SESSION THEN THE UNILATERAL PROCEDURE IS INCLUDED INTO THE BILATERAL PROCEDURE AT THE SAME OP SITE.

EXAMPLE:
40842 (VESTIBULOPLASTY, POSTERIOR, UNILATERAL) BILLED WITH

40843 (VESTIBULOPLASTY, POSTERIOR, BILATERAL) AT THE SAME OP SESSION. PAY 40843 AND DENY 40842 W/EOB 324.

NOTE: PAY THE MOST COMPREHENSIVE BY DEFINITION AND DENY ALL OTHERS AS INCLUDED IF MULTIPLE ARE BILLED AT THE SAME OP SESSION FOR THE SAME OP SITE. (40845 INCLUDES 40840-40844. 40844 INCLUDES 40840-40843. 40843 INCLUDES 40840-40842, ETC)

J. IF ENDOSCOPIC PROCEDURES ARE PERFORMED WITHIN THE SAME OP SITE ACCESS THESE PROCEDURES THE MORE COMPREHENSIVE PROCEDURE WOULD INCLUDE THE LEAST COMPREHENSIVE PROCEDURE. ALSO ANY PROCEDURE REPRESENTING GAINING ACCESS TO THE ORGAN SYSTEM FOR THE MORE COMPREHENSIVE PROCEDURE WOULD BE INCLUDED INTO THE MORE COMPREHENSIVE PROCEDURE.

EXCEPT: IF ANY PROCEDURE IS TERMED IN THE CPT AS A SEPARATE PROCEDURE, REFER BACK TO THOSE INSTRUCTIONS IN THIS TEXT.

EXCEPT:
WHEN A LARYNGOSCOPY (31505, 31520, 31525 OR 31575) IS BILLED WITH A BRONCHOSCOPIC OR ESOPHAGOSCOPIC PROCEDURE - DENY THE LARYNGOSCOPY & PAY THE BRONCHOSCOPY &/OR ESOPHAGOSCOPY PROCEDURE. IF ONLY BRONCHOSCOPY AND ESOPHAGOSCOPY ARE BILLED & THE "B" IS DIAGNOSTIC (31622) - DENY THE "B" INTO "E". OTHERWISE, APPLY DECREASING PERCENTAGE CRITERIA.

EXAMPLE:
ANY LYSIS OF ADHESION AND/OR LAPAROTOMY PROCEDURE REPRESENTING GAINING ACCESS TO THE ORGAN SYSTEM OF THE RELATED COMPREHENSIVE PROCEDURE IS INCLUDED INTO THE COMPREHENSIVE PROCEDURE. (44143 INCLUDES 49000 AND/OR 44005/58740)

3. CCI EDITING CATEGORY "SEQUENTIAL PROCEDURE":

AN INITIAL APPROACH TO A PROCEDURE MAY BE FOLLOWED AT THE SAME OPERATIVE SESSION BY A SECOND, USUALLY MORE INVASIVE APPROACH. THERE MAY BE SEPARATE CPT CODES DESCRIBING EACH SERVICE. THE SECOND PROCEDURE IS USUALLY PERFORMED BECAUSE THE INITIAL APPROACH WAS UNSUCCESSFULL IN ACCOMPLISHING THE MEDICALLY NECESSARY SERVICE. THESE PROCEDURES ARE CONSIDERED "SEQUENTIAL PROCEDURES". ONLY THE CPT CODE FOR ONE OF THE SERVICES, GENERALLY THE MORE INVASIVE SERVICE, SHOULD BE BILLED.

IN THE PERFORMANCE OF A SURGICAL PROCEDURE, IT IS ROUTINE TO EXPLORE THE SURGICAL FIELD. ACCORDINGLY, CODES DESCRIBING EXPLORATION OF THE SURGICAL FIELD CANNOT BE REPORTED SEPARATELY. THIS WOULD INCLUDE LAPAROTOMIES AND SCOPIES WHEN FOLLOWED BY A RELATED MORE COMPREHENSIVE PROCEDURE AT THE SAME OP SESSION. (EXAMPLE: 31300 INCLUDES 31575 OR 32491 INCLUDES 31622,31645, 32601,32602,32602,32650-32656, AND/OR 32960)

WHEN, IN THE COURSE OF A PROCEDURE, A BIOPSY IS OBTAINED AND SUBSEQUENTLY THE EXCISION, REMOVAL, DESTRUCTION OR OTHER ELIMINATION OF THE ORGAN OR LESION BIOPSIED IS PERFORMED, THE BIOPSY IS INCLUDED INTO THE EXCISION, REMOVAL, DESTRUCTION OR OTHER ELIMINATION PROCEDURE. UNLESS THE BIOPSY WAS STAGED (MOD 58) OR PERFORMED ON A DIFFERENT LESION OR DIFFERENT OP

SITE/ORGAN. DENY THE LESSER ALLOWED PROCEDURE W/EOB 324.

NOTE: THE FOLLOWING CRITERIA IS DETERMINED BY THE DEFINITION WITHIN THE CPT CODING MANUAL.

EXAMPLE:

A. 47605 (EXCISION - CHOLECYSTECTOMY WITH CHOLANGIOGRAPHY) BILLED AT THE SAME OP SESSION AS 47562 (LAPAROSCOPIC, SURGICAL, CHOLECYSTECTOMY WITH CHOLANGIOGRAPHY) PAY THE HIGHEST ALLOWED AND DENY THE LESSER ALLOWED W/EOB 324.

B. 33420 (VALVOTOMY, MITRAL VALVE, CLOSED HEART) BILLED AT THE SAME OP SESSION AS 92987 (PERCUTANEOUS BALLOON VALVULOPLASTY, MITRAL VALVE). PAY THE HIGHEST ALLOWANCE DENYING THE LESSER ALLOWED W/EOB 324.

C. 27750 (CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE) BILLED AT THE SAME OP SESSION AS 27758 (OPEN TREATMENT OF TIBIAL SHAFT FRACTURE) ON THE SAME LEG. PAY THE HIGHEST ALLOWANCE PROCEDURE AND DENY THE LESSER ALLOWANCE PROCEDURE W/EOB 324.

D. 31365 INCLUDES 31525 AND 31526. (-ECTOMY INCLUDES -OTOMY).

E. 37207 (TRANSCATHETER OPEN PLACEMENT) INCLUDES 37205 (TRANSCATHETER PERCUTANEOUS PLACEMENT).

F. 60225 INCLUDES 60100.

ANY QUESTIONS - ASK SUPV/TRAINER/MMIS

4. CCI EDITING CATEGORY "WITH VERSUS WITHOUT PROCEDURES":

IN THE CPT MANUAL, THERE ARE VARIOUS PROCEDURES THAT HAVE BEEN SEPARATED INTO TWO CODES WITH THE DEFINITIONAL DIFFERENT BEING "WITH" VERSUS "WITHOUT". BOTH PROCEDURE CODES CANNOT BE REPORTED WHEN BILLED TOGETHER THE "WITHOUT" PROCEDURE IS INCLUDED INTO THE "WITH" PROCEDURE.

DENY THE PROCEDURE WITH THE DESCRIPTION OF "WITHOUT" (OR ANY WORDING THAT WOULD MEAN THE SAME) W/EOB 324.

EXAMPLE:
A. 27252 (CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC, REQUIRING ANESTHESIA) INCLUDES 27250 (CLOSED TREATMENT OF

HIP DISLOCATION, TRAUMATIC, WITHOUT ANESTHESIA). DENY PROCEDURE CODE 27250 W/EOB 324.

B. 27240 (CLOSED TREATMENT OF INTERTROCHANTERIC, PERTROCHANTERIC, OR SUBTROCHANTERIC FEMORAL FRACTURE, WITH MANIPULATION WITH OR WITHOUT SKIN OR SKELATAL TRACTION) INCLUDES 27238 (CLOSED TREATMENT OF INTERTROCHANTERIC, PERTROCHANTERIC, OR SUBTROCHANTERIC FEMORAL FRACTURE, WITHOUT MANIPULATION). DENY 27238 W/EOB 324.

5. CCI EDITING CATEGORY "PROCEDURE CODE DEFINITION":

THE FORMAT OF THE CPT MANUAL INCLUDES DESCRIPTION OF PROCEDURES, WHICH ARE, IN ORDER TO CONSERVE SPACE, NOT LISTED IN THEIR ENTIRETY FOR ALL PROCEDURES. THE PARTIAL DESCRIPTION IS INDENTED UNDER THE MAIN ENTRY, AND CONSTITUTES WHAT IS ALWAYS FOLLOWED BY A SEMICOLON IN THE MAIN ENTRY. THE MAIN ENTRY THEN CONTAINS THE PORTION OF THE DESCRIPTION PRECEDING THE SEMICOLON. THE MAIN ENTRY APPLIES TO AND IS A PART OF ALL INDENTED ENTRIES, WHICH FOLLOW WITH THEIR CODES.

DENY THE LESS COMPREHENSIVE DESCRIPTIVE PROCEDURE W/EOB 324.

EXAMPLE:
A. 11040 DEBRIDEMENT(SEMICOLON) SKIN, PARTIAL THICKNESS
11041 SKIN, FULL THICKNESS
11042 SKIN, AND SUBCUTANEOUS TISSUE
11043 SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE
11044 SKIN, SUBCUTANEOUS TISSUE, MUSCLE AND BONE

11044 WOULD INCLUDE 11040-11043 BY DESCRIPTION IF NO DIAGNOSIS OR MODIFIER FOR DIFFERENT OP SITE. DENY 11040-11043 W/EOB 324.

B. 47605, 47610, 47612 AND 47620 WOULD INCLUDE 47600. DENY 47600 W/EOB 324. NO MOD WOULD JUSTIFY PAYMENT AS IS ALWAYS SAME OP SITE.
C. 47612 WOULD INCLUDE 47610. DENY 47610 W/EOB 324. NO MOD WOULD JUSTIFY PAYMENT AS IS ALWAYS SAME OP SITE.

IN THE COURSE OF OTHER PROCEDURE DESCRIPTIONS, THE CODE DEFINITION SPECIFIES OTHER PROCEDURES THAT ARE INCLUDED IN THE COMPREHENSIVE CODE. THE COMPREHENSIVE PROCEDURE CODE THUS INCLUDES ALL PARTS WHICH SHOULD NOT BE BILLED INDEPENDANTLY.

EXAMPLE:
29855 (ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL/PLATEAU (SEMICOLON) UNICONDYLAR, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)) INCLUDES 29870 AND 29871. DENY 29870 AND/OR 29871 W/EOB 324.

TOTAL VS PARTIAL OR PARTS:
42420 INCLUDES 42410 PER WORDING OF "TOTAL" WITHIN DESCRIPTION OF PROCEDURE 42420 VS "LATERAL LOBE" ONLY IN PRO-

CEDURE 42410.

(PRE CCI)

1. REPAIR CODES:
   A. PRIOR TO 04/15/02 JULIAN DATE (02105) OR 04/13/02 CYCLE: SIMPLE REPAIR CODES (12001-12018) SHOULD BE DENIED W/EOB 324 IF BILLED IN COMBINATION WITH DERMATOLOGY EXCISION CODES (11400-11446 OR 11600-11646). DO NOT INCLUDE REPAIR INTO OTHER EXCISION CODES IN THE DERMATOLOGY AREA UNLESS NOTED IN THIS TEXT.

   B. 04/15/02 JULIAN DATE (02105) OR 04/13/02 CYCLE AND AFTER:
      1. SIMPLE REPAIR CODES (12001-12018) SHOULD BE DENIED W/ EOB 324 IF BILLED IN COMBINATION WITH DERMATOLOGY EXCISION CODES (11200,11300-11313,11440-11446 OR 11600-11646) PER CPT DEFINITION AND GUIDELINE INSTRUCTIONS.

      2. WOUND REPAIR CODES (12001-12057, 13100-13160) SHOULD BE DENIED W/EOB 324 IF BILLED IN COMBINATION WITH DERMITOLOGY EXCISION CODES (11450-11451, 11462-11463, 11470-11471) PER DEFINITION.

2. PROCEDURES W/DESCRIPTION OF SINGLE VS MULTIPLE (I.E. 36470/36471). DO NOT PAY CODES IN COMBINATION W/EACH OTHER. IF MULTI'S ARE DONE, THEY SHOULD BE BILLING THE CODE FOR MULTI VEINS, 1 TIME. DENY MULTIPLE 36470'S WITH EOB 302 OR IF 36470 BILLED IN COMBINATION WITH 36471, DENY 36470 W/EOB 324. ALWAYS CHECK DESCRIPTION OF CODE AND IF UNSURE, ASK MMIS.

3. PARING OR CURETTEMENT (11055-11057) DO NOT ALLOW ANY OF THE FOLLOWING CODES IN COMBINATION ON THE SAME DAY. DESCRIPTION OF THE CODE TELLS THEM WHICH TO BILL PER HOW MANY LESIONS.
   11055 - 1 LESION
   11056 - 2-4 LESIONS
   11057 - MORE THAN 4 LESIONS

   NOTE: IF PROVIDER HAS BILLED INCORRECTLY (I.E.2-11055'S DENY BOTH W/EOB 302/158. 1-11055 AND 1-11056, DENY 11055 W/EOBS 324/158.

   NOTE: IF PAYING 11056/11057 AND BILLED CHARGE NOT ENOUGH TO PAY MAX ALLOWABLE, UTILIZE MONIES FROM DENIED LINES (11055 OR 11056) ADDING IT TO THE LINE BEING PAID (11056 OR 11057). USE INFO EOB 001.

4. DESTRUCTION OF LESION (17000,17003,17004):
   A. IF BILLING FOR 1 LESION, ALLOW 17000.
   B. IF BILLING FOR 2-14 LESIONS, ALLOW 1-17000 AND UP TO 13 17003'S.
   C. IF BILLING FOR 15 OR MORE LESIONS, ALLOW 1-17004. 17004 INCLUDES 17001 AND 17003.
   NOTE: IF BILLING INCORRECTLY, DENY W/EOB 302.

--EXAMPLE: 2-17000'S, PAY 1-17000 AND DENY THE OTHER W/EOB 302.
NOTE: DO NOT ALLOW ANY COMBINATIONS OF 17004 WITH 17000 AND/OR 17003. DENY 17000/17003 WITH EOB 324.
NOTE: APPLY ALL OTHER 053 CRITERIA AGAINST OTHER SURGICAL PROCEDURES AS APPROPRIATE.

TEXT KEY TEXT DESC

55 CRITICAL CARE, ADMIT, CALLS & SURGERY/PROCEDURE NOT COVERED IN COMB.

LOC 55 - MANAGED MEDICARE CLAIMS - WORK PER 988 TEXT.

NOTE: 055 ONLY POSTS ON THE CALLS/CONSULTS/CRIT CARE/ETC, THUS IF PER THE TEXT YOU WILL BE FORCING THE 055 & DENYING THE SURGERY/PROC, MANUALLY DENY THE LINE AS FOLLOWS: (EOB 000 A). THIS LINE WILL SHOW AS A PAID AT $0 LINE IF IT IS REBILLED, ENABLING A SECOND DENIAL IF APPROPRIATE.

NOTE: MMIS - DO NOT REMOVE ANY INFORMATION FROM THIS TEXT, AS ONLY PIECES AND SECTIONS WERE HARD CODED IN THE SYSTEM AND THE TEXT CAN NOT STAND ALONE WITHOUT THESE PIECES.

EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) BATCH RANGE (953-957) - AND IF DETAIL LINE PROCEDURE, MONEY AND UNITS ARE AN EXACT MATCH - IF CARRIER CODE ON HX CLAIM IS (1111)- FORCE, OR IF "ADJ-R" IS "E" - FORCE, OTHERWISE - DENY WITH EOB 830.

NOTE: RES/ADJ CALLS (99201-99285, 99341-99353, 99231-99239, 99301-99333), ADMITS (99221-99223),INCLUDING (99201-99215) IN POS 2,22 CONSULTS (99241-99263) AND PROLONGED SERVICES (99354,99356), IF VS EACH OTHER/THEMSELVES, IF AN UNRELATED DX & CLAIM OR REPORT SPECIFICALLY INDICATES DIFFERENT TIMES OR HAS JUSTIFICATION FOR 2 OF THE ABOVE SERVICES - FORCE, W/THE EXCEPTION OF SERVICES W/DX (290-319) - APPLY RULES IN THIS TEXT/MULTI SERVICE RULES. ANY QUESTIONS - SEE SANDY/MMIS.

IF THE TEXT BELOW INDICATES TO DENY THE CALL,CRITICAL CARE,ETC AGAINST THE SURGERY/PROCEDURE AND YOU ARE NOT PAYING THE SURGERY/ PROCEDURE - DENY THE CALL ANYWAY. (IT IS A GLOBAL FEE)
EXCEPTION: IF THE PROCEDURE IS CONSIDERED BUNDLED & WILL BE DENIED W/EOB 800 - FORCE THE CALL/E&M.

NOTE: DIFFERENT PERFORMING PROV & CLAIM LOOKS LIKE A BILLING ERROR - (BILLING CLERK REBILLED W/DIFF PERF PROV) - DENY 041/280.

NOTE: EYE EXAMS (92012-92014) VS ANYTHING ELSE IN THIS TEXT - USE THE INFORMATION UNDER EYE EXAMS TO ADJUDICATE THE CLAIM.

1. OFFICE CALL (99211-99215), HOSPITAL CALLS (99231-99239), HOSPITAL OBSERVATION (99217-99220, 99234-99236) VS
   A. SURGERY/PROCEDURE
      1. HOSP CALLS (99231-99239) - BILLED BY AN ANESTHESIOLOGIST (PT 48 OR 49) - PAY UP TO 2 ON SAME DAY, DENY ALL OTHERS W/EOB 757.
      2. MOD 25 ON THE E&M CODE - FORCE.
      3. DIFFERENT PERFORMING PROV. - FORCE.
      4. UNRELATED DX - FORCE.
      5. CASTING/SPLINTING - FORCE.
      6. 57/QI MOD. W/CALL VS SURGERY. FORCE IF FOLLOWUP DAYS ARE 90.

NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
7. CALL BILLED W/INSERTION OF IUD/DIAPHRAGM/CERVICAL CAP (57170) &/OR INTRAUTERIN DEVICE (9911M/9912M) - FORCE. THE CALL IS USUALLY FOR A YEARLY FAMILY PLANNING EXAM, NOT JUST TO INSERT THE DEVICE.
8. DO NOT PAY A CALL ON THE SAME DAY AS A PROCEDURE/SURG (INCLUDING ENDOSCOPIC PROCEDURES "SCOPIES")- DENY W/EOB 324, UNLESS PROVIDER INDICATES MODIFIER 25, THEN FORCE. (EXCEPTION) PAY ALL OTHER DIAGNOSTIC PROCEDURES IN COMB W/CALLS
NOTE: 53670/51701/51702 IN POS "3" IS CONSIDERED DGNSTIC.
NOTE: SEE RES/ADJ TRAINER/SUPERVISOR FOR A PARTIAL LIST OF PROCEDURES THAT ARE CONSIDERED DIAGNOSTIC. THIS TEXT CANNOT POSSIBLY INCLUDE ALL.

B. ALL ELSE, (CALL VS CALL, EG, CALL VS ADMIT)
1. DIFFERENT PERFORMING PROV. - FORCE. (EXCEPTION: PAY ONLY 1 (99238,99239) DISHCHARGE PER DAY, DENY ADDITIONALS W/EOB'S 041/280.
2. 99238,99239 VS (99301-99303,99311-99313,99321-99323,99331-99333) - FORCE.
3. SAME PERFORMING PROV. - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD, DENY THE CURRENT W/EOB 910. (EXCEPTION: CALL VS CRITICAL CARE - FORCE IF UNRELATED DIAGNOSIS. IF RELATED DX, DENY OR RECOUP AND DENY THE LESSER W/EOB 825).

2. OFFICE CALLS (99201-99205) VS
A. SURGERY/PROCEDURE- FORCE.(THIS INCLUDES INJECTION PROCEDURES & THE INSERTION OF IUD/DIAPHRAGM/CERVICAL CAPS)
B. ALL ELSE, (CALL VS CALL, EG, CALL VS ADMIT)
1. CALL VS CRITICAL CARE - UNRELATED DX - FORCE.
2. DIFFERENT PERFORMING PROV. -FORCE.
3. SAME PERFORMING PROV. - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD, DENY THE CURRENT W/EOB 910. (EXCEPTION- CALL VS CRITICAL CARE - DENY OR RECOUP AND DENY THE LESSER W/EOB 825).

3. ADMITS (99221-99223),INCLUDING CODES (99201-99215 IF POS 2,22)
A. ADMIT VS ADMIT - FORCE IF UNRELATED DX, OTHERWISE PAY 1 PER PATIENT PER DAY -DENY CURRENT W/EOB 181 IF HX IS PAID.
EXCEPTION: HOSP/CLINICS DOING DIAGNOSTIC WORKUPS FOR CHILDREN -- IE(AUP/COH/CHILDRENS UNIV MED GRP) - FORCE (99201-99215) BILLED IN COMBINATION W/EACH OTHER IF BILLED IN (POS 2,22).
B. ADMIT (99221-99223) VS CRITICAL CARE (99291-99292) - FORCE.

---SURGERIES/PROCEDURES---
C. 99201-99205 - FORCE AGAINST SURGERY
D. 57/QI MODIFIERS W/ADMITS VS SURGERY - FORCE IF FOLLOWUP DAYS ARE 90.NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
E. PROCEDURES ABOVE BILLED W/MOD 25 ARE PD IN ADDITION TO SURGERY.
F. ADMITS ARE PD W/SURGERIES/PROCEDURES IF THE DX IS TOTALLY UN-RELATED. (IE-EYE SURGERY VS ADMIT FOR FRACTURE)
G. DENY ADMITS WITH DELIVERIES:
1. ITA ADMITS VS DELIVERY - FORCE.
2. ADMITS FOR ILL BABY DX AT BIRTH VS DELIVERY - FORCE.

3. ADMITS VS DELIVERY:
   A. BILLED W/59409,59514,59612,59620 & DX IS OTHER THAN V22 -V23.9 & NO PROLONGED CODES OR ANTE/POST PARTUM CODES ON CLAIM - FORCE.
   B. ALL ELSE - DENY W/EOB 324.
4. ADMITS BILLED W/PROLONGED SERVICE CODES 99356-99357 & MOD TH IS ALSO PRESENT ON THE CLAIM:
   A. DIFFERENT PERFORMING PROV - FORCE.
   B. SAME PERFORMING PROV - DENY ADMITS & PROLONGED SERVICES VS DELIVERY W/EOB 324, EXCEPT IF MOD 80/81/82 ARE ON THE DELIVERY CODE, THEN FORCE.

H. AN ADMIT IS PD IN ADDITION TO THE SURGERY/PROCEDURE IF THE DIAGNOSIS IS EMERGENT. TO DETERMINE IF THE DX IS EMERGENT, PF4 UNDER THE DX ON THE SURG/PROC OR THE ADMIT. IF THE PA INDICATOR IS AN "E", IT'S EMERGENT).

I. FORCE ADMITS AGAINST NB RESUCITATION (99440).

J. OTHERWISE, DO NOT PAY AN ADMIT ON THE SAME DAY AS A PROCEDURE OR SURGERY (INCLUDING ENDOSCOPIC PROCEDURES "SCOPIES") - DENY W/EOB 324. (EXCEPTION) PAY ALL OTHER DIAGNOSTIC PROCEDURES IN COMBINATION W/ADMITS.
   NOTE: SEE RES/ADJ TRAINER/SUP FOR A PARTIAL LIST OF PROCEDURES THAT ARE CONSIDERED DIAGNOSTIC. THIS TEXT CANNOT POSSIBLY LIST ALL.

K. ALL ELSE - (EG,ADMIT VS ER VISIT)
   A. DIFFERENT PERFORMING PROV. - FORCE.
   B. SAME PERFORMING PROV. - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD - DENY THE CURRENT W/EOB 910. EXCEPTION: ADMIT VS NICU - PAY THE HIGHER IF BOTH CLAIMS ARE SUSPENDING. IF HX IS PD - DENY OR OR RECOUP AND DENY THE LESSER W/EOB 825.

4. EMERGENCY ROOM CALLS (99281-99285) INCLUDING CODES (99201-99220 IF POS IS 5,23).
   A. CALL VS SURGERY - FORCE.
   B. CALL VS TRIAGE (9910M) - DENY OR RECOUP AND DENY THE TRIAGE W/EOB 825.
   C. ER VS ER:
      1. UNRELATED DX - FORCE.
      2. DIFFERENT PERFORMING PROV - FORCE.
      3. SAME PERFORMING PROVIDER:
         A. IF 2 DIFFERENT TIMES ARE LISTED (IE AM/PM, 3:00/5:00, MORNING/AFTERNOON) - FORCE.
         B. IF TIME SAME OR NOT LISTED - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD - DENY CURRENT W/EOB 910.

D. ALL ELSE - (EG,ER VS ADMIT)
   1. ER (99281-99285) VS CONSULTS (99241-99245) - FORCE.
   2. ER VS CRITICAL CARE - UNRELATED DX - FORCE.
   3. DIFFERENT PERFORMING PROV. - FORCE.
   4. SAME PERFORMING PROV. - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD- DENY CURRENT W/EOB 910. (EXCEPTION - ER VS CRITICAL CARE - DENY

OR RECOUP AND DENY THE LESSER W/EOB 825).

5. CONSULTATIONS (99241-99245,99251-99255,99261-99263,99271-99275)
   A. CONSULT (99241-99245,99251-99255,99271-99275) VS SURGERY/PROCEDURE - FORCE CLAIMS BEFORE 1/1/99 DOS. AFTER 1/1/99 DOS SEE BELOW.
   B. CONSULTS (99241-99245, 99251-99255, 99271-99272) FOR 1/1/99 DOS & AFTER AND CONSULTS (99261-99263) FOR ALL DOS VS SURGERY/PROCEDURE -
      A. MOD 57/QI MOD BILLED W/CONSULT - FORCE IF FU DAYS ARE 90. NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
      2. DIFFERENT PERF PROV/UNRELATED DX/MOD 25 - FORCE.
      3. DIAGNOSTIC OR THERAPEUTIC PROCEDURES - FORCE.
      4. ALL ELSE - DENY THE CONSULT W/EOB 324.
   C. CONSULTS (99241-99263) VS CRITICAL CARE (99291-99292) - FORCE.
   D. CONSULTS (99241-99245) VS ER (99281-99285) - FORCE.
   E. CONSULT VS ROUTINE NB CARE (99431) - FORCE.
   F. CONSULT VS CONSULT -
      1. DIFFERENT PERFORMING PROVIDER - FORCE.
      2. SAME PERFORMING PROVIDER - DENY W/EOB 910.
   G. ALL ELSE - (IE CONSULT VS ADMIT)
      1. DIFFERENT PERFORMING PROV. - FORCE.
      2. SAME PERFORMING PROV. - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD - DENY CURRENT W/EOB 910. (EXCEPTION: CONSULT VS NICU - DENY OR RECOUP AND DENY W/EOB 825).
6. TRIAGE (9919M)
   A. TRIAGE VS ER CALL - DENY OR RECOUP & DENY THE TRIAGE W/EOB 825.
   B. TRIAGE VS PROCEDURE - IF THE DX ON THE SURGERY/PROCEDURE IS EMERGENT AND UNRELATED TO THE DX ON THE CALL - FORCE. OTHERWISE DENY THE TRIAGE.

7. ESTABLISHED PATIENT:
   NURSING HOME - (99311-99313),DOMICILARY,REST HOME,CUSTODIAL CARE & HOME SERVICES (99331-99333, 99347-99353). NURSING FACILITY DISHCHARGE (99315, 99316)
   A. MOD 57/QI BILLED W/CALL - FORCE IF FU DAYS ON SURGERY ARE 90. NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
   B. OTHERWISE, CALLS BILLED W/SURGERY/PROCEDURE - DENY W/EOB 324, EXCEPTION - IF BILLED WITH MODIFIER 25 - FORCE.
   C. 99238 (HOSPITAL DISCHARGE) VS 99311-99313,99331-99333 NURSING FACILITY CALLS - FORCE.

8. NEW PATIENT:
   NURSING HOME - (99301-99303),DOMICILARY,REST HOME,CUSTODIAL CARE & HOME SERVICES (99321-99333,99341-99343), NURSING FACILITY DISHCHARGE (99315,99316)
   A. 99321-99333, 99341-99345 - FORCE AGAINST SURGERY
   B. MOD 57/QI BILLED W/CALL - FORCE IF FU DAYS ON SURGERY ARE 90. NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
   C. OTHERWISE, CALLS BILLED W/SURGERY/PROCEDURE - DENY W/EOB 324.
   D. 99238,99239 (HOSPITAL DISHCHARGE) VS 99301-99303,99321-99333 - - FORCE.
   ALL ELSE -ABOVE CODES BILLED W/ANY OTHER CALLS:

1. CALLS VS CRITICAL CARE - UNRELATED DX - FORCE.
2. DIFFERENT PERFORMING PROV - FORCE.
3. SAME PERFORMING PROV - PAY THE HIGHER IF BOTH SUSPENDING. DENY THE LESSER W/EOB 910. IF HX IS PD, DENY THE CURRENT W/EOB 910. (EXCEPTION-ABOVE VS CRITICAL CARE- DENY OR RECOUP AND DENY.

9. NEONATAL & PEDIATRIC CRITICAL CARE
99293/99295 - INTIAL DAY
99294/99296 - 99298 - SUBSEQUENT DAY'S
--ONLY ONE OF THE ABOVE PROCEDURES ALLOWED PER DAY:
A. SAME PERFORMING PROVIDER - DENY ADDITIONALS W/EOB 910.
B. DIFFERENT PERFORMING PROVIDER - DENY ADDITIONALS W/EOB'S 910/280.

NEO/PEDI VS E&M
A. DIFFERENT PERFORMING PROVIDERS - FORCE.
B. MOD 25 ON THE E&M CODE - FORCE.
C. NICU VS ANY OTHER CALLS, CRITICAL CARE, CONSULTATIONS OR ADMITS - PAY THE HIGHER IF BOTH SUSPENDING "REMEMBER TO CONSIDER CRITICAL CARE AS PKG". IF HX IS PAID, DENY OR RECOUP AND DENY THE LESSER W/EOB 825.
D. NEO/PEDI VS 99354-99357,99431,99440 OR 99360 - FORCE.

NEO/PEDI VS ALL ELSE
A. DIFFERENT PERFORMING PROVIDERS - FORCE.
B. THE FOLLOWING PROCEDURES AND SERVICES ARE INCLUDED IN NEO/PEDI, DENY PROCEDURES/SERVICES W/EOB 789.
31500,36000,36140,36410,36415,36420,36430.36440,36488,36490, 36510,36540,36600,36620,36660,43752,51000,53670,62270,71010, 71015,71020,92953,93561,93562,94656,94657,94660,94662,94760, 94761,94762,91105,99090.
C. OTHERWISE - NICU VS PROCEDURE/SURGERY - FORCE.

10. CRITICAL CARE (99291,99292)
A. CRITICAL CARE VS CRITICAL CARE -
1. CC IN THE ER (POS 5,23) - PAY 1ST,DENY OTHERS W/EOB 280.
2. DIFFERENT PERFORMING PROVIDER:
A. UNRELATED DX (MULTIPLE ORGAN SYSTEMS) - FORCE UP TO A MAX OF 3 HRS (1 INIT/4 SUBSQ)FOR EA PP BILLING UNRELATED CRITICAL CARE.
B. OTHERWISE - DENY W/EOB 280.
3. SAME INDEPENDENT BILLING PROVIDER OR SAME PERFORMING PROVIDER- FORCE UP TO A MAX OF 3 HRS - DENY ADDITIONALS W/EOB 339.
NOTE: (PAY 1 99291 AND DENY ADDITIONALS W/EOB 302. PAY UP TO 4 99292'S AND DENY ADDTIONALS W/EOB 339).

B. ADMIT (99221-99223) VS CRIT CARE (99291-99292) - FORCE.
C. CRITICAL CARE VS CONSULTATIONS (99241-99263) - FORCE.
D. CRITICAL CARE VS SURGERY/PROCEDURE -
1. CC VS 31500, 36430, 36488, 36490, 36510, 36660, 51010, 62270, 32000-32020, AND ALL BURR HOLES. (PROCEDURES THAT ARE NOT CONSIDERED SURGICAL) - FORCE.
QUESTIONS ABOUT WHETHER OR NOT A PROCEDURE IS SURGICAL - SEE MMIS.

2. MODIFIER 57 MOD W/CC - FORCE IF FOLLOW UP DAYS ARE 90.
NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
3. DIFFERENT PROVIDER OR PERFORMING PROVIDER - FORCE.
4. UNRELATED DX - FORCE.
5. MOD 25 - FORCE. IF MOD 25 IS BILLED ON INITIAL HR & NOT BILLED ON ADDITIONAL HRS, CONSIDER PACKAGE & FORCE.
6. OTHER WISE PAY THE CALL OR SURGERY/PROCEDURE, WHICHEVER IS HIGHER.

E. ALL ELSE (IE, C CARE VS OFFICE CALL)
1. DIFFERENT PERF PROV - FORCE.
2. 99291-99292 VS 99440 - FORCE.
3. UNRELATED DX - FORCE, EXCEPT NICU - SEE (C) BELOW.
4. OTHERWISE, PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 825. IF HX IS PAID, DENY OR RECOUP AND DENY THE LESSER W/EOB 825.

NOTE: RES/ADJUSTMENTS: IF C CARE IS PERFORMED AT A DIFFERENT TIME THAN THE SURGERY/PROCEDURE - FORCE.

11. INITIAL/SUBSEQUENT HOSPITAL CARE FOR NEWBORNS

A. PROCEDURE CODES 99431, 99433 & 99435
1. FORCE AGAINST DELIVERIES
2. FORCE AGAINST SERVICES FOR MOTHER
3. IF CODE 99431 VS EMERGENT PROCEDURES (IE INTUBATION, RESUSCITATION, NEWBORN INTENSIVE CARE, ETC) - FORCE.
4. FORCE AGAINST CIRCUMCISION (54150, 54160)

B. NEWBORN CARE VS NEWBORN CARE
1. TWINS OR TRIPLETTS - PAY ONE NB CARE PER DAY FOR EACH BABY.
2. 99431 VS 99436 - FORCE.
3. OTHERWISE; PAY ONE NB CARE PER DAY.
A. SAME PERFORMING PROVIDER, BOTH SUSPENDED - PAY HIGHER AND DENY OTHER W/EOB 910. HX PD, DENY CURRENT W/EOB 910.
B. DIFFERENT PERFORMING PROVIDER, BOTH SUSPENDED- PAY HIGHER AND DENY OTHER W/EOB 280. HX PD, DENY CURRENT W/EOB 280.

C. NEWBORN CARE VS ALL ELSE
1. MOD 57/QI BILLED W/NB CARE - FORCE IF SURGERY FU DAYS ARE 90.
NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
2. DIFFERENT PERFORMING PROVIDER OR UNRELATED DIAGNOSIS - FORCE.
3. SAME PERFORMING PROVIDER
A. NB CARE VS SURGERY/PROCEDURE - BOTH SUSPENDED - PAY HIGHER AND DENY OTHER W/EOB 825. HX PD - DENY CURRENT W/EOB 825.
B. NB CARE VS ALL ELSE - BOTH SUSPENDED- PAY HIGHER AND DENY OTHER W/EOB 910. HX PD - DENY CURRENT W/EOB 910.

12. OPTHALMOLOGICAL EXAM (92012-92014)

A. EXAM VS SURGERY/PROCEDURE
1. MOD 25 AND SAME PERFORMING PROVIDER - FORCE.
2. 57/QI MOD W/CALL VS SURGERY, FORCE IF FOLLOWUP DAYS ARE 90.
NOTE: IF MULTI PROCEDURES - FORCE IF AT LEAST 1 IS 90 DAYS.
3. UNRELATED DX AND DIFFERENT PERFORMING PROVIDER - FORCE.
4. ALL ELSE - DENY W/EOB 324.

B. EXAM VS CALL
1. MOD 25 AND SAME PERFORMING PROVIDER - FORCE.
2. DIFFERENT PERFORMING PROVIDER - FORCE.

3. ALL ELSE - PAY THE HIGHER AND DENY THE LESSER W/EOB 764.

C. EXAM VS EXAM - IF AUDIT (081) IS FAILING, WORK IT FIRST.
1. DIFFERENT PERFORMING PROVIDER NUMBERS AND FORCING THE (081) OR NO LIMIT AUDIT - O'LOC TO 83 (REVIEW ON 2 PROVIDERS IN CLINIC PERFORMING EYE EXAMS)
2. SAME PERFORMING PROVIDER - DENY LESSER ALLOWANCE W/EOB 910

13. INSERTION OF INDWELLING CATHETER IN OFFICE (G0002) - DENY IF POSTING AGAINST THE MAJOR PROCEDURE (USUALLY DEFINED BY 90 DAY POST OP). FORCE ALL ELSE. IN DOUBT - SEE YOUR LEAD/SUP/TRAINER.

14. CARE PLAN OVERSIGHT (G0064-G0066)
SAME PROVIDER - UNRELATED DX, MOD 25 - FORCE,OTHERWISE - DENY.
DIFFERENT PROVIDER - UNRELATED DX - FORCE, OTHERWISE - DENY.

15. TEAM CONFERENCE (99361,99362) & TELEPHONE CALLS (99371 - 99373)
A. DIFFERENT PERFORMING PROVIDER - FORCE.
B. SAME PERFORMING PROVIDER:
1. VERSUS OTHER CALLS - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 910. IF HX IS PD, DENY THE CURRENT W/EOB 910.
2. VERSUS SURGERY/OTHER PROCEDURES:
A. SAME OR RELATED DX - DENY.
B. UNRELATED DX - FORCE.

TEXT KEY	TEXT DESC
59	

TEXT KEY TEXT DESC

61 ONE INITIAL PROCEDURE PAID IN 30 DAYS, SAME PROVIDER.(DIFFERENT PP IN A CLINIC ARE CONSIDERED SAME PROV). WHEN AN INITIAL OR SUBSEQUENT PROCEDURE WAS PREVIOUSLY PAID:

1. DOS THRU 9/30/03 - CHANGE OR RECOUP & CHANGE CODE TO THE APPROPRIATE SUBSEQUENT CODE USING INFO EOB 360.
2. DOS 10/01/03 & AFTER - DENY OR RECOUP & DENY NEWEST INITIAL CODE.

EXCEPTION: IF NOT THE SAME INTITIAL/SUBSEQUENT PROCEDURE COMBINATION - FORCE.

NOTE: FORCE INITIAL AGAINST SUBSEQUENT ON SAME DAY.
NOTE: PAY INITIAL TO OLDEST DATE OF SERVICE.
NOTE: IF YOU HAVE A REBILL THAT WAS PREVIOUSLY REDUCED, DENY W/EOB 161.
NOTE: 92225 W/MOD(S) 50,LT OR RT ON SAME DAY - FORCE.

INITIAL		SUBSEQUENT	INITIAL		SUBSEQUENT
30905	-CHANGE-TO-	30906			
31645	----------	31646	61000	----------	61001
33010	----------	33011	92225	----------	92226
46940	----------	46942	93561	----------	93562
49080	----------	49081	94650	----------	94651
53600	----------	53601	94656	----------	94657
53620	----------	53621	94664	----------	94665
53660	----------	53661	94667	----------	94668

TEXT KEY	TEXT DESC
64	J CLAIMS PARAMETER (1006) - OVERLOC TO LOCATION 80 LOCATION 80 PRIOR TO 7/1/02, DATE OF SERVICE, IF 0998M IS BILLED IN COMBINATION WITH 0997M - DENY. 7/1/02 AND AFTER, IF 0998M IS BILLED IN COMBINATION WITH 0997M-FORCE IF CORRECT BACKUP IS WITH THE CLAIM. 10/1/03 PROCEDURE CODES CHANGE S0215=0998M AND T1013=0997M

TEXT KEY TEXT DESC

65

SPEECH THERAPY IS ALLOWED 36 SESSIONS PER CALENDAR YEAR WHEN DIAGNOSIS ON CURRENT CLAIM IS ON LIST 1017. COUNT ALL CLAIMS IN HISTORY TOWARDS THE 36 REGARDLESS OF WHETHER DIAGNOSIS IS ON LIST 1017 OR NOT. IF AUTH PRESENT, REVIEW FOR POSSIBLE. PAYMENT. AUDIT DOESN'T APPLY TO AGE 20 & UNDER.

CLAIM TYPE M (OUTPATIENT) - REV CODE 420/430 - FORCE. *SR
NOTE: IF PROVIDER BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY W/EOB 968/365 AT HEADER.

ALL CLAIM TYPES:
IF OVER MAX CUT TO MAX WITH INFO EOB 101, ALL ELSE DENY.

CLAIM TYPE J/P:
PROVIDER TYPE 36, 40, OR ANY UNUSUAL SITUATIONS, OVERLOC TO 75.

TEXT KEY	TEXT DESC
67	DISPOSABLE UNDERPADS - MAXIMUM LIMIT 180.

EXCEEDS MAXIMUM ALLOWABLE

WHEN THERE ARE OVERLAPPING MONTHS ON THE CLAIM, CONSIDER ONLY THE "FROM DATE", THE DAY THE ITEM WAS PURCHASED, WHEN WORKING THIS EXCEPTION

EXAMPLE: IF THE DATE SPAN ON THE CLAIM IS 6/15/02-7/15/02 FOR 180 AND THE CLAIM IT IS POSTING AGAINST IS FROM 5/15/02-6/14/02 FOR 180 THEN THE FIRST CLAIM IS FOR THE CALENDAR MONTH OF JUNE AND THE SECOND CLAIM IS FOR THE CALENDAR MONTH OF MAY. THE OVERLAPPING DATES ARE IRRELEVANT TO THE LIMITATION.

IF DUP ALSO FLAGGING - WORK THE DUP FIRST.

REVIEW HISTORY TO DETERMINE IF MAXIMUM ALLOWABLE FOR CALENDAR MONTH IS EXCEEDED.

IF PRIOR AUTH # PRESENT - REVIEW TO SEE IF UNITS BEYOND LIMITATION HAVE BEEN AUTHORIZED - IF SO - FORCE.

IF NO PRIOR AUTH PRESENT - REDUCE UNITS TO MAXIMUM ALLOWABLE W/EOB 101 AND/OR RECOUP/DENY W/EOB 309/339 AS APPROPRIATE.

'DY' MODIFER AND NO 169 POSTING - OVERLOC TO 83.

TEXT KEY TEXT DESC
68

OCCUPATIONAL THERAPY IS LIMITED TO 36 PROGRAM VISITS PER CALENDAR YEAR (12 INITIAL VISITS, & 24 ADDITIONAL FOR SPECIAL DIAGNOSIS ON LIST 1016). SYSTEM CHECKS DIAGNOSIS BILLED & POSTS APPROPRIATE AUDIT. READ THE ENTIRE TEXT BEFORE ADJUDICATING CLAIM.

CLAIM TYPE M (OUTPATIENT) - REV CODE 420/440 - FORCE. *SR
NOTE: IF PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY W/EOBS 968/365 AT HEADER.

ALL CLAIM TYPES:
DOS 070199 & AFTER: LIMIT IS CHANGED TO FAIL AT 36 UNITS DUE TO PROGRAM CHANGES. SEE THE FOLLOWING DEFINITIONS OF PROGRAM VISITS TO DETERMINE MAXIMUM ALLOWABLE UNDER THE OCCUPATIONAL THERAPY PROGRAM.

0701M-0702M, 97532-97533 & 97770: EACH UNIT EQUALS ONE PROGRAM VISIT.

TWO UNITS OF THE FOLLOWING PROCEDURE CODES IN ANY COMBINATION EQUAL ONE PROGRAM VISIT:
97110 THERAPEUTIC EXERCISES
97112 NEUROMUSCULAR REDUCTION
97113 AQUATIC THERAPY
97520 PROSTHETIC TRAINING
97530 THERAPEUTIC ACTIVITIES
97535 SELF CARE MNGMENT TRAINING
97537 COMMUNITY/WORK REINTEGRATION

IF AUTHORIZATION PRESENT, REVIEW FOR POSSIBLE PAYMENT:

EFFECTIVE DOS 070100 EXPEDITED AUTHORIZATION (AUTH BEGINS WITH 870000) IS ALLOWED FOR LIMITATION EXTENSIONS (LE) FOR THE FOLLOWING CODES:

644 - AN ADDITIONAL 12 OCCUPATIONAL THERAPY VISITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED VISITS FOR THE CURRENT YEAR AND HAS ONE OF THE FOLLOWING: HAND/UPPER EXTREMITY JOINT SURGERY OR CVA NOT REQUIRING ACUTE INPATIENT REHABILITATION.

645 - ADDITIONAL 24 OCCUPATIONAL THERAPY VISITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED VISITS FOR THE CURRENT YEAR AND HAS RECENTLY COMPLETED AN ACUTE INPATIENT REHABILITATION STAY.

LE ARE SUBJECT TO POST PAY REVIEW, AND EXAMINERS ARE NOT REQUIRED TO VERIFY THAT THE REQUIRED CONDITIONS HAVE BEEN MET.

IF OTHER THAN EXPEDITED, AND AUTHORIZATION COVERS THE PROCEDURE AND DATE OF SERVICE - FORCE. OTHERWISE DENY SERVICES OVER THE ESTABLISHED PROGRAM LIMITS FOR DATE OF SERVICE.

ALL ELSE: IF SUSPENDED LINE EXCEEDS LIMITATION - DENY.

ANY UNUSUAL SITUATIONS OL 75.

TEXT KEY	TEXT DESC
70	HOME HEALTH SERVICES OVER $750.00

1. IF ANY OTHER EXCEPTION IS FAILING, WORK THAT EXCEPTION FIRST.

2. IF THE DATES OF SERVICE PER LINE ARE NOT IN THE SAME CALENDAR MONTH:
   A. ELECTRONIC CLAIMS - DENY WITH EOB 177.
   B. HARD COPY CLAIMS - SPLIT DOS INTO 2 SEPARATE LINES (ONE CALENDAR MONTH PER LINE).

LOC 36:

1. IF AUTH # ON CLAIM, FORCE OR DENY ACCORDING TO THE AUTH SCREEN. EXCEPTION: IF PROCEDURES, DATES AND/OR UNITS DON'T MATCH - DENY WITH DENY W/EOB 717.
2. IF NO AUTH # - STAGE WORKSHEET TO CLAIM AND BACKUP AND ROUTE TO DHSQS/QFFS, MS 45506. (IF NO CLAIM AND/OR BACKUP - ROUTE WORKSHEET).
3. WHEN CLAIM IS RETURNED - ADJUDICATE PER INSTRUCTIONS (USE INFO EOB 373).

TEXT KEY TEXT DESC
72

HIGH RISK VS HIGH RISK

1. SURGEON VS ASSIST (MOD 80,81,82)-FORCE.
2. NO MOD VS NO MOD -
   A) CLAIM FOR ASSIST W/NO MOD - DENY OR RECOUP AND DENY W/EOB 562.
   B) TWINS:PAY ONLY ONE. IF BOTH SUSPENDING, PAY THE HIGHER. IF ONE IS PAID, DENY CURRENT.
3. ALL ELSE - PAY ONLY ONE HIGH RISK PER PREGNANCY.

NOTE: ANY QUESTIONS - SEE YOUR SUPERVISOR.

TEXT KEY	TEXT DESC
74	

TEXT KEY	TEXT DESC
75	J CLAIMS PARAMETER (1034,1038) CRITICAL CARE INCLUDES ANCILLARY SERVIES CRITICAL CARE CODES (99291-99292) SHOULD NEVER BE DENIED. 1. DIFFERENT POS - FORCE. 2. IF PROCEDURE CODES (71010,71020,71015,93561,93562) BILLED W/MOD 26 - DENY, IF BILLED W/O MOD 26 - FORCE. 3. ALL ELSE - DENY OR RECOUP & DENY THE ANCILLARY SERVICES W/EOB 789.

TEXT KEY	TEXT DESC
77	J CLAIMS PARAMETER (1035, 1039) PEDIATRIC/NEONATE INCLUDES ANCILLARY SERVICES PEDIATRIC/NEONATE CODES (99293-99296) SHOULD NEVER BE DENIED 1. DIFFERENT POS - FORCE. 2. IF PROCEDURE CODE (94375) BILLED W/MOD 26 - DENY, IF BILLED W/O MOD 26 - FORCE. 3. ALL ELSE - DENY OR RECOUP & DENY THE ANCILLARY SERVICE CODES W/EOB 789.

TEXT KEY	TEXT DESC
81	ONE EYE EXAM ALLOWED IN A TWO YEAR PERIOD

IF PATIENT IS A DDD CLIENT, INDICATED BY EXCEPTION 498 POSTING - FORCE.@

IF CLIENT IS CURRENTLY 21 OR OLDER AND WAS UNDER AGE 21 AT ANY TIME DURING HX CLAIMS - FORCE.

IF AUTHORIZATION ON THE CLAIM AND:
1. AUTH IS FOR SERVICES BILLED - FORCE
2. SERVICES BILLED ARE NOT LISTED ON THE AUTH FILE - DENY (ADDING INFO EOB 251)

PAY THE OLDEST DATE OF SERVICE FIRST. DENY AND/OR RECOUP AS NECESSARY.

TEXT KEY TEXT DESC

82 ONE LOWER DENTURE ALLOWED IN 10 YEARS

DOS PRIOR TO 11-1-02:
1. IF NO JUSTIFICATION - DENY.
2. IF JUSTIFICATION - FORCE.

DOS 11-1-02 TO 7-31-03:
1. DATES OF SERVICE ARE LESS THAN A YEAR APART:
   A. IF AUTHORIZATION - FORCE.
   B. IF NO AUTH - DENY W/EOB 023 IN SECOND SLOT.
2. IF DATES OF SERVICE ARE MORE THAN 1 YEAR APART:
   A. IF AUTHORIZATION - FORCE.
   B. IF NO JUSTIFICATION - DENY.
   C. IF JUSTIFICATION IS "NO LONGER SERVICEABLE" OR "DAMAGED BEYOND REPAIR" - FORCE.
   D. IF JUSTIFICATION SAYS "LOST" ALLOW 1 REPLACEMENT WITHIN THE 10 YEAR PERIOD - IF MORE THAN 1 SET WITH THE JUSTIFICATION OF LOST - DENY WITH EOB 339.

DOS 8-1-03 OR AFTER:
1. AGE 21 AND OVER:
   A. IF AUTHORIZATION - FORCE.
   B. IF NO AUTHORIZATION - DENY.
2. AGE 20 OR UNDER - FOLLOW DIRECTIONS UNDER DOS 11-1-02 TO 7-31-03.

0515D VS 05120 OR 5120D OR D5120 AND SAME PROVIDER:
1. DATES OF SERVICE ARE MORE THAN A YEAR APART - FORCE.
2. DATES OF SERVICE ARE WITHIN A YEAR OF EACH OTHER - STAGE TO DETERMINE IF THE 0515D IS FOR THE SAME SERVICE.
   A. IF THE SRVICES ARE THE SAME - DENY WITH EOB 189.
   B. IF THE SERVICES ARE DIFFERENT - FORCE.

TEXT KEY TEXT DESC
87 MULTIPLE ANESTHESIA

THE INTENT OF THIS AUDIT IS TO PAY ONE BASE AND TOTAL TIME UNITS PER OPERATIVE SESSION. THIS MAY INVOLVE ONE OR MORE PROCEDURES, ONE OR MORE PROVIDERS.

NOTE: TO CALCULATE ALLOWABLE FEE FOR MULTI ANESTHESIA SERVICES BILLED ON SAME CLAIM - ADD MAJOR PROCEDURE BASE (HIGHEST BASE) AND TOTAL TIME UNITS BILLED FOR ALL PROCEDURES.
--EXCEPT: 01968 AND 01969 (ADD ON CODES) - PAY THE BASE FOR BOTH THE ADD ON CODES (01968 OR 01969) BILLED IN COMBO WITH 01967.
NOTE: CALCULATE UNITS FROM TIME ON CLAIM OR IN COMMENTS. 1 UNIT = 1 MINUTE OF TIME.
NOTE: 1 LINE CLAIM BILLED W/1 UNIT - EMC DENY W/EOB 452. HARDCOPY STAGE TO SEE IF TIME ON CLAIM OR DENY W/EOB 452.
EXCEPTION: (01996) - DO NOT DENY, CUT TO 1 UNIT W/EOB 431. PRIOR TO 1/1/01 PAY W/MOD AS ANES BASE, BUT DO NOT INCLUDE IN ANES PRICING, 1/1/01 & AFTER - NO MOD, NO BASE - FORCE.
NOTE: MULTI LINE CLAIM & ANES PROCEDURES W/A MOD W/ONE UNIT FOR SAME DOS AS MAJOR ANES SHOULD NOT BE CALCULATED IN TOTAL TIME UNITS - DENY W/EOB 542.
EXCEPTION: (01996) - DO NOT DENY, CUT TO 1 UNIT W/EOB 431. PRIOR TO 1/1/01 PAY W/MOD AS ANES BASE, BUT DO NOT INCLUDE IN ANES PRICING, 1/1/01 & AFTER - NO MOD, NO BASE - FORCE.
ALSO PROCEDURES THAT SHOULD BE PAID SEPARATELY AT 100% - LETTER A, PG 2 OF THIS TEXT.

NOTE: SURGICAL PROCEDURES BILLED BY AN ANESTHESIOLOGIST AND NO ANESTHESIA MODS ARE INVOLVED SHOULD BE CONSIDERED INDEPENDENT AND SUBJECT TO 053 AUDIT.

NOTE: ORGAN DONOR VS ORGAN RECIPIENT ONLY - FORCE. IF IN DOUBT SEE YOUR TRAINER.

NOTE: 01953 (ANES FOR 2ND,3RD DEGREE BURNS) IS AN ADD ON PROCEDURE TO 01952. MULTI UNITS ARE NOT PAID AS TIME UNITS. MAA WILL PAY A MAX OF 10 UNIT FOR THIS PROCEDURE.

NOTE: 01968/01969 (ADD ON CODES) CAN ONLY BE BILLED WITH 01967 -
1. 01968/01969 BILLED WITH OBSTETRIC CODES OTHER THAN 01967 - DENY W/EOB 365.
2. 01968-01969 BILLED BY THEMSELVES - DENY W/EOB 757.
3. 01967 AND 01968/01969 BILLED TOGETHER VS ANY C-SECT OR VAGINAL ANESTH CODE:
   A. 01967 AND 01968/01969 ON CURRENT CLAIM WITH C-SECT OR VAGINAL DELIVERY FOR ANES PD IN HX - DENY BOTH 01967 & 01968/01969 W/EOBS 803/189.
   B. BOTH CLAIMS SUSPENDING - PAY 01967 AND 01968/01969, DENYING THE OTHER DELIVERY(S) ANESTH W/EOBS 803.

NOTE: 01960 & 01961 IN COMBO - DENY BOTH IF SUSPENDING W/EOB 365.

IF ONE PAID DENY CURRENT W/EOB 102 IF SAME PROVIDER/PERFORMING PROVIDER. IF DIFFERENT PROVIDER/PERFORMING PROVIDER DNY W/EOB 280.
**UNLESS DX OF TWINS OR MORE AND REPORT HAS JUSTIFICATION - O'LOC TO 83.
01960 &/OR 01961 BILLED IN COMBO W/01967/01968/01969 - DENY W/EOB 365.

NOTE: DOS PRIOR TO 01/01/02 00840/00846 PD IN HX OR BILLED ON CURRENT AND 5913M/5914M BILLED ON SAME DOS - RESEARCH FOR POSSIBLE REC & DENY OF 00840/00846 W/EOBS 302/589. DOS 01/01/02 & AFTER 00840 VS 00846,00851,00869,01962,01963,01969 ON SAME DOS - RESEARCH FOR POSSIBLE RECOUP &/OR DENY OF 00840. ANY QUESTIONS ASK MMIS/SUPV/TRNR.

NOTE: 00940 PD IN HX OR BILLED ON CURRENT & 01964/5915M ON SAME DOS - RESEARCH FOR POSSIBLE RECOUP & DENY OF 00940.

NOTE: PT 49 (CRNA) HAS A BLANKET DENIAL ON FILE, WHICH MEANS MDCR DOES NOT PAY FOR CRNA SERVICES. FOLLOW ALL POLICY IN THIS TEXT, EXCEPT DO NOT RECOUP A CROSS OVER CLAIM YOU SEE PD IN HX FOR THE PT 48 (ANESTHESIOLGIST).

1. THE FOLLOWING PROCEDURES ARE TO BE DENIED W/EOB 314 IF BILLED IN COMBINATION W/EACH OTHER. IF BILLED IN COMBINATION W/OTHER ANESTHESIA PROCEDURES - ADD UNITS TO TOTAL TIME AND DENY LINE WITHOUT UNITS W/EOB 542. (THE ABOVE APPLIES TO PROCEDURES WHERE THERE IS NO ANESTHESIA BASE FOR DOS)

20937,20938,22103,22116,22145,22226,22230,22328,22585,22614,
22632,22650,22840,33517,33518,33519,33521,33522,33523,33530,
33572,33924,35390,35681,35700,37250,37251,38102,38746,38747,
43496,43635,44121,48400,49568,61495,63035,63048,63057,63066,
63076,63082,63086,63088,63091,63308,92981,92984,92996.

2. PAYMENT MODIFIERS TO DETERMINE ADJUDICATION -

A. 100% PAYMENT
1. MOD AA,QZ - 8/1/94-99/99/99
2. AA - ANESTH SVCS FURNISHED BY ANESTH - PROVIDER TYPE 48
3. QZ - ANESTH SVCS FURNISHED BY CRNA, WITHOUT MEDICAL DIRECTION PROVIDER TYPE 49

B. 50% PAYMENT
1. MOD AD,QK,QX,QY - 07/01/00 - 99/99/99
2. MOD QX,AB,AC,AD,QJ,QO,QQ,QK - 10/01/95-06/31/00
3. MOD QY - 7/1/98-99/99/99

AD - MEDICAL DIRECTION BY ANESTH OF MORE THAN 4 CONCURRENT ANESTH SVCS - PROVIDER TYPE 48
QK - MEDICAL DIRECTION BY ANESTH OF 2,3 OR 4 CONCURRENT ANESTH SVCS - PROVIDER TYPE 48
QY - MEDICAL DIRECTION BY ANESTH OF CRNA - PROVIDER TYPE 48
QX - CRNA MEDICALL DIRECTED BY ANESTH FOR ANESTH SVCS - PROVIDER TYPE 49

NOTE: DO NOT APPLY ANY MANUAL PRICING TO THE 9T MOD FOR TRAUMA, EFF 4/4/02 PROCESS DATE - 6/30/03 DOS. IF OTHER PRICING MODS ON CLAIM, YOU MAY REMOVE 9T & ADD TO COMMENTS, USE INFO EOB 877 AT HEADER. SEE PAGE23 IN INFO TEXT.

MOD 9T/ST (TRAUMA ENHANCEMENT) ALL POLICY & PROCEDURE MUST BE FOLLOWED FIRST, & THEN APPLY (TRAUMA ENHANCEMENT) IF NOT A VALID POS PER BELOW - & ANOTHER MOD ON DETAIL LINE - KEY IT IN, OTHERWISE, RETAIN THE 9T/ST. REFER TO EXCEPTION 368 FOR PRICING AND POLICY. *S

1. 11/1/99 - 12/31/00 DOS - ALLOW 300% OF PDDD ALLOWED FOR POS (1,2,5)
2. 1/1/01 - 3/17/02 DOS - ALLOW 400% OF PDDD ALLOWED FOR POS (1,2,5)
3. 3/18/02 DOS FOR ALL CLAIMS PRICED UP THRU PROCESSING DATE OF 4/3/02 (NOT DOS) - ALLOW 250% FOR POS (1,2,5).
4. 7/1/03 DOS & AFTER - ALLOW 250% OF PDDD ALLOWED FOR POS (1,2,5,21,22,23,51,52)

SAMPLE: 61343 & DOS 2/1/01 - PDDD ALLOWED IS $1323.63 X 400% = $5294.00

NOTE: ALL CLAIMS SHOULD BE REVIEWED BY LOC 09.

3. 100% MOD VS 50/50% MOD OR 100% MOD VS 100% MOD (SAME PROCEDURE)
   A. IF DIFFERENT OPERATIVE SESSIONS - FORCE.
   B. IF SAME OPERATIVE SESSION, SAME OR DIFFERENT PROVIDER - PAY FIRST CLAIM IN AND DENY THE SECOND CLAIM BILLED W/EOB 803.

4. 50% MOD VS 50% MOD
   A. CLAIMS SAME PROCEDURE OR RELATED ANATOMICALLY PROCEDURE WITH DIFFERENT PERFORMING PROVIDERS #'S (1 PT 48 AND 1 PT 49) - FORCE.
      EXAMPLES:
      1. 00400 VS 00402 DX 174.9 ON BOTH PROCEDURES IS CONSIDERED SAME PROCEDURE, RELATED ANATOMICALLY BY DESCRIPTION OF PROCEDURES.
      2. 00902 VS 00940 W/DIFFERENT DX INDICATES TWO PROCEDURES AT SAME OP SESSION - APPLY AUDIT INTENT AND 087 POLICY.

      EXCEPTION: PT 48 VS PT 48 OR PT 49 VS PT 49 - 1 PROCEDURE ONLY - DENY W/EOB 280.
   B. CLAIM(S) WITH MULTIPLE PROCEDURES AT SAME OP SESSION - APPLY PAYMENT FOR 1 BASE (THE HIGHEST BASE) PER POLICY, MANUAL PRICING WHEN NECESSARY.

FOLLOW THE CURRENT FORMULA CALCULATION FOR TOTAL OP ALLOWANCE. PAY THE HIGHEST BASE 100% (BOTH 50% PROVIDER(S)) SUBTRACTING THE HIGH BASE ALLOWANCE FROM THE TOTAL OP ALLOWANCE. THEN DIVIDE THE REMAINDER BY 2, PAYING BOTH 50% LESSER BASE PROVIDER(S) 1/2 OF THE REMAINDER OF THE TOTAL OP SESSION ALLOWANCE.

EXAMPLE: HIGH BASE 6-100 MINUTES/LOW BASE 3-50 MINUTES, DOS 060102 6X15+150X15.49 DIVIDED BY 15 =
247.84(TOTAL OP ALLOWANCE) HIGH BASE 6 50% 100 MINUTES

PAYS 98.10 X 2 (PROVIDER(S)) FOR A TOTAL OF 196.20. TOTAL OP ALLOWANCE 247.84 MINUS 196.20 = 51.64. DIVIDE 51.64 BY 2 = 25.82 AND PAY BOTH THE 50% PROVIDER(S) OF THE LESSER BASE PROCEDURE THE REMAINDER OF THE TOTAL OP SESSION ALLOWANCE.

C. CLAIM W/2 DIFFERENT PROVIDERS OR SAME OR DIFFERENT PROCEDURE(S) AND (2 DIFFERENT PAYMENT MODS I.E. AB VS QX) - DENY ON LINE OR HEADER, WHICHEVER IS APPROPRIATE W/EOB 961.

D. CLAIM OR CLAIMS W/DUMMY #'S OR NO #'S - FORCE.

E. CLAIMS WITH SAME PROVIDER # - IF BOTH CLAIMS ARE SUSPENDING, PAY CLAIM W/CORRECT MOD, (CRNA MOD QX OR ANESTHESIOLOGIST MODS AB,AC,AD,QJ,QK,QO,QQ) AND DENY CLAIM WITH INCORRECT MOD. IF ONE IS PAID, DENY CURRENT. IF HISTORY CLAIM PAID WITH INCORRECT MOD, ALSO GIVE INFO EOB 189.

ANY SITUATION THAT IS NOT ADDRESSED ABOVE OR ANY QUESTIONS - SEE YOUR SUPERVISOR OR TRAINER.

5. DIFFERENT OPERATIVE SESSION: (AT LEAST 15 MIN) SIMILIAR OR DIFFERENT PROCEDURES, UNRELATED DIAGNOSIS, DIFFERENT POS, DIFFERENT OP SIGHT (1 PROC IS FOR A COMPLICATION OR A COMPLICATION DIAGNOSIS IS USED OR CLAIM INDICATES DIFFERENT OPERATIVE SESSION).

NOTE: REVIEW ICD-9 FOR FULL DESCRIPTION ,DX OF POST OP OR PROCEDURE DESCRIPTION IS POST OP.

NOTE: DO NOT CONSIDER DIFFERENT IF IT LOOKS LIKE PATIENT WAS IN AN ACCIDENT & YOU HAVE MULTIPLE OP SIGHTS FOR FRACTURES OR OTHER TRAUMATIC INJURIES.

NOTE: EFFECTIVE 7/1/00 DOS MAA WILL ADOPT MDCRS POLICY OF ALLOWING DISCONTINUOUS ANESTHESIA. PROVIDERS MAY BILL UNITS THAT ARE FROM ESTABLISHMENT OF VENOUS ACCESS THRU CONCLUSION OF ANESTHESIA ATTENDANCE, THERE MAY BE BREAKS IN TIME/MINUTES ON THE CLAIM, THEREFORE DO NOT CONSIDER DIFFERENT OP SESSIONS, UNLESS OBVIOUS. ANY QUESTIONS - SEE MMIS/SANDY A.

A. PAY BASE AND TOTAL TIME TO EACH PROCEDURE (APPLY 087 CRITERIA TO MULTIPLE PROCEDURES WITHIN SAME OP SESSION).

B. USE 814 OVERCODE.

6. SAME OPERATIVE SESSION: SAME, SIMILIAR OR DIFFERENT PROCEDURES, RELATED DIAGNOSIS, SAME OPERATIVE SIGHT.

A. SAME CLAIM - ANESTHESIA BASIC VALUE ALLOWABLE FOR MULTIPLE SURGERIES IS THE VALUE OF THE MAJOR PROCEDURE ONLY, ADMINISTRATION OF ANESTHESIA BILLED FOR MORE THAN ONE PROCEDURE CODE IS AUDITED AS FOLLOWS;

NOTE: PAY THE BASE FOR 01968/01969 (ADD ON CODES) BILLED IN COMBO WITH 01967 DO NOT APPLY MAJOR BASE CRITERIA.

1. ADD THE BILLED AMOUNT OF THE LESSER PROCEDURE(S) ONTO THE BILLED AMT OF THE MAJOR PROCEDURE USING INFO EOB 001.
2. CHANGE THE BILLED AMT TO $00 FOR THE PROCEURE(S) CODE WITH THE LESSER BASE ANESTHESIA VALUE.

3. DENY THE $00 LINE(S) W/EOB 542.
4. CALCULATE TOTAL ANESTHESIA TIME UNITS FOR BOTH PROCEDURES AND ENTER THE APPROPRIATE ANESTHESIA UNITS FOR THE MAJOR PROCEDURE LINE. ENTER 1 UNIT ON BOTH DETAIL LINES.

NOTE: IF ROUTINE DELIVERY AND C-SECTION ARE BILLED ON SAME CLAIM, ALLOW 360 UNITS TOTAL. REMEMBER, WHEN CUTTING BACK UNITS TO MAX ON ONE OR BOTH PROCEDURES, USE EOB'S 416/001.

--APPLY THE 360 MINUTE LIMIT TO 01968 AND 01967, ALWAYS CHECK CLAIM FOR ACCURACY OF TOTAL OP TIME TO UNITS BILLED IF AVAILABLE.

1. IF BILLED UNITS ARE 360 OR OVER ON THE LINE FOR 01967 - PAY 01968 UNITS AS BILLED, SUBTRACTING THIS FROM 360 UNITS ALLOWED PAYING REMAINDER OF UNITS ON 01967.
2. IF OVER BILLED UNITS ARE 360 OR OVER ON BOTH 01967 AND 01968 - PAY 1 UNIT ON 01968 AND 359 UNITS ON 01967 W/INFO EOB 416.

NOTE: DO NOT APPLY LIMIT OF 360 UNITS TOTAL TO 01962/01969. DO APPLY 087 CRITERIA.

NOTE: ANESTHESIA PROCEDURES WITH A MOD W/ONE UNIT FOR SAME DOS AS MAJOR ANESTHESIA SHOULD NOT BE CALCULATED IN THE TOTAL TIME UNITS - DENY W/EOB 542. (EXCEPTION - SEE PRECEDING TEXT FOR PROCEDURES THAT SHOULD BE PAID SEPERATELY AT 100% - LETTER A, PG.1 OF THIS TEXT.)

B. DIFFERENT CLAIM

NOTE: PAY THE BASE FOR 01968/01969 (ADD ON CODE) BILLED IN COMBO WITH 01967 DO NOT APPLY MAJOR BASE CRITERIA.

NOTE: DO NOT APPLY LIMIT OF 360 NITS TOTAL TO 01962/01969, DO APPLY 087 CRITERIA.

DETERMINE WHICH PROCEDURE IS THE MAJOR PROCEDURE USING THE CONVERSION FACTORS AND CALCULATING FEES SECTION FOR FORMULA FOR DOS TO DETERMINE THE TOTAL SESSION ALLOWANCE. SUBTRACT ALLOWED FROM MAJOR PROCEDURE OR PAID HX, THIS WILL EQUAL THE DIFFERENCE. MANUAL PRICE CURRENT CLAIM AT THE DIFFERENCE USING INFO EOB 823.

NOTE: MANUAL PRICING SHOULD BE APPLIED TO THE CLAIM W/THE LESSER ANES BASE IF BOTH SUSPENDING. IF HX PAID - MANUAL PRICE CURRENT CLAIM.

--EXCEPTION TO ABOVE:

1. DIFFERENT PROCEDURE, SAME PROVIDER OR PERFORMING PROVIDER AND IS A REBILL (SAME MONEY,UNITS) - DENY W/EOB 803/189.
2. SAME PROCEDURE, SAME PROVIDER OR PERFORMING PROVIDER - DENY W/EOB 803/189.
3. SAME PROCEDURE, DIFFERENT PROVIDER OR PERFORMING PROVIDER - USE 087 CRITERIA AND EOB 001.
4. WHEN CALCULATING TOTAL TIME UNITS, YOU ONLY USE UNITS FROM 50/50 SPLIT ONCE + UNITS FROM 100% MOD =TOTAL TIME.

C. IF ALL SERVICES ARE SUSPENDING, FOLLOW THESE GUIDELINES:
1. PAY THE PROCEDURE (100%) OR PROCEDURES (50%/50%) WITH THE HIGHEST BASE FULL AMT - FORCE THE 087.
2. BALANCE DUE- TO DETERMINE THE REMAINING ALLOWABLE FEE, SUBTRACT THE AMT (100%) OR AMOUNTS (50/50%) FROM THE SUM TO EQUAL BALANCE, IF PAYING 100% MOD FULL VALUE, THEN BALANCE LEFT WILL BE SPLIT 50/50%. IF PAYING 50%/50% MODS FULL VALUE, THEN BALANCE LEFT WILL BE PAID TO 100% MOD.

(IE)TOTAL ALLOWABLE IS $200
100% MOD ALLOWABLE GETS $100

50/50% MODS SPLIT THE REMAINING $100.
(50% MODS EACH GET $50)

NOTE: USE 814 OVERCODE IF YOU DETERMINE THAT YOU HAVE DIFFERENT OPERATIVE SESSIONS. EXCEPTION - DELIVERIES.

7. DELIVERIES: POLICY IS TO PAY A MAX. OF 6 HRS (360 UNITS) FOR VAGINAL DELIVERY & C-SECTION IN COMBINATION WHEN PERFORMED ON THE SAME DAY OR CONSECUTIVE DAYS. IF NOT CONSECUTIVE DAYS IT IS CONSIDERED DIFFERENT OP SESSIONS AS DISCONTINUED ANESTHESIA.

NOTE: DELIVERY BILLED ON SAME DATE AS AN ABORTION - IF BOTH PROCEDURES IN SUSPENSE, DENY BOTH W/EOB 190. IF ONE PROCEDURE PAID IN HX, DENY CURRENT PROCEDURE W/EOB 190.
NOTE: DO NOT PAY SEPARATE OP SESSIONS FOR VAG AND C-SECT IF PERFORMED ON SAME OR CONSECUTIVE DAYS.
NOTE: VAG DEL VS TUBALS - FORCE 087. C-SECT VS TUBALS - APPLY 087.
NOTE: ALLOW 1 DELIVERY ANESTHESIA ADD-ON PER PREGNANCY.
--01968-01969 ADD ON FOR C-SECT, ALLOW ONCE WITH PROCEDURE CODE 01967, ONCE PER PREGNANCY.
NOTE: 01960-01961 PRIOR TO 01/01/02 DO NOT APPLY FOR MATERNITY LIMITATION, DOS AFTER 01/01/02 APPLY 360 UNIT LIMIT. ANY QUESTIONS ASK SUPV/TRAINER/MMIS.

A. IF VAGINAL IS THE ONLY DELIVERY BILLED - PAY UP TO A MAX OF 360 UNITS.
B. IF C-SECTION IS THE ONLY DELIVERY BILLED - PAY UP TO A MAX OF 360 UNITS.
C. IF C-SECTION AND VAG ARE BILLED IN COMBINATION - PAY UP TO MAX OF 360 UNITS. NOTE: ALWAYS USE THE BASE FOR THE C-SECTION WHEN BILLED IN COMBO. IF MAX UNITS PAID IN HISTORY FOR VAG AND CURRENT CLAIM IS FOR C-SECTION, YOU MUST CALCULATE TOTAL ALLOWANCE USING C-SECTION BASE, THEN DEDUCT AMOUNT PAID ON VAG, PAYING DIFFERENCE ON C-SECTION W/EOB'S 001/416 (SAME CLAIM) OR (DIFFERENT CLAIM) W/EOB'S 823/416 AND CUT UNITS TO EQUAL THE 360 ALLOWED.
--EXCEPT - 01968/01969 DO NOT APPLY MAJOR BASE CRITERIA - APPLY 360 MAX LIMIT PAYING 01968 UNITS BILLED, REDUCING 01967'S UNITS TO REMAINDER OF THE UNITS. (I.E. - 01968 BILLED UNITS 32 AND 01967 BILLED UNITS 416. PAY 01968

32 UNITS AND REDUCE 01967 UNITS TO 328 UNITS FOR THE MAX
OF 360. REC AND ADJUST PD HX UNITS IF NECESSARY FOR 01967.

D. VAGINAL VS VAGINAL OR C-SECTION VS C-SECTION -
1. IF MAX UNITS NOT MET BETWEEN HISTORY AND CURRENT-
APPLY 087 POLICY.
2. IF MAX NOT MET IN HISTORY BUT UNITS ON CURRENT COMBINED
W/HISTORY EXCEED MAX, CUT UNITS TO EQUAL MAX W/EOB 416.
THEN APPLY 087 POLICY.
3. IF HISTORY WAS PAID AT MAX, DENY CURRENT W/EOBS 803/416.

8. OVER 999 UNITS: (THIS IS EFFECTIVE UP THRU 8/29/03 ONLY)
UNITS BILLED FOR 1 PROCEDURE EQUALS MORE THAN 999 MINUTES,
MINUTES, THE 2 METHODS OF BILLING THAT WOULD BE THE MOST
COMMON ARE AS FOLLOWS:

A. 2 LINES OF THE SAME PROCEDURE, MONEY ON BOTH LINES AND
999 UNITS ON LINE 1 AND REMAINING UNITS ON LINE 2.
1. CALCULATE TOTAL UNITS FROM BOTH LINES + BASE IN COMB-
INATION W/FORMULA FOR ANESTHESIA = ALLOWABLE.
NOTE: IF SPLIT MODS (I.E. QX,AB,AC, ETC) YOU MUST CALCULATE
FROM TOTAL ALLOWABLE (I.E. 50/50)
2. SUBTRACT ALLOWANCE OF LINE 1 FROM TOTAL ALLOWABLE
AND MANUAL PRICE LINE 2 WITH THE BALANCE USING EOB 001.

B. ONE LINE WITH A PROCEDURE, TOTAL MONEY AND UNITS EITHER
ON THE LINE, ON THE CLAIM OR IN THE COMMENTS.
1. KEY 999 UNITS ON LINE 1.
2. KEY A SECOND LINE ON THE CLAIM WITH SAME DOS, POS, PROC-
EDURE AND UNITS IN THE EXCESS OF 999 (LEAVE CHARGES ON
LINE 1).
3. CALCULATE UNITS + BASE IN COMBINATION W/FORMULA FOR ANES-
THESIA AND MANUAL PRICE ON LINE 1 W/EOB 001.
4. DENY LINE 2 W/EOB 387.

CONVERSION FACTORS AND CALCULATING FEES:
1/1/03 - 999999 - BASE X 15 + TOTAL TIME UNITS X CONVERSION
($20.23) DIVIDED BY 15 = SUM.
7/1/02 - 12/31/02- BASE X 15 + TOTAL TIME UNITS X CONVERSION
($15.70) DIVIDED BY 15 = SUM.
7/1/01 - 6/30/02 - BASE X 15 + TOTAL TIME UNITS X CONVERSION
($15.49) DIVIDED BY 15 = SUM.
7/1/00 - 6/30/01 - BASE X 15 + TOTAL TIME UNITS X CONVERSION
($15.10) DIVIDED BY 15 = SUM.
7/1/99 - 6/30/00 - BASE X 12 + TOTAL TIME UNITS X CONVERSION
($12.96) DIVIDED BY 12 = SUM.
7/1/97 - 6/30/99 - BASE X 12 + TOTAL TIME UNITS X CONVERSION
($12.75) DIVIDED BY 12 = SUM.
7/1/96 - 06/30/97 - BASE X 12 + TOTAL TIME UNITS X CONVERSION
($12.63) DIVIDED BY 12 = SUM.

TEXT KEY TEXT DESC

88 J CLAIMS

PARAMETER (1000)
99078 (DIABETES/ASTHMA GRP COUNSEL) WORK 105 1ST, OTHERWISE, ALLOW UP TO 4 UNITS FOR EA SPAN OF DX (250.00-250.93 AND 493.00-493.92). DENY ALL ELSE.

PARAMETER (1002)
86812 - 86822 (TISSUE TYPING MAX "15") MAXIMUM OF 15 TISSUE TYPING PROCEDURES ALLOWED, ANY COMBO - DENY OR CUTBACK TO MAX W/EOB 101. PAY OLDEST DOS FIRST ON SUSPENDING CLAIMS.
NOTE: IF AUTH ON CLAIM - FORCE UP TO ALLOWED.

PARAMETER (1005)
99401 - 99402 (SMOKE CESSATION) MAX OF 10 SMOKE CESSATION PROCEDURE CODES ALLOWED, ANY COMBO. PAY OLDEST DOS FIRST ON SUSPENDING CLAIMS. IF CLAIM STATES DIFFERENT PREGNANCY - FORCE UP TO A MAXIMUM OF 10.

EXCEPTION: 99401 WITH V65.44 DIAGNOSIS - FORCE. THIS IS FOR AIDS COUNSELING, NOT SMOKING CESSATION. *BJS

PARAMETER (1011)
ALLOW A COMBINATION OF 12 OF THE FOLLOWING (96100,96110,96111, 96115,96117). PAY THE FIRST 12 & DENY ALL ELSE. EXCEPTION:
IF AUTH # SPECIFICALLY REQUESTS OVER LIMIT OR ADDITIONAL - FORCE.

PARAMETER (1025)
ALLOW 2 NEUROPSYCH (96100) IN A LIFETIME W/O AUTH. IF AUTH FOR ADDITIONAL CODE & DOS - FORCE, IF NO AUTH DENY OVER 2.
EXCEPTION: PER MH DIVISION, IF "I" IN ITA FIELD, ALLOW 2 EVERY 90 DAYS, DENY OVER 2 IN 90 DAY PERIOD UNLESS AUTH FOR CODE AND *S DOS.

K CLAIMS

PARAMETER (1018)
D9110 (PALLIATIVE TREATMENT) - ONE PALLIATIVE TREATMENT ALLOWED PER DAY. ALLOW ONE AND DENY ALL OTHERS.

TEXT KEY	TEXT DESC
94	INTERPRETER SERVICES, MAX 7 UNITS

DENIAL REASONS FOR PREPAYMENT REVIEW:

1. CONTRACTOR DOES NOT RESPOND TO EMAIL FOR CLAIM DATA OR HAS NOT SENT IN DSHS FORM 17-123 - DENY WITH 0224 EOB.
2. PERFORMING PROVIDER NUMBER ON CLAIM DOESN'T MATCH INTERPRETER FORM CONTRACTOR OR 17-123 FORM - DENY WITH EOB 429.
3. PERFORMING PROVIDER NUMBER NOT A VALID INDIVIDUAL MEDICAID ID NUMBER FOR DATE OF SERVICE ON CLAIM - DENY WITH EOB 080.
4. INTERPRETER SERVICE REQUESTED INAPPROPRIATELY - DENY WITH EOB 757.
5. INSUFFICIENT WRITTEN JUSTIFICATION ON 17-123 FORM OR INPATIENT HOSPITAL - DENY WITH EOB 348.
6. INTERPRETER SERVICE UNITS VERIFIED BY 17-123 FORM AND REDUCED PER TIME - REDUCE UNITS ON LINE WITH SECOND EOB 101 AND FORCE EXE. 094.

TEXT KEY	TEXT DESC
96	MAXIMUM ALLOWED - 10 PER MONTH (NONDURABLE, REUSABLE SUPPLIES)

--EXCEPTION: FOR THE FOLLOWING CODES W/DOS 3/1/01 & AFTER ALLOW 20 PER MONTH.
A5061
A5062
A5063
A5071
A5072
A5073

TEXT KEY TEXT DESC

98 THIRD RX WITHIN A CALENDAR MONTH MUST HAVE MEDICAL CONSULTANT APPROVAL OR APPROVAL FOR 3RD RX IS INDICATED IN THE NOTES AREA OF A PRIOR AUTH NUMBER.

SAME PROVIDER, SAME NDC (FIRST NINE DIGITS).

NOTES: CLAIMS IN HISTORY WITH APPROVAL - DO NOT APPLY THIS EDIT.

---FORCE---
IMITREX - PF4 UNDER THE NDC
MEDICAL SUPPLIES - THERAPEUTIC CLASSES START WITH '8'

ALL ELSE DENY.

TEXT KEY TEXT DESC
99 J CLAIMS

PARAMETER (1001)
99078 (DIABETES/ASTHMA GRP CONSEL) IS INCLUDED IN THE E&M ON SAME DAY FOR RELATED DIAGNOSIS - DENY. DIAGNOSIS IS UNRELATED - FORCE.

PARAMETER (1003 & 1004) OLD 738/050 AUDITS
TRIMESTER CARE (5951M,5952M), ANTEPARTUM CARE (59425,59426) OR POST PARTUM CARE (59430) IS INCLUDED IN TOTAL OB CARE (59400) OR C-SECTION (59501,59510,59515,59516,59521) OR VAG DELIVERY W/POST PARTUM (59410,59610,59614) OR C-SEC W/POST PARTUM (59622).

(INSTRUCTIONS FOR ADJUDICATING)
-CHECK YOUR OB CODE TO IDENTIFY WHETHER OR NOT IT INCLUDES TRI CARE/ ANTEPARTUM CARE OR POST PARTUM CARE, SO THAT YOU WILL KNOW IF APPLICABLE.
IF NOT APPLICABLE - FORCE.
-IF THE TRI CARE/ANTPARTUM CARE IS FOR NEW PREGNANCY - FORCE.
-OTHERWISE, DENY OR RECOUP & DENY THE TRI CARE/ANTEPARTUM CARE OR POSTPARTUM CARE W/EOB 303.

NOTE: ALWAYS FORCE THE 099 POSTING ON CODES CONTAINING DELIVERIES.

TEXT KEY TEXT DESC
101 EXACT DUPLICATE

IF CLAIM IN HISTORY WAS PAID AT $0.00 OR IS TO BE PAID AT $0.00 - FORCE;

EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) BATCH RANGE (953-957) -
AND IF DETAIL LINE PROCEDURE, MONEY AND UNITS ARE AN
EXACT MATCH - IF CARRIER CODE ON HX CLAIM IS (1111) - FORCE,
OR IF "ADJ-R" IS "E" - FORCE, OTHERWISE - DENY WITH EOB 830.
EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) FOR QRS/PIP AND
CAMERA/REEL # IS (77) - SEE YOUR SUP BEFORE PROCESSING.

CHECK CLAIMS FOR BABY VS. PARENT BEFORE ADJUDICATING.

IF CLAIM IS A REBILLING OR AN EXACT DUPLICATE OF A CLAIM IN HISTORY &:
1. IT WAS PAID AT $0.00 WITH EOB 090 - DENY WITH EOB 309.
2. IF IS A DRG CLAIM SHOWING PAYMENT WITH EOB 090 - DENY W/EOB 309.
3. IF CLAIM WAS PAID AT $0.00 OR PARTIALLY PAID BECAUSE OF INSURANCE
PAYMENT AND HAS AN EOB OF 031 OR 032 - DENY.
4. IF CLAIM WAS PAID AT $0.00 BECAUSE OF PT. PAYMENT - DENY.

EPSDT (L) VS EPSDT (L)
1. THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF THE FOLLOWING DUP
CRITERIA IS EXACTLY THE SAME ON EACH CLAIM -
A. PIC CODE
B. PROVIDER NUMBER
C. DATE OF SERVICE
D. PROCEDURE CODE
E. BILLED AMOUNT

2. IF ABOVE DUP CRITERIA IS MET, DO THE FOLLOWING:
A. CLAIM IS A REBILLING OR EVERY LINE POSTING 101 - DENY.

B. 0252M, 99381-99395 - SCREENING CODES - DENY 910.

C. LAB (80000-89999, 36415, P9007)
1. 82947 GLUCOSE TEST - PAY MULTIPLES.
2. IF BILLED ON SEPARATE CLAIMS, CHECK PDD FILE, IF 1 IN DUP
CHECK, FORCE; OTHERWISE DENY W/EOB 910.
3. DENY MORE THAN 1 PER DAY W/EOB 910.

D. 90476-90749 (IMMUNIZATIONS)-IF EXACT CODES - DENY W/EOB 910.
EXCEPTION: 90724 ALLOW MULTIPLES IF DIFFERENT FLU STRAINS.

E. 9000M (MEDICAL ENCOUNTER) UNTIL DATE OF SERVICE 9/30/03 OR
T1015 (FQHC MED ENCOUNTER) 10/01/03 DATES OF SERVICE & AFTER:
ALLOW ONE PER DAY, DENY ADDITIONAL W/EOB 910. INCLUDING
L(EPSDT) VS J(PHYSICIANS). FORCE THE 553 EXC ON THE E&M WHEN
IT FAILS ONCE THE ENCOUNTER CODE IS DENIED, UNLESS DENYING THE
E&M FOR ANOTHER EXCEPTION.

F. ALL ELSE - FORCE.

MEDICAL VENDOR (P) VS. MEDICAL VENDOR (P)

1. THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF THE FOLLOWING DUP CRITERIA IS EXACTLY THE SAME ON EACH CLAIM -
   A. PIC CODE
   B. PROVIDER NUMBER
   C. DATE OF SERVICE
   D. PROCEDURE CODE
   E. BILLED AMOUNT

IF CLAIM IS A REBILLING OR AN EXACT DUPLICATE OF CLAIM IN HISTORY THAT WAS PAID AT $0.00 WITH EOB 090 - DENY 309.

1. PHYSICAL THERAPY
   A. IF AUTHORIZATION NUMBER PRESENT REVIEW & PAY ACCORDINGLY.
   B. CONSECUTIVE CLAIMS- FORCE PROCEDURES WITH A 1 IN THE DUP CHECK IF IT APPEARS TO BE FOR MULTIPLE SERVICES, OTHERWISE DENY.
   C. ALL ELSE, DENY. NOTE: ANY UNUSUAL SITUATIONS OR QUESTIONS OL 83.

2. REFRACTIONS EXACT DUP - DENY EXCEPT:
   A. IF IT APPEARS TO BE AN ADJUSTMENT - DENY 189 AT CLAIM LEVEL.
   B. IF IT APPEARS TO BE FOR A SECOND PAIR OF GLASSES & CLAIM IS NOT APPROVED - DENY 339.
   C. CONTACT LENSES - ALLOW 2, 1 FOR EACH EYE.

3. CAREMARK SPECIAL AGREEMENT TRIP FOR CLOZARIL (0852J-0858J)(90862)
   A. IF TRIP CHARGE (0854J) - ALLOW UP TO 2; ALL ELSE DENY.
   B. IF 0852J, 0853J, 0855J-0858J OR 90862 - DENY

4. EARMOLDS/HEARING AIDS/REPAIRS-

   A. OVERLOC TO 67.

5. OXYGEN
   A. 5B OR U2 MOD VS RR MOD - FORCE.
   B. 5B OR U2 MOD VS NO MOD OR 1P - FORCE.
   C. 5B MOD VS 5B MOD - DENY.
   D. E0441 - E0444 (DOS PRIOR TO 1/1/00)
      1. SAME OR CONSECUTIVE CLAIM - FORCE
      2. DIFFERENT CLAIM - DENY
   E. E0441 - E0444 (DOS 1/1/00 & AFTER) - DENY.
   F. E0450, E0453, E0460 - VENTILATORS - (DOS 1/1/99 & AFTER)
      (IF 5B MOD BILLED WITH TOS 9 - CHANGE TOS TO R FOR RENTAL.)
      1. 5B OR U2 MOD VS RR MOD - FORCE.
      2. 5B MOD VS 5B MOD - DENY.
   G. E0450, E0453, E0460 - DOS PRIOR TO 1/1/99
      PAY UP TO 2 VENTS PER CLIENT IF BILLED ON THE SAME OR CONSECUTIVE CLAIM. OTHERWISE DENY.
   H. IF NOT ADDRESSED ABOVE AND HX CLAIM IS CONSECUTIVE AND APPEARS TO BE ADDITIONAL SUPPLIES THEN CHECK PDDD FILE FOR A '1' IN THE "DUP CHECK", IF '1' - FORCE.

(CONSECUTIVE CLAIM = CLAIM THAT FALLS IN THE SAME JULIAN DATE AND THE SAME BATCH RANGE.)
I. ALL ELSE - DENY.

6. MEDICAL NUTRITION FORMULAS, SUPPLIES & EQUIPMENT (PT 26 OR 39)
   A. MEDICAL NUTRITION FORMULAS/PARENTERAL SOLUTIONS - SAME CLAIM OR CONSECUTIVE CLAIM - FORCE. DIFFERENT CLAIM - DENY.
   B. PUMPS - SAME OR DIFFERENT CLAIM - IF CLAIM HAS STATEMENT: "NOT A DUP"(OVERCODE 444) OR "2 PUMPS-HOME & SCHOOL" - FORCE. OTHERWISE - DENY.
   C. ALL ELSE - DENY.

7. NONDURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES (PT 26 OR 39)
   (NOTE: SEE "I" FOR DME - DURABLE MEDICAL EQUIPMENT)
   A. AUTH # PRESENT - PAY ACCORDING TO AUTH FILE.
   B. FORCE THE FOLLOWING IF ON SAME OR CONSECUTIVE CLAIM
      1. DRESSING, TAPES, GAUZE, BANDAGES, GLOVES
      2. WOUND FILLERS, SKIN BARRIERS, LUBRICANT
      3. SALINE OR WATER
      4. FITTING FEE FOR VASCULAR SUPPORT
      5. OSTOMY FILTERS
      6. BRACES - RT VS LT
      7. HEEL OR ELBOW PROTECTOR
      8. CONDUCTIVE PASTE OR GEL
      9. TENS (TRANSUTANEOUS NERVE STIMULATOR SUPPLIES) SUPPLIES & EQUIPMENT
      10. METERED DOSE INHALER
      11. MISC CODES
   C. ALL ELSE DENY

8. INFUSION THERAPY (PT 40)
   A. PUMPS - SAME OR DIFFERENT CLAIM - IF CLAIM HAS STATEMENT: "NOT A DUP" (OVERCODE 444) OR "2 PUMPS-HOME & SCHOOL" - FORCE. OTHERWISE - DENY.
   B. TAPE, GAUZE, DRESSINGS, NEEDLES, GLOVES - SAME CLAIM OR CONSECUTIVE CLAIM - FORCE.
   C. CAPS, ADAPTER SETS, PINS, HEPARIN LOCK, CATHS - SAME CLAIM OR CONSECUTIVE CLAIM - FORCE.
   D. ALL ELSE - DENY.

9. DME (DURABLE MEDICAL EQUIPMENT) PT 26 OR 39
   (I.E. WHEELCHAIRS, BEDS, WALKERS, BATHROOM EQUIP, COMMODES, BLOOD GLUCOSE MONITORS, ALL EQUIPMENT ACCESSORIES, MODIFICATIONS AND REPAIRS)
   A. IF PRIOR AUTH # PRESENT - PAY ACCORDING TO AUTH FILE.
   B. IF EXPEDITED AUTH # (BEGINNING W/'87') & CLAIM IN HX PAID - DENY.
   C. MONTHLY RENTAL CODES WITH FIRST OR LAST DATES OF SERVICE OVERLAPPING - FORCE.
   D. SAME OR CONSECUTIVE CLAIMS - FORCE:
      1. GRAB BARS OR RAILS FOR BATH OR TOILET
      2. BED PANS AND URINALS
      3. POSITIONING BELT FOR SHOWER OR COMMODE CHAIR
   E. ALL ELSE-DENY

10. NURSE DELEGATION (8900N-8903N)
    A. SAME/CONSECUTIVE CLAIMS OR IN SAME BATCH - FORCE.
    B. IF CLAIM IS A CARBON - DENY W/EOB 042

11. ADULT DAY HEALTH - ALLOW ONLY ONE CALL (0803H-0821H) PER DAY - IF MORE ARE BILLED DENY WITH EOB 339. ALLOW ONE 0801H OR 0802H WITH THE OTHER CODES (0803H-0821H).

12. GROUND AMBULANCE (PT 51)
    BRING UP HX CLAIM IN 4 SCREEN IF NECESSARY. USE MODIFIERS TO IDENTIFY SEPARATE TRIPS. SEE TRAINER IF QUESTIONS.

*** CLAIMS WITH DATES OF SERVICE THROUGH 9/30/03 ADJUDICATE AS FOLLOWS:
    A. 0001A, 0002A, 0007A - DENY
    B. 0003A, 0004A, 0008A, 0015A, 0016A
       1. IF DIFFERENT MODS - FORCE.
       2. SAME MODS AND 4TH TRIP INDICATED-FORCE
       3. SAME MODS AND NO INDICATION OF ADDITIONAL TRIP-DENY
*** CLAIMS WITH DATES OF SERVICE 10/01/03 AND AFTER ADJUDICATE AS FOLLOWS:
12. A. A0426, A0427, A0433 OR A0434
    B. A0425, A0428 OR A0439
       1. DIFFERENT MODS - FORCE
       2. SAME MODS BUT INDICATION OF NEW TRIP - FORCE
       3. SAME MODS AND NO INDICATION OF NEW TRIP - DENY
*** CLAIMS WITH DATES OF SERVICE THROUGH 9/30/03 ADJUDICATE AS FOLLOWS:
    C. 0044A (ALLOW ONLY 1 PER TRIP - DENY ALL OTHERS)
       1. DIFFERENT TRIP - FORCE
       2. SAME TRIP - DENY.
*** CLAIMS WITH DATES OF SERVICE 10/1/03 AND AFTER ADJUDICATE AS FOLLOWS:
    D. A0394 (ALLOW ONLY 1 PER TRIP - DENY ALL OTHERS)
       1. DIFFERENT TRIP OR DIFFERENT MODS - FORCE
       2. SAME TRIP OR SAME MODS - DENY
    E. 0036A
       1. DIFFERENT TRIP - FORCE
       2. SAME TRIP - DENY.
***   FOR CLAIMS WITH DATES OF SERVICE THROUGH 9/30/03 ADJUDICATE AS FOLLOWS:
    F. 0010A
       1. DIFFERENT TRIP - FORCE
       2. SAME TRIP - DENY. EXCEPTION: IF TRIP EXCEEDS 50 MILES (IE SPOKANE TO SEATTLE) - FORCE.
***   FOR CLAIMS WITH DATES OF SERVICE 10/01/03 AND AFTER ADJUDICATE AS FOLLOWS:
    G. A0422
       1. DIFFERENT TRIP - FORCE
       2. SAME TRIP - DENY. EXCEPTION: IF TRIP EXCEEDS 50 MILES (IE SPOKANE TO SEATTLE) - FORCE.

    H. ANY QUESTIONS SEE TRAINER/SUPERVISOR.

13. AIR AMBULANCE (PT 53)
    A. PAY 2 LIFT OFFS AND 2 MILEAGES IF THERE IS A STATEMENT ON THE CLAIM FOR 2 TRIPS.
    B. PAY A LIFT OFF FEE FOR EACH CLIENT WHEN TWO OR MORE CLIENTS ARE TRANSPORTED ON A SINGLE AIR AMBULANCE TRIP. THE MILEAGE MUST BE DIVIDED EQUALLY BY THE NUMBER OF CLIENTS TRANSPORTED. FORCE IF MULTIPLE CLIENTS. ASSUME MILEAGE HAS BEEN DIVIDED, UNLESS "TOTAL" MILEAGE IS INDICATED ON CLAIM OR BACKUP AND CONFLICTS WITH "DIVIDED" MILEAGE - IF THAT IS THE CASE, PAY BOTH "LIFT-OFFS" AND DENY ONE MILEAGE W/EOB 339/158.
    C. ALL ELSE - DENY.

14. PROSTHETIC & ORTHOTIC - (PT 38, 39)
    A. IF AUTH # PRESENT - PAY ACCORDING TO AUTH FILE.
    B. RT VS LT - FORCE.
    C. ALL ELSE - O'LOC TO 83.

15. ALL ELSE - DENY

MEDICARE X-OVER(O)TOS 9 OR R VS MED VENDOR (P)

1. RESEARCH 'P' CLAIM AND IF PAID AT $0.00 - FORCE 'O' CLAIM.
2. IF SERVICE(S) ARE PAID IN HX AND SUSPENDING CLAIM SHOWS MEDICARE PAYING ON THE SAME SERVICE(S) - FORCE SUSPENDING 'O' CLAIM & RECOUP & DENY HX 'P' CLAIM AS DUPLICATE W/EOB 960.

MEDICARE X-OVER (O) TOS 9 OR R VS. MEDICARE X-OVER (O) TOS 9 OR R

1. HARDCOPY VS TAPE - DENY (WHETHER OR NOT MODIFIERS MATCH).
   IF ENTIRE CLIAM IS A REBILL - DENY W/EOB 960.
   (SOMETIMES PROVIDER REBILLS ENTIRE CLAIM BUT MAY USE A DIFFERENT MEDICARE CODE OR A STATE UNIQUE CODE FOR THE SAME SERVICE PREVIOUSLY PAID ON A MEDICARE TAPE. RESEARCH HX CLAIM IN 04 SCREEN TO DETERMINE WHETHER ENTIRE CLAIM IS A REBILL).

2. TAPE VS TAPE - FORCE EXCEPT IF CLAIM APPEARS TO HAVE BEEN ADJUSTED AND REPAID BY MEDICARE - RESEARCH. IF SERVICE DATES, BILLED AMOUNT AND UNITS ARE THE SAME RECOUP AND DENY ORIGINAL CLAIM W/EOB 960. FORCE LIVE CLAIM.

3. HARDCOPY VS HARDCOPY
   A. "J" CODES OR E0590 - DENY REGARDLESS OF MODIFIERS
   B. "RT" VS "LT" MODS - FORCE
   C. "1P" VS NO MOD - DENY
   D. "NU" VS ANY OTHER MOD - DENY
   E. "KS" VS NO MOD - DENY
   F. "X1 - X9" VS NO MOD - DENY
   G. "ZX" VS NO MOD - DENY
   H. IF SAME OR CONSECUTIVE CLAIM & '1' IN DUP CHECK - FORCE
   I. "RR" VS "RR" AND PROCEDURE CODE IS E0450- FORCE
   J. IF ENTIRE CLAIM APPEARS TO BE A REBILL - DENY
   K. P.T. 51- DIFFERENT MODS - FORCE
   L. ALL ELSE - OL TO 83.

DENTAL (K) VS DENTAL (K)

1. THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF THE FOLLOWING DUP CRITERIA IS THE SAME ON EACH CLAIM:
   A. PIC CODE
   B. PROVIDER #
   C. DATE OF SERVICE
   D. PROCEDURE CODE
   E. TOOTH #
   F. TOOTH SURFACE
   G. BILLED AMOUNT

2. IF ABOVE DUP CRITERIA IS MET - DENY UNLESS ANY OF THE FOLLOWING:
   A. 00230/D0230 - ALLOW UP TO 13 ON THE SAME DAY.
   B. 00240/D0240 - ALLOW UP TO 4 ON THE SAME DAY.
   C. 00270/D0270 OR 00272/D0272 - DENY WITH EOBS 041 AND 302.
   D. 00501/D0501 - IF PROVIDER INDICATES NOT A DUP - FORCE.
   E. 0200D (FQHC ENCOUNTER CODE) -

NOTE: GLOBAL ISSUES - DENTURES, CROWNS, ROOT CANALS AND SURGERIES, ANY QUESTIONS SEE SUPV/TRAINER/MMIS.
1. 101 IS FAILING ON BOTH THE PROCEDURE AND THE ENCOUNTER - IF DENYING THE PROCEDURE ALSO DENY THE ENCOUNTER CODE.
2. 101 IS FAILING ONLY ON THE ENCOUNTER - CHECK HISTORY. IF GLOBAL PROCEDURE WAS DIFFERENT - FORCE THE ENCOUNTER.

NOTE: DENTISTS (PT 27) WILL BILL THE DENTAL ENCOUNTER W/PROC CODE T1015 AS OF 10/01/03 FORWARD. THIS CODE IS LIMITED TO ONE ENCOUNTER PER DAY. MULTIPLE UNITS ARE ALLOWED (ON SAME CLAIM ONLY) WHEN BILLED IN COMBO W/ GLOBAL DENTAL PROCEDURE CODES. OTHERWISE, DENY ADDITIONALS W/EOB 910.

   F. 02110-02161, 02330-02335, 02380-02387, D2110-D2161, D2330-D2335, D2380-D2387 AMALGAM/COMPOSITE/RESIN RESTORATIONS:
      1. IF O (OCCLUSAL) & I (INCISAL) SURFACES ON SAME TOOTH- DENY.
      2. IF B (BUCCAL) & F (FACIAL) SURFACES ON SAME TOOTH - DENY.
      3. OTHER COMBINATIONS - FORCE.
   G. 03426/D3426 OR 03430/D3430 - IF TEETH 1-5, 12-16, 17-21, 28-32 - FORCE.
   H. 03950/D3950
      1. DOS PRIOR TO 11-1-02 - ALLOW UP TO 3 DOWEL POSTS PER TOOTH
      2. DOS 11-1-02 OR AFTER - DENY.
   I. 05850 (TISSUE CONDITIONING MAXILLARY) DOS 4-1-99 OR AFTER DENY THE 2ND WITH EOB 302. (05851 SHOULD BE USED FOR LOWER)
   J. 06010/D6010 ALLOW UP TO 6 TIMES.
   K. 07110-07286, D7110-D7286 - STAGE, IF SUPERNUMARY TOOTH- FORCE.
   L. D9110 - PALLIATIVE TREATMENT
      1. DOS PRIOR TO 11-1-02 - ALLOW 2 TEETH PER QUADRANT - DENY EXTRAS WITH EOB 339.
      2. DOS 11-1-02 AND AFTER - DENY
   M. 09220/D9220 - FORCE IF ON SAME CLAIM.
   N. 09610/D9610 - FORCE IF ON SAME CLAIM.
   O. 09630/D9630 - ALLOW MULTIPLES IF DIFFERENT MEDICATION.
   P. 4482D-4489D, 4501D-4506D ENHANCED DENTAL PROJECT ADD-ONS

1. IF O (OCCLUSAL) & I (INCISAL) SURFACES ON SAME TOOTH- DENY.
2. IF B (BUCCAL) & F (FACIAL) SURFACES ON SAME TOOTH - DENY.
3. OTHER COMBINATIONS - FORCE.

Q. CPT SURGERY PROCEDURE CODES (11100-64600) ON SAME OR CONSECUTIVE CLAIM - IF PROCEDURE CAN BE DONE MORE THAN ONCE - FORCE 101 AND APPLY EXCEPTION 040 POLICY. EXCEPTION: THE FOLLOWING PROCEDURES HAVE A LIMIT ON THE NUMBER THAT CAN BE DONE - DENY ANY OVER THIS LIMIT WITH EOB 339:
1. 11100 - ALLOW 1
2. 20605, 29800, 29804, - ALLOW 2 OF EACH CODE.
3. 41828 - ALLOW UP TO 4.
4. 41874 - ALLOW 1 PER QUADRANT.

OUTPATIENT (M) VS OUTPATIENT (M)

1. HOSPICE PROVIDER (TYPE 63) (# BEGINS WITH 399....) - DENY
2. SAME DIAG - DIFFERENT HOURS - FORCE
3. DIFFERENT DIAGNOSIS - VERIFY HOUR OF CARE. DIFFERENT HOURS - FORCE SAME HOUR OR UNABLE TO DETERMINE HOUR OF CARE - DENY.
4. EXACT DUPLICATE - DENY.
5. KIDNEY DIALYSIS (820-889) - IF SERVICES ON ONE CLAIM ARE FOR DIALYSIS AND OTHER CLAIM IS FOR FICA TAXES - FORCE. IF SERVICES ARE DIFFERENT REVENUE CODES - FORCE.
6. HOME HEALTH (PT 44) - (NOTE) SEE DATE SPAN SPECIAL KEYING INSTRUCTIONS IN 991 TEXT BEFORE WORKING THIS EXCEPTION.
   A. AUTH # PRESENT - SEE AUTH SCREEN.
   B. IF 444 OVERCODE PRESENT- FORCE.
   C. IF EXACT DUP OF AN ENTIRE PAID CLAIM - DENY.
   D. IF MONEY DOES NOT MATCH PAID CLAIM - DENY W/189.
   E. 421, 431, 441, 558, 571, & 590 - DENY MULTIPLE SERVICES ON THE SAME DAY W/EOB 910.
   F. 551, 580 - PAY UP TO 2 VISITS PER DAY IN ANY COMBINATION (PAY 1 551 AND 1 580/DAY, OR 2 551/DAY, OR 2 580 DAY).

DRG (R) VS DRG (R) - EXACT DUPLICATE - DENY.

DRG (R) VS. INPATIENT (S) - SAME DOS, PROVIDER AND TOTAL SUBMITTED CHARGE - DENY.

INPATIENT (S) VS. INPATIENT (S) - EXACT DUPLICATE - DENY.

NURSING HOMES (T) VS. NURSING HOMES (T) - EXACT DUPLICATE - DENY.

MEDICARE X-OVERS (V), (W), (X) - EXACT DUPLICATE - DENY.

NOTE: SEE PAGE 1 BEFORE EXAMINING AS A DUPE.

PHYSICIAN X-OVER (O) VS. PHYSICIAN X-OVER (O)

NOTE: IF ON SAME/CONSECUTIVE CLAIMS OR IN SAME BATCH AND APPEARS TO BE A MULTIPLE SERVICE AND MEDICARE HAS PAID ON BOTH - FORCE.
NOTE: PHYSICIAN SERVICES - APPLY PHYSICIAN PORTION OF THIS TEXT
ALL ELSE - SEE (PHYSICIANS OR MED VENDOR SECTION)
NOTE: SEE PAGE 1 BEFORE EXAMINING AS A DUPE.

NOTE: MODIFIER LT/RT OR E1/E3 OR E2/E4 PRICING (PHYSICIAN SERVICES)
ANY MEDIAS
1. PF-4 UNDER PROCEDURE CODE ON SECOND LINE.
2. IF NOT A PROCEDURE WE ALLOW BILATERAL ON (N IN BILAT-FIELD)-
   A. IF CODE PER PDDD DESCRIPTION & ANATOMY DOES NOT ALLOW MULTIPLES - SEE TRAINER.
   B. ALL ELSE - FORCE 101.
3. IF PER PDDD DESCRIPTION BI-100% - PAY ONE FOR EACH SIDE.
4. IF A PROCEDURE WE ALLOW BILATERAL ON (Y IN BILAT-FIELD)
   A. LOOK AT MAX ALLOWED FOR DOS.
   B. MULTIPLY MAX ALLOWED X 50% = NEW MAX ALLOWED AT 50%.
   C. COMPARE OUR NEW MAX ALLOWED TO MDCRS.
      1. IF OURS IS LESS - DENY DUPE W/EOB 030.
      2. IF OURS IS MORE:
         A. SUBTRACT MDCRS PAYMENT FROM NEW MAX ALLOWED & MANUAL PRICE LINE W/PAYMENT DUE, FORCE 101 AND 430.
         B. IF MDCR PD MORE THAN WE ALLOW - DENY 101 W/EOB 030.

HARD COPY VS TAPE - DENY (EXCEPT)

1. NO MOD VS MOD 80,81,82 OR VICE VERSA - FORCE.
2. PT 20 VS PT 48,49, 7 ANES MOD OR VICE VERSA - FORCE.
3. ANESTHESIA VS ANESTHESIA 7 DIFFERENT MODS - SEE 087 TEXT.
4. STAGE AND ROUTE TO MMIS/5564/SANDY (PHYSICIAN) /DEBBIE (MED VEND)
   IF AT LEAST ONE OF THE FOLLOWING IS TRUE:
   A. THERE IS MORE THAN 1 YEAR FROM DOS TO MCARE PAID DATE
   B. 125 (PAY STATUS) IS POSTING ON CLAIM AND PROCEDURE CODES HAS MCARE EOMB CO-B4 FOR THAT LINE(S).
   C. MCARE PD ON DETAIL LINE IS DIFFERENT THAN MCARE PD AT HEADER (USUALLY MORE)

TAPE VS. TAPE OR HARD COPY VS. HARD COPY - DENY. (EXCEPT)

1. SAME OR CONSECUTIVE CLAIM AND MEDICARE PAID - FORCE. EXCEPT:
   IF TAPE VS TAPE - SEE SUP TO SEE IF PAYMENT SHOULD BE MADE.
2. NO MOD VS MOD 80/81/82 OR VICE VERSA - FORCE.
3. ANESTHESIA VS ANESTHESIA 7 DIFFERENT MODS - SEE 087 TEXT.
4. SURGERIES 10000 - 69999, IF PER PDDD DESCRIPTION & BY ANATOMY WE WOULD NOT PAY MULTI - SEE TRAINER.

PHYSICIAN (J) VS PHYSICIAN (J)

NOTE: SEE PAGE 1 BEFORE EXAMINING ANY DUP CLAIM.

THE FOLLOWING IS A LIST OF DEFINITIONS, EXPLANATIONS AND PROCEDURE FOR USE IN THE FOLLOWING TEXT.

REBILL: A CLAIM OR SERVICE THAT HAS BEEN PAID AND BILLED AGAIN IN ERROR, BILLED AGAIN BEFORE PAYMENT WAS MADE ON THE ORIGINAL BILLING, OR WAS PAID AND THE PROVIDER IS TRYING TO CHANGE SOMETHING.

CARBON: A CLAIM THAT IS IDENTICAL TO THE ORIGINAL AND IS USUALLY THE FOLLOWING CLAIM. THIS IS AN ERROR ON THE PROVIDERS PART AND SHOULD

NOT BE CONFUSED WITH PROVIDER ATTEMPTING TO BILL FOR MULTIPLE SERVICES. (SOMETIMES YOU CANNOT CLARIFY).

INTERMEDIARY PROBLEM: (EMC) CLAIMS THAT WERE SUBMITTED IN ERROR IN SAME JULIIAN DAY (USUALLY CLAIM FOR CLAIM IN SEPARATE BATCHES OR POSSIBLY DIFFERENT DAYS). THIS IS USUALLY CAUGHT IN RESOLUTIONS SORT, BUT BEWARE OF ANY CONSISTENCY OF REPETETIVE CLAIMS.

DUP CHECK (1): IF (1) IN THE (DUP CHK) FIELD ON THE PDDD FILE IT OVERIDES THE 101 AND ALLOWS MULTIPLE SERVICES ON SAME CLAIM. IF NO DUP CHK (1) ON THE PDDD - DO NOT ALLOW MULTIPLE SERVICES UNLESS TEXT INDICATES TO DO SO.

PAYMENT PROCEDURE: MULTIPLE SERVICES ARE BOTH SUSPENDING - ALLOW THE HIGHER OF THE TWO, OTHERWISE - DENY CURRENT W/EOB 910.

ADDITIONAL SERVICES IDENTIFICATION:
(NOTE) THE FOLLOWING INFORMATION MAY BE USED ON A REBILL - SEE YOUR TRAINER

1. CLAIM STATES "NOT A DUPE" OR HAS AN OVERCODE OF (444) (DUPE CHECK 1 ON PDDD - FORCE).
2. SEPARATE CLAIMS - 2 SERVICES ON HX CLAIM, 1 PAID, 1 DENIED AND 1 IS BEING REBILLED AND SHOULD BE PAID.
3. DUP CHK IS (1) ON PDDD, MONIES/UNITS ARE DIFFERENT

MULTIPLE SERVICES: SERVICES THAT WERE PERFORMED MORE THAN ONCE AND THE PROVIDER HAS BILLED MULTIPLE LINES OR MULTIPLE CLAIMS.

1. (HARDCOPY) - CONSIDER MULTIPLE SERVICE ATTEMPT IF IN SAME BATCH AND CLAIM IS NOT A MIRROR IMAGE.
2. (ELECTRONIC) - CONSIDER MULTIPLE SERVICE ATTEMPT IF ANY CLAIM IN THE SAME JULIAN DATE AND
   A. CLAIM IS CONSECUTIVE
   B. CLAIM IS NOT A MIRROR IMAGE
   NOTE: IF UNABLE TO DETERMINE MULTIPLE/ADDITIONAL SERVICES OR A REBILL - DENY W/EOB 102.

THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF FOLLOWING DUP CRITERIA IS THE SAME:

1. PIC CODE
2. PROVIDER NUMBER
3. PERFORMING PROVIDER NUMBER
4. DATE OF SERVICE
5. PROCEDURE CODE - 5 DIGIT MATCH ON ALL CODES EXCEPT (92002 - 92014, 90800 - 90899) ARE A 2- DIGIT MATCH ONLY.
6. PROCEDURE CODE MODIFIER
7. BILLED AMOUNT.

IF ABOVE CRITERIA IS MET A 101 WILL POST TO THE CLAIM. IT MAY POST AGAINST SAME CLAIM OR ANOTHER CLAIM.

1. IF CLAIM IS A REBILL - DENY. SEE FOLLOWING EXCEPTIONS:

A. FQHC ENCOUNTER CODES:

1. 9001M AND 5900M:
NOTE: GLOBAL PROCEDURES - DELIVERY AND PRENATAL CARE ONLY (59400,59410,59610-59614,59618,59622,5951M-5952M, 5953M-5955M)
   A. 101 IS FAILING ON BOTH THE PROCEDURE & THE ENCOUNTER DENY.
   B. 101 FAILING ONLY ON THE ENCOUNTER:
      1. IF A DIFFERENT GLOBAL PROCEDURE CODE - FORCE.
      2. ALL ELSE - DENY W/EOB 910.

2. 9006M - CLAIM LOOKS LIKE A REBILL AND:
   A. 101 IS FAILING ON BOTH THE PROCEDURE & THE ENCOUNTER - IF DENYING THE PROCEDURE ALSO DENY THE ENCOUNTER CODE.
   B. 101 IS FAILING ONLY ON THE ENCOUNTER - CHECK HISTORY, IF PROCEDURE WAS DIFFERENT - FORCE THE ENCOUNTER.

B. RADIOLOGY BILLED W/DX V59.0-V59.9, CLAIM OR COMMENTS INDICATE DONOR OR NOT A DUPE - FORCE EVEN IF IT APPEARS TO BE A REBILL.

C. LAB BILLED W/DX OF V59.0-V59.9, CLAIM OR COMMENTS INDICATES DONOR OR NOT A DUPE - FORCE MULTIPLES EVEN IF IT APPEARS TO BE A REBILL.

D. PROV TYPE 73 - IF PROVIDER STATES "NOT A DUPE, DIFFERENT STAFF, DIFFERENT TIMES",NAME OF PERFORMING PROVIDER IS DIFFERENT, OR IF CLAIM OR ADJUSTMENT STATES "SERVICE IS IN ADDITION TO PREVIOUSLY BILLED SERVICES" - FORCE.

E. INTERPRETER SERVICES- AMERICAN SIGN LANGUAGE ONLY (ASL)- PT 40 WITH SPEC 60 OR 63.

PRIOR TO 100103 - FOR 0997M OR 0998M AND DATES 100103 AND AFTER T1013 OR S0215 - IF DIFFERENT REFERRING NUMBER, DIFFERENT DOCTOR'S LISTED, COMMENTS ANYWHERE ON CLAIM STATING "NOT A DUPLICATE" OR SIMILAR STATEMENT, COMMENT ON CLAIM STATING "SECOND APPOINTMENT" AND/OR "TEAM INTERPRETING FOR ASL", OR CLAIM HAS 444 OVERCODE - FORCE. BJS

F. BEFORE DENYING A CLAIM AS A REBILL, REVIEW THE MULTIPLE SERVICE SECTION. IN SOME INSTANCES, WHAT LOOKS LIKE A REBILL MAY BE, AN ATTEMPT AT MULTIPLE SERVICES AND MAY BE FORCEABLE IF CERTAIN CRITERIA IS MET. (IE) DIFFERENT TIMES, DIFFERENT ANTIGENS OR UNRELATED DX, ETC,ETC

2. IF CLAIM IS A CARBON - DENY.
3. IF CLAIM IS AN INTERMEDIARY PROBLEM (EMC) CONTACT CLAIMS CONTROL, THROUGH YOUR SUPERVISOR.
4. IF CLAIM IS FOR MULTIPLE SERVICES - SEE FOLLOWING GUIDELINES. IF NOT OTHERWISE SPECIFIED, REMEMBER TO APPLY DUP CHK (1) CRITERIA OTHERWISE DENY ADDITIONALS W/EOB 910.

NOTE: X-OVER CLAIMS - YOU MAY NEED TO REVIEW THE EOMB TO SEE HOW MDCR PAID/DENIED BEFORE YOU MAKE YOUR DECISION FROM THE FOLLOWING TEXT.

A. RADIOLOGY - (70002-79999, 7612M-7614M, R0070, R0075)
(NOTE) IF OVERCODE 222 IS USED ON THE LINE - SEE MOD 76.
(NOTE) WHEN DENYING RADIOLOGY BECAUSE MULITPLE SERVICES ARE NOT ALLOWED, TIMES NOT INDICATED, OR LT/RT ARE NOT INDICATED ON THE CLAIM - USE EOB 111, EXCEPT MRI/MRA OR VASCULAR GRAPHIES/GRAMS - SEE BELOW.

1. MODIFIER 76 - DO NOT DENY MULTIPLE SERVICES AS A DUPE - FORCE, UNLESS OTHERWISE ADDRESSED IN TEXT, EXCEPT MRI/MRA, CT, VASCULAR GRAPHIES/GRAMS, OR 72295.
2. CAT SCANS -
   A. DIFFERENT TIMES - FORCE.
   B. LT VS RT MOD - FORCE.
   C. 76375 W/MOD 76 - FORCE.
   D. ALL ELSE - DENY W/EOB 111.
3. MRI -
   A. DIFFERENT TIME SESSIONS - FORCE.
   B. LT VS RT MOD FOR LIMBS - FORCE.
   C. LIMBS INDICATED & NO LT/RT - DENY W/EOB 111.
4. PROCEDURE 78990 (PROVISION OF DIAGNOSTIC RADIOPHARMACE-UTICAL) DONE FOR DIFFERENT TESTS - FORCE.
5. MEGAVOLTAGE (77401-77416 & 77419-77430):
   A. (77401 - 77416) DAILY TREATMENT DELIVERY - MULTIPLE TREATMENTS ARE PAYABLE ON THE SAME DAY IF CLAIM/ /BACKUP/COMMENTS INDICATE A DISTINCT BREAK OF AT LEAST 6 HRS, OTHERWISE DENY ADDITIONALS W/EOB 910.
   B. (77419 - 77430) WEEKLY THERAPY MANAGEMENT - EACH CODE IS EQUAL TO 2 OR MORE TREATMENT SESSIONS & SHOULD BE COMPLETED IN 1 WK. MULTI SESSIONS IN 1 DAY MAY BE COUNTED IN THE TOTAL SESSIONS FOR THAT WEEK, BUT CAN ONLY BE BILLED ONCE PER WK. DENY ADDITIONALS W/EOB'S 910/339.

ANY QUESTIONS ON MEGAVOLTAGE - SEE SANDY/MMIS.

6. LOCALIZATION OF BREAST NODULE (76096) - ALLOW 2 (1 FOR EACH BREAST), DENY ADDITIONALS W/EOB 339.
7. ULTRASOUND ECHOGRAPHY/ULTRASONIC GUIDANCE
   A. YEAR 2003 FOR 76801-76828:
      1. 76801, 76805, 76811, 76825, 76827 - ALL 1 AND DENY ALL OTHERS W/EOB 302 TO BILL "FOLLOW UP OR REPEAT STUDY" CODE.
      2. 76802, 76810, 76812, 76826, 76828 - ALLOW 1 PER EACH ADDTL FETUS (TWINS, TRIPLETTS, ETC) - DENY ALL OTHERS W/EOB 111.
      3. 76815, 76816, 76817, 76818, 76819 - ALLOW 1 PER EACH FETUS AND DENY ALL OTHERS W/EOB 111.
   B. YEAR 2001-2002 FOR 76805-76828:
      1. 76805 BILLED MULTIPLES WITH DX/COMMENT OF TWIN, TRIPLETT, ETC - DENY ALL W/EOB 302 TO BILL 76810 FOR MULTIPLE GESTATION UNDER ONE CODE.
      2. 76805 BILLED MULTIPLES SINGLE FETUS - PAY 1 AND DENY ALL OTHERS W/EOB 302 TO BILL "FOLLOW UP OR REPEAT STUDY" CODE.

3. 76810, 76815, 76818, 76819, 76825, 76827 - PAY 1 AND DENY ALL OTHERS W/EOB 302 TO BILL FOR "FOLLOW UP OR REPEAT STUDY" CODE.
4. 76816, 76826, 76828 - PAY 1 FOR EACH ADDTL FETUS (TWINS, TRIPLETTS, ETC) AND DENY ALL OTHERS W/EOB 111.

8. RADIOLOGY BILLED W/DX (V59.0-V59.9) - CLAIM OR COMMENTS INDICATE DONOR OR NOT A DUPE- FORCE.
9. RT/LT MODS & MULTIPLE BODY PARTS - ALLOW 1 EACH. NOTE: 2 BILATERAL PROCEDURES (BY PDD/CPT DESCRIPTION) DO NOT FALL INTO THIS CATEGORY - DENY W/EOB 324.
10. COMPARISON STUDIES - ALLOW 1 UNLESS TIME OR JUSTIFICATION IS STATED FOR ADDITIONALS, IE. (1 IN MORN & 1 IN AFTER-NOON, X-RAY BEFORE REPAIR & X-RAY AFTER REPAIR)
11. ANY RADIOLOGY PROCEDURE WITH UNILATERAL DESCRIPTION AND CPT LISTS A BILATERAL CODE: IF BILLED ON MULTIPLE LINES, DENY ALL LINES WITH EOB 302.
12. VASCULAR GRAPHIES & GRAMS ONLY (75600-75774,75790-75898)
    A. DESCRIPTION IS UNILATERAL & NO BILATERAL CODE AVAILABLE PER PDDD/CPT - ALLOW 2 & DENY ALL OTHERS W/EOB'S 800/373.
    B. DESCRIPTION IS UNILATERAL & BILATERAL CODE AVAILABLE-PER PDDD/CPT - DENY ALL OF SAME CODE W/EOB 302.
    C. DESCRIPTION IS BILATERAL & ALL ELSE - ALLOW 1 & DENY ALL OTHERS W/EOB'S 800/373.
    D. ANY SITUATIONS OTHER THAN THE ABOVE - SEE TRAINER.
13. 72295 - DENY W/EOB 910.

B. LAB (80000-89999,8000M,8001M,8720M,0065M,36415,36416 OR 36450)
1. IF POS 1 - FORCE.
2. DRAWING/HANDLING FEES:
   A. DRAWING FEE IS BILLED IN CONJUNCTION W/(82951 OR 82952) - FORCE.
   B. CLAIM INDICATES RUNNING MULTIPLE GLUCOSE TESTS OR DX IS FOR DIABETES, IE(DX IS 250) - FORCE.
3. LAB BILLED W/DX OF V59.0-V59.9, CLAIM OR COMMENTS INDI-CATES DONOR OR NOT A DUPE - FORCE.
4. SAME TEST AND DIFFERENT TIMES INDICATED - FORCE.
5. 83018 - CLAIM INDICATES TEST RUN ON DIFFERENT SPECIMENS, IE BLOOD, HAIR, URINE, SERUM - FORCE.
6. STAT CHARGES (8949M/S3600) ALLOW ONLY 1 PER DAY, DENY ALL OTHERS W/EOB 339.
7. IF MOD QR/91 OR O'CODE 221 - FORCE.
8. MOD 76 OR O'CODE 222 - DOES NOT APPLY TO LAB PROCEDURES.
9. 87328 - DOS IS PRIOR TO 1/1/04 - PAY UP TO 2. DOS IS 1/1/04 & AFTER - PAY 1 & DENY ALL ELSE.

C. MISCELLANEOUS:
ALLOW SPECIFIC LIMITS FOR THE FOLLOWING PROCEDURES.
1. SPEECH THERAPY (92507 OR 92508) ALLOW 1 PER DAY.
2. ELECTROCARDIOGRAPHY (9301M-9303M) - FORCE.
3 SLEEP STUDIES (95819-95830 & POS IS 1 - FORCE
4. EYE SERVICES:

A. 92225 - SEE 061 AUDIT.
B. DUP CHECK ON PDDD FILE - FORCE.
C. "Y" IN B-SURG FIELD OR DESCRIPTION OF BI-100% - ALL UP TO 2 - DENY ALL OTHERS W/EOB 339.
D. ALL ELSE:
1. DESCRIPTION OF UNILATERAL - DENY W/EOB 111.
2. ALL ELSE - ALLOW 1, DENY ADDITIONAL W/EOB 324.

5. AUDIOMETRIC TESTS (92551-92599) - ALLOW 1, DENY ADDITIONAL TESTS W/EOB 324.
6. CRITICAL CARE (99291/99292) & PROLONGED SERVICES (99355/99357)
A. CRITICAL CARE:
99291 - PAY ONE, DENY ADDITIONALS W/EOB 302.
99292 - PAY UP TO 4, DENY ADDITIONALS W/EOB 339.
B. PROLONGED SERVICES:
99354/99356 - PAY 1, DENY ADDITIONALS W/EOB 302
99355/99357 - PAY UP TO 4, DENY ADDITIONALS W/EOB 339.
7. IMPRESSION CASTING (1602L) - ALLOW 2, 1 FOR EACH FOOT, DENY ADDITIONALS W/EOB 339. IF 2 1600L'S - DENY BOTH W/EOB 302, PROVIDER SHOULD BE BILLING 1601L FOR THE PAIR.
8. FLU IMMUNIZATION (90724) ALLOW MULITPLES IF DIFFERENT STRAINS.NOTE: IF 90724 BILLED IN COMBO W/90657-90660 - DENY 90724 W/EOB 365.
9. SURGICAL ASSISTANT (MOD 80,81 OR 82) - ALLOW 1 PER SURGERY, DENY ADDITIONALS W/EOB 366.
10. SERVICES W/DX OF MULTIPLE BIRTHS (V31-V37):
A. IDENTIFIED - FORCE AND OVERCODE APPROPRIATELY
B. UNIDENTIFIED - DENY W/EOB 779 AND OVERCODE 886
11. CLAIM INDICATES PATIENT IS ON A VENTILATOR OR MOD 76 IS BILLED (94010-94642, 94652,94660-94662,94680-94750, 94770-94799)- FORCE.
12. VARIOUS INITIAL PROCEDURES -(30905,31645,33010,46940 49080,53600,53620,53660,61000,92225,93561,94650,94656, 94664,94667)- SEE 061 AUDIT.
13. ANTIGENS:
A. 95125 - PT 93 - DIFFERENT ANTIGENS - FORCE
B. 95117,95125,95144-95199- PT OTHER THAN 93 - FORCE
14. STERILE TRAY - (A4550) - IF COMMENT/DESCRIPTION INDICATES CVC OR IV TRAY - ALLOW 1 OF EACH
15. CASTING/SPLINTING/BRACES - ALLOW 2 IF LT & RT IS INDICATED.
16. IV INFUSION:
A. 90780 - ALLOW 1, DENY ADDITIONALS W/EOB 302.
B. 90781 - ALLOW UP TO A MAX OF 8, DENY ADDITIONALS W/EOB 339.
17. SPECIMEN HANDLING(9018M) OR SPECIAL MAILING (9019M) FAILING AGAINST EACH OTHER OR ANY OTHER 90--- SERIES - FORCE.
18. INTRAOCULAR LENS (V2630, V2631, V2632) - ASSUME 1 FOR LEFT AND 1 FOR RIGHT - FORCE.
19. CHEMOTHERAPY INFUSION:
A. 96410 - PAY 1, DENY ADDITIONALS W/EOB 302.
B. 96412 - ALLOW TO A MAX OF 7 UNITS, DENY ADDITIONALS W/EOB 339.

C. 96414 - PAY 1, DENY ADDTIONALS W/EOB 339.

20. IMMUNIZATION ADMINS (90471 OR 90472)
    A. BILLED IN COMBO W/EACH OTHER:
       1. PRIOR TO DOS 7/1/00 - DENY W/EOB 910.
       2. 7/1/00 DOS & AFTER - ALLOW 1 OF EACH PER SESSION.
    B. BILLED IN COMBO W/VACCINES (90476-90749) & THERE IS OR SHOULD BE A MOD 1H/SL ON ALL OF THE VACCINES ON THE CLAIM - DENY THE ADMIN W/EOB 365.
    C. IF THERE IS AT LEAST 1 VACCINE THAT DOES NOT REQUIRE THE MOD 1H/SL - FORCE THE ADMIN.
21. VACCINES/IMMUNOGLOBULINS (90281-90470, 90473-90699 - POSTING AGAINST EACH OTHER - FORCE.
22. VASCULAR STUDIES (93875 - 93990)
    A. RT/LT MODS & MULTI BODY PARTS - ALLOW 1 EACH.
       NOTE: 2 BILAT PROCEDURES (BY PDDD/CPT DESCRIPTION) DO NOT FALL UNDER THIS CATAGORY.
    B. DESCRIPTION IS UNILATERAL & NO BILATERAL CODE AVAILABLE PER PDDD/CPT - ALLOW 2 & DENY ALL OTHERS W/EOB'S 800/373.
    C. DESCRIPTION IS UNILATERAL & BILATERAL CODE AVAILABLE PER PDDD/CPT - DENY ALL OF SAME CODE W/EOB 302.
    D. DESCRIPTION IS BILATERAL & ALL ELSE - ALLOW 1 & DENY ALL OTHERS W/EOB'S 800/373.
    NOTE: DESCRIPTION IS EXTREMITIES ALLOW ONCE FOR LEGS AND ONCE FOR ARMS IF DEFINED BY DX, STATEMENT ON CLAIM OR BACKUP.
    E. ANY SITUATIONS OTHER THAN THE ABOVE - SEE TRAINER.

23. MIFEPRISTONE/MISOPROSTOL (RU-486)
    A. S0190 - ALLOW UP TO 3, DENY ALL OTHERS W/EOB 339.
    B. S0191 - ALLOW UP TO 2, DENY ALL OTHERS W/EOB 339.

24. VARICILLIN (90396) - ALLOW UP TO 5, DENY ALL OTHERS W/EOB 339.

25. DOPPLER COLOR FLOW VELOCITY MAPPING (93325) BILLED IN COMBO W/(76825-76828), ALLOW 1 FOR EACH FETUS.

26. 95860-95875:
    A. 95860-95863, 95867 - DENY ALL BILLED W/EOB 302.
    B. 95864 AND 95868-95870 - DENY MULTIPLES W/EOB 324.
    C. 95875 - DENY, UNLESS JUSTIFICATION OF SEPARATE LIMBS.

27. MSS/ICM -PT 35(0400M - 0405M, 0420M & 0421M)
    DATES OF SERVICE 9/30/03 AND BEFORE - ALLOW 1 PER DAY.
    DATES OF SERVICE 10/1/03 & AFTER- ALLOW MULTIPLES.
    NOTE: ALLOW MULTIPLES ON T1017 W/MOD HD AS OF 10/1/03

28. FQHC ENCOUNTER CODES:
    A. 9000M - J(PHYSICIAN) VS L(EPSDT) - ALLOW 1 PER DAY, DENY ADDITIONALS W/EOB 910. FORCE 553 EXC ON E&M WHEN IT FAILS ONCE THE ENCOUNTER CODE HAS BEEN DENIED, UNLESS DENYING THE E&M FOR ANOTHER EXCEPTION.

B. 9001M, 5900M/OR T1015 W/MOD TH DOS 10/01/03 FORWARD.
NOTE: GLOBAL PROCEDURES - DELIVERY AND PRENATAL CARE ONLY (59400,59410,59425, 59426, 59610-59614, 59618, 59620, 59622, 5951M-5952M)

1. MULTIPLE LINES OF FQHC ENCOUNTER CODE BILLED WITH ANY GLOBAL PROCEDURE CODE ON SAME DOS - FORCE ALL FQHC ENCOUNTER CODES.
2. FQHC ENCOUNTER CODE BILLED WITH GLOBAL PROCEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH DIFFERENT GLOBAL PROCEDURE CODE - DENY W/EOB 910.
3. FQHC ENCOUNTER CODE BILLED WITH GLOBAL PROCEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH SAME GLOBAL PROCEDURE CODE - DENY MULTIPLE FQHC ENCOUNTER CODES W/EOB 910.
4. FQHC ENCOUNTER CODE BILLED WITH GLOBAL PROCEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH NON-GLOBAL PROCEDURE CODE - DENY THE FQHC ENCOUNTER CODE BILLED WITH THE NON-GLOBAL PROCEDURE CODE.
5. FQHC ENCOUNTER CODE BILLED WITH NON-GLOBAL PRO-CEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH SAME OR DIFFERENT NON-GLOBAL PROCEDURE CODE - DENY MULTIPLE FQHC ENCOUNTER CODES W/EOB 910.
6. FQHC ENCOUNTER CODE PAID IN HX WITH A NON-GLOBAL PROCEDURE CODE VS CURRENT FQHC ENCOUNTER CODE WITH MULTIPLE UNITS BILLED WITH GLOBAL PROCEDURE CODE - PAY CURRENT FQHC ENCOUNTER CODE WITH GLOBAL PROCEDURE CODE THEN REC AND DENY HX FQHC ENCOUNTER W/EOB 339.

ANY QUESTIONS SEE SUPV/TRAINER/MMIS

C. 9006M:
1. DIFFERNET FEE FOR SERVICE PROCEDURE ON SAME DOS, ALLOW 1 PER EACH FEE FOR SERVICE PROCEDURE
2. ALL ELSE - DENY W/EOB 910.

D. T1015 WITH MOD HE (MENTAL ENCOUNTER) OR
T1015 W/O MOD BEGINNING DOS 10/01/03 FORWARD:
(FQHC ENCOUNTER WHEN PROV SPEC = 90)
ALLOW 1 ENCOUNTER PER DAY. DENY ADDITIONALS WITH EOB 910. FORCE 553 EXC ON E&M WHEN IT FAILS ONCE THE ENCOUNTER CODE HAS BEEN DENIED, UNLESS DENYING THE E&M FOR ANOTHER EXCEPTION.

D. SURGERIES (10000-69999,92975-92984,92986-92998,93501-93533, 0001T,0002T,0005T-0009T,0012T-0014T,0016T-0017T)
NOTE: IF 053 OR 087 NOT POSTING - O'LOC TO 36.
NOTE: IF NOT ADDRESSED BELOW AND 053 POSTING - O'LOC TO 36.
1. MULTIPLE DIAGNOSTIC, THERAPEUTIC, SELF-LIMITING OR UNI-LATERAL PROCEDURES DONE BILATERALLY - FORCE. UNILAT-ERAL PROCEDURES DONE BILATERALLY & PER ANATOMY ONLY 2 ALLOWED - PAY UP TO 2 - DENY ALL OTHERS W/EOB 800/589.
2. MOHS SURGERY(17304-17310) - FORCE MULTIPLES AT SAME OP SESSION PER DR. NICOLAUS. EXCEPTION: CLAIM OR REPORT

INDICATES SAME TUMOR - DENY W/EOB 302
3. CRYOTHERAPY (17340) - ALLOW 1 PER DAY
4. DESTRUCTION OF LESIONS (17100-17104) SEE 053
5. X-OVER SURGERY CLAIMS (MOD LT/RT) - SEE EXCEPTION 368 (MOD 50) FOR PRICING.

E. INDIAN HEALTH (PT 15) -
1. 5999M - ALLOW ONE MEDICAL CALL AND ONE DENTAL CALL PER DAY. IF THEY BILL MORE THAN ONE MEDICAL CALL OR ONE DENTAL CALL A DAY - DENY WITH EOB 339.
EXCEPTION - IF EMERGENCY AND DIFFERENT DX ON SAME DAY, A SECOND ENCOUNTER IS ALLOWED.
2. 5988M - ONE ALLOWED PER DAY. IF MORE BILLED - DENY 339.
EXCEPTION - IF EMERGENCY AND DIFFERENT DX ON SAME DAY, A SECOND ENCOUNTER IS ALLOWED.

F. THERAPIES, AUDIOLOGY & VARIOUS TESTING PROCEDURES BILLABLE BY PROVIDER TYPES 18 20 36 37 40 & 93:
1. (0701M) OCCUPATIONAL THERAPY INIT. 30 MIN-IF BILLING SPANS OF DATES WITH 1 UNIT, DENY W/EOB'S 910/417. ALL ELSE DENY 910.
2. (0002M) - CUSTOM SPLINTS - ALLOW 2, DENY ADDITIONALS W/EOB 339.
3. 92543 - ALLOW 1 UNIT PER IRRIGATION, UP TO 4 UNITS FOR EACH EAR. PAY UP TO MAX OF 8 W/EOB 101, DENY ALL OTHERS W/EOB 339.
4. 92546 - ALLOW 1 UNIT PER VELOCITY/PER DIRECTION, UP TO 3 UNITS FOR EACH DIRECTION. DENY ADDITIONAL WITH EOB 339.
5. 97504 - ALLOW MAX OF 2 PER DAY W/INFO EOB 101,& FORCE 101 EXCEPTION. DENY ADDITIONAL W/EOB 339.
6. 97703 - ALLOW MAX OF 2 PER DAY W/INFO EOB 101, & FORCE 101 EXCEPTION. DENY ADDITIONAL W/EOB 339.
7. 97803 - ALLOW UP TO 4 PER DAY. DENY ALL OTHERS W/EOB 339.
8. 97804 - DOS PRIOR TO 7/1/02: ALLOW 2 PER DAY. DENY ALL OTHERS W/EOB 339.
DOS 7/1/02 AND AFTER: ALLOW 4 PER DAY. DENY ALL OTHERS W/EOB 339.

G. AMBULATORY SURGERY CENTER (PT 22) - FORCE MULTIPLE SERVICES.
NOTE: IF 053 EXCEPTION NOT POSTING - SEE YOUR SUP.

H. ANESTHESIA SERVICES (00100 - 01999 OR 5911M - 5915M) PT 48/49 - O'LOC TO 12.

I. SCHOOL SERVICES (PT 58)
(0110S - 0170S) - FORCE, EVEN IF IT APPEARS TO BE A REBILL.
NOTE: (0110S-0150S)- IF HX LINE PAID AT $0.00 - O'LOC TO 83

J. COMMUNITY MENTAL HEALTH (PT 73) - 9701M - FORCE.

K. SUBSTANCE ABUSE (PT 75-INTAKE PROCESSING, GROUP THERAPY OR CASE MANAGEMENT)
1. 0159M - THROUGH DOS 6/30/03 - FORCE. DENY AS OF 7/1/03.
2. 0155M, 0156M - AS OF 7/1/03 FORWARD - FORCE.
3. 0143M, 0153M, 96154, 96155 W/MODIFIER HF OR HZ - AS OF

DOS 10/01/03 FORWARD - FORCE. *SR
4. 0141M, 0149M, 0151M, 0161M, 0169M, 0341M, 0369M, 2131M, 2135M, 2141M, 2149M, 2151M, 2159M, 2165M, 2166M, 2171M, 2179M, 2182M, 2185M, 2189M, & 2195M - FORCE ANY DOS.
5. DENY ALL OTHER PT 75 (DASA) CODES.

L. RURAL HEALTH (PT 88) - ALLOW ONE, DENY ALL OTHERS W/EOB 910.

M. MIDWIVES (PT 94)- 9804M OR 59409 W/SU MODIFIER - OVERLOC TO 83.

N. ER CALLS VS ER CALLS (99281-99285)
1. UNRELATED DX - FORCE
2. TIMES INDICATED - FORCE

O. CALLS (99201-99285, 99341-99353,99231-99239,99301-99333, 90801-90871,9011M-9014M,9020M,9083M-9089M,0252M) ADMITS (99221-99223) CONSULTS 99241-99263) AND PROLONGED SERVICES (99354,99356)
1. ADJ/RES ONLY - IF UNRELATED DX AND CLAIM SPECIFICALLY INDICATES DIFFERENT TIMES OR HAS JUSTIFICATION FOR 2 CALLS - FORCE, EXCEPT SEE 2 BELOW.
2. PSYCH PROCEDURE VERSUS PSYCH PROCEDURE (908XX) SEE EXCEPTION 015.
3. ADMIT & PSYCH EVAL (9084M) VS PSYCHIATRIC ITA PHYSICAL EXAM (9083M) - FORCE.
4. ADMITS/PSYCH EVALUATIONS/THERAPY VS COURT TESTIMONY (9085M-9087M OR 99075) - FORCE.
5. ADMIT VS ADMIT (99221-99223), INCLUDING CODES (99201-99215 IN POS 2) - FORCE IF UNRELATED DX, OTHERWISE PAY 1 PER PATIENT PER DAY-DENY CURRENT W/EOB 181 IF HX IS PAID. EXCEPTION: HOSP/CLINICS DOING DIAGNOSTIC WORKUP FOR CHILDREN - IE (AUP/COH/CHILDRENS UNIV MED GRP - BILLING (99201-99215) IN COMBINATION (POS 2) - FORCE.
6. ITA PHYSICAL EXAM (9083M) VS (PSYCH EVAL(90801,90802, 90820)-FORCE.
7. HOSPITAL DISCHARGE (99238/99239) VS NURSING FACILITY (99301-99333) - FORCE.
8. HOSPITAL CALLS (99231-99239) BILLED BY AN ANESTHESI-OLOGIST - (PT 48/49) - PAY UP TO 2 ON SAME DAY, DENY ALL OTHERS W/EOB 757.
9. TB TREATMENT SERVICES (9011M, 9012M) VS AIDS COUNSELING SERVICES (9020M) - FORCE.
10. AIDS COUNSELING (9020M) PAY 2 (1 FOR PRE AND 1 FOR POST), DENY ANY ADDITIONALS.
11. COURT TESTIMONY (99075) PAY 5 & DENY ALL ELSE W/EOB 339.

TEXT KEY TEXT DESC
102 ALL CLAIM TYPES:

POSSIBLE DUPLICATE - IF CLAIM IN HISTORY WAS PAID AT $0.00 OR IS TO BE PAID AT $0.00 - FORCE.

EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) BATCH RANGE (953-957) - AND DETAIL LINE MONEY, PROCEDURE AND UNITS ARE AN EXACT MATCH - IF CARRIER CODE ON HX CLAIM IS (1111) - FORCE, OR IF "ADJ-R" IS "E" - FORCE, OTHERWISE - DENY WITH EOB 830.
EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) FOR QRS/PIP AND CAMERA/REEL # IS (77) - SEE YOUR SUP BEFORE PROCESSING.

EXCEPTIONS: IF CLAIM IS A REBILLING OR AN EXACT DUPLICATE OF CLAIM IN HISTORY AND:
1. IT WAS PAID AT $0.00 WITH EOB 090 - DENY WITH EOB 309.
2. IT IS A DRG CLAIM SHOWING PAYMENT WITH EOB 090 - DENY W/EOB 309.
3. IF CLAIM WAS PAID AT $0.00 OR PARTIALLY PAID BECAUSE OF INSURANCE PAYMENT AND HAS AN EOB OF 031 OR 032 - DENY.
4. IF CLAIM WAS PAID AT $0.00 BECAUSE OF PATIENT PAYMENT - DENY.

MED VENDOR 'P' VS MED VENDOR 'P'.....PG.10
MED VENDOR 'P' VS MED VENDOR X-OVER 'O'.....PG.20
MED VENDOR X-OVER 'O' VS MED VENDOR 'P'.....PG.20
MED VENDOR X-OVER 'O' VS MED VENDOR X-OVER 'O'.....PG.25
PHYS X-OVER 'O' VS PHYS X-OVER 'O'.....PG.23

HOSPITALS - GENERAL INFORMATION

IF SUSPENDED CLAIM OR HISTORY CLAIM IS A HOSPICE PROVIDER (TYPE 63) (# BEGINS WITH 399....) OVERLOC SUSPENDED CLAIM TO LOC 67.

1. CONSECUTIVE ICN'S - STAGE
2. CLAIMS FOR BABY VS CLAIMS FOR PARENT - FORCE (FOR 1 YEAR ONLY).
3. IF CLAIM INDICATES "DONOR CHARGES" OR DX CODES V59.0-V59.9 - FORCE.
4. IF NOT ADDRESSED IN TEXT - DENY.

OUTPATIENT (M) VS OUPATIENT (M):
1. SAME DATES OF SERVICE, SAME DIAGNOSES, SAME AMOUNTS. IF SUSPENDED CLAIM APPEARS TO BE AN ADJUSTMENT - DENY W/EOB 189.

2. IF SUSPENDED OR HISTORY CLAIM IS FOR A KIDNEY CENTER OR DIALYSIS SERVICES, CHECK INDIVIDUAL DOS & SERVICES ON EACH CLAIM, IF CLAIM APPEARS TO BE A DUPLICATE- DENY. IF DIFFERENT DOS &/OR SERVICES- FORCE.

3. HOME HEALTH (PT 44) NOTE: SEE 991 TEXT FOR SPECIAL KEYING INSTRUCTION PRIOR TO WORKING THIS EXCEPTION.
A. IF AUTH # PRESENT - SEE AUTH SCREEN.
B. IF EXACT DUP ON AN ENTIRE PAID CLAIM - DENY.

C. IF MONEY DOES NOT MATCH PAID CLAIM - DENY 189.
D. 571, 421, 431, 441, 558, & 590 - DENY MULTIPLE SERVICES ON SAME DAY W/EOB 910.
E. 551 & 580 - PAY UP TO 2 VISITS PER DAY IN ANY COMBINATION.

4. SAME OR OVERLAPPING DATES OF SERVICE:
A. FORCE CLAIMS FOR THERAPIES WITH DIFFERENT REVENUE CODES (42X PHYSICAL, 43X OCCUPATIONAL THERAPY, OR 44X SPEECH THERAPY). PROVIDERS MUST BILL THESE ON SEPARATE CLAIMS.
B. SAME OR DIFFERENT DX - STAGE. VERIFY HOUR OF CARE:
1. IF HOUR OF CARE IS NOT GIVEN (ON BOTH CLAIMS) - DENY SUSPENDED CLAIM W/EOB 595.
2. IF HOUR OF CARE IS GIVEN (ON BOTH CLAIMS) - FORCE IF DIFFERENT OTHERWISE - DENY.
C. IF CHARGES ARE OBVIOUSLY A REBILL OF CHARGES THAT WERE PREVIOUSLY DENIED AND THE PROVIDER IS REBILLING ONLY THOSE CHARGES THAT WERE PREVIOUSLY DENIED - FORCE.
D. IF THERE IS A STATEMENT ON THE CLAIM OR IN THE COMMENTS/REMARKS INDICATING "LATE CHARGES" "ADDITIONAL CHARGES" OR "PATIENT SEEN TWICE ON THE SAME DAY" - FORCE.

OUTPATIENT (M) VS DRG (R) OR "R" VS "M":
1. OP CHARGES ARE INCLUDED IN THE DRG REIMBURSEMENT:
A. IF OP CLAIM IS SUSPENDING - DENY W/EOB 504.
B. IF DRG CLAIM IS SUSPENDING - FORCE 102 & RECOUP OP CLM W/EOB 504.
2. IF SUSPENDED CLAIM OR HISTORY CLAIM IS FOR A KIDNEY CENTER OR KIDNEY DIALYSIS SERVICES - OVERLOC TO 67.

OUTPATIENT (M) VS INPATIENT (S) OR "S" VS "M":
1. IF OUT OF STATE PROVIDER FOR AIR AMBULANCE - FORCE.
2. IF TRANSPLANT & ONE OF THE CLAIMS IS FOR THE DONOR - FORCE.
NOTE: WE PAY FOR DONOR SERVICES UNDER THE CLIENT'S PIC.
3. IF SUSPENDED CLAIM OR HISTORY CLAIM IS FOR A KIDNEY CENTER OR KIDNEY DIALYSIS SERVICES - OVERLOC TO 67.
4. ALL ELSE:
A. IF OP CLAIM IS SUSPENDING - DENY W/EOB 515.
B. IF INPATIENT CLAIM IS SUSPENDING - FORCE & RECOUP OP CLAIM W/EOB 515.

OUTPATIENT (M) VS MEDICARE X-OVERS (W):
1. IF OUTPATIENT CLAIM IS FOR SERVICES NOT COVERED BY MEDICARE IE: DENTAL, ETC. - FORCE. (SEE 261 TEXT FOR LIST OF SVCS NOT COVERED BY MEDICARE). ALL ELSE - FORCE WITH OVERCODE 111.
2. IF OUTPATIENT CLAIM IS A KIDNEY CENTER BILLING NON-COVERED CHARGES:
A. REVENUE CODES 260, 303, 304, 825, 835, 845, 855, 880, 881, 889 - FORCE.
B. ALL ELSE - FORCE WITH OVERCODE 111.
3. KIDNEY CENTERS/OP DIALYSIS & PHARMACY REV CODE 250 - FORCE WITH OVERCODE 111.

OUTPATIENT (M) VS INPATIENT X-OVER (V):
1. IF OP CLAIM INDICATES "NO PART B" - FORCE.
2. ALL ELSE - FORCE WITH OVERCODE 111.

INPATIENT (S) VS INPATIENT (S):
1. DETOX CENTER (PROVIDER SPECIALITY 93) DUPING AGAINST DETOX CENTER - IF ADMIT/DISCHARGE DATES OVERLAP - FORCE. OTHERWISE DENY.
2. SAME OR OVERLAPPING DATES OF SERVICE AND CLAIM IN SUSPENSE APPEARS TO BE AN ADJUSTMENT - DENY W/EOB 189.
3. IF TRANSPLANT AND ONE OF THE CLAIMS IS FOR THE DONOR - FORCE.
   NOTE: WE PAY FOR DONOR SERVICES UNDER THE CLIENT'S PIC.
4. LATE CHARGES AND/OR ADDITIONAL CHARGES (MUST BE STATED ON THE CLAIM OR IN THE COMMENT FIELD). ENTER 444 IN THE OVERCODE FIELD AND FORCE.
5. DISCHARGE & READMIT SAME DAY - FORCE.
6. IF CHARGES ARE OBVIOUSLY A REBILL OF CHARGES THAT WERE PREVIOUSLY DENIED AND THE PROVIDER IS REBILLING ONLY THOSE CHARGES THAT WERE PREVIOUSLY DENIED - FORCE.

INPATIENT (S) OR DRG (R) VS X-OVER (V): FORCE "R", "S", OR "V" CLAIM WITH OVERCODE 111.

INPATIENT (S) VS DRG (R) OR "R" VS "S":
1. "LATE CHARGES" "ADDITIONAL CHARGES" CANNOT BE PROCESSED AS DIFFERENT CLAIM TYPES - DENY WITH EOB 189.
2. OVERLAPPING DATES OF SERVICE.
   A. IF THE ADMIT DATE ON ONE CLAIM IS THE SAME AS THE DISCHARGE DATE ON THE OTHER CLAIM (TRANSFER WITHIN A FACILITY) - FORCE.
   B. CLAIM APPEARS TO BE AN ADJUSTMENT - DENY W/EOB 189.

DRG (R) VS DRG (R):
1. LATE CHARGES AND/OR ADDITIONAL CHARGES (MUST BE STATED ON THE CLAIM OR IN THE COMMENT FIELD) CANNOT BE PAID UNTIL THERE IS A PAID OUTLIER CLAIM IN HISTORY. KEY 444 IN THE OVERCODE FIELD:
   A. IF THE CLAIM IN HISTORY IS NOT AN OUTLIER - DENY W/EOB 798.
      NOTE: IF THE CLAIM IN HISTORY IS FOR LATE CHARGES AND THE CLAIM IN SUSPENSE IS THE DRG - FORCE & RECOUP THE HX CLAIM W/EOB 798.
   B. IF THE CLAIM IN HISTORY IS AN OUTLIER - WORK EXCEPTION 102 PER THE 230 TEXT AND PAY LATE CHARGES THE SAME AS AN INTERIM OUTLIER.
      NOTE: IF THE CLAIM IN HISTORY IS FOR THE LATE CHARGES - FORCE AND SUBMIT AN ADJUSTMENT TO PRICE HISTORY CLAIM AS AN INTERIM OUTLIER.
   --IF YOU ARE NOT SURE THE SVCS ARE LATE CHARGES - SEE TRAINER/SUPV.
2. IF CLAIM APPEARS TO BE AN ADJUSTMENT - DENY W/EOB 189.
3. DISCHARGED & READMITTED ON THE SAME DAY - OVERLOC TO 10.
   EXCEPTION: IF EITHER CLAIM IS PSYCH DRG 424-432 OR 748-753 - FORCE.
4. MULTIPLE CLAIMS FOR FALSE LABOR (DRG 382) ON SAME DOS - DENY 507.
5. SPLIT CLAIMS - CLAIMS SHOULD BE EXACTLY THE SAME EXCEPT FOR THE THE BILLED AMOUNTS.
A. IF NEITHER CLAIM IS AN OUTLIER - OVERLOC TO 72.
B. IF ONLY ONE OF THE CLAIMS IS AN OUTLIER - LET THE SYSTEM PRICE THE OUTLIER CLAIM AND PRICE THE OTHER CLAIM PER THE 230 TEXT.
   NOTE: IF THE CLAIM IN SUSPENSE IS THE OUTLIER & THE CLAIM IN HX IS ALREADY PAID - FORCE EXCEPTION 102 & SUBMIT AN ADJUSTMENT TO PRICE THE HISTORY CLAIM PER THE 230 TEXT.
C. IF BOTH CLAIMS ARE OUTLIERS - LET THE SYSTEM PRICE ONE OF THE CLAIMS AND WORK EXCEPTION 102 PER THE 230 TEXT.
D. ANY QUESTIONS - SEE TRAINER/SUPERVISOR.

--NOTE: ALWAYS USE 387 IN THE 2ND EOB ON SPLIT CLAIMS.

INPATIENT (S) VS X-OVER (W): IF "S" CLM DOES NOT INCLUDE PART B CHARGES
1. IF THE "S" CLAIM DOES NOT INCLUDE PART B CHARGES (SEE 259 TEXT FOR (LIST) - FORCE.
2. IF THE "S" CLAIM INCLUDES PART B CHARGES - FORCE THE "S" OR THE "W" CLAIM (WHICHEVER CLAIM IS POSTING 102) WITH OVERCODE 111.

OUTPATIENT X-OVER (W) VS DRG (R):
1. IF OUTPATIENT X-OVER CLAIM IS SUSPENDING AGAINST A DRG CLAIM - DENY THE X-OVER CLAIM W/EOB 504 (PART B CHARGES ARE INCLUDED IN THE DRG REIMBURSEMENT).
2. IF DRG CLAIM IS SUSPENDING AGAINST AN OUTPATIENT X-OVER CLAIM - ENTER "111" IN THE OVERCODE FIELD AND FORCE EXCEPTION 102. --DO NOT RECOUP THE OUTPATIENT X-OVER.

OUTPATIENT X-OVER (W) VS OUTPATIENT X-OVER (W)
1. ELECTRONIC CLAIMS: IF BOTH CLAIMS ARE ELECTRONIC BILLINGS, AND THE DOLLAR AMOUNTS ARE THE SAME - DENY. OTHERWISE FORCE.
2. HARD COPY CLAIMS: IF ONE OR BOTH CLAIMS ARE HARD COPY, STAGE - IF EOMB OR OTHER BACKUP INDICATES ADJUSTMENT, DENY USING EOB 189 IN SECOND SLOT. OTHERWISE FORCE.

INPATIENT X-OVER (V) VS INPATIENT X-OVER (V)
1. DIFFERENT DOLLAR AMOUNTS, ORIGINAL CLAIM PAID - CLAIM IN SUSPENSE APPEARS TO BE AN ADJUSTMENT - DENY WITH EOB 189.
2. SAME DATES OF SERVICE/OVERLAPPING DATES OF SERVICE - DENY.

MED VENDOR (P) VS MED VENDOR (P)

THIS EXCEPTION WILL POST ON DETAIL LINES IF THE FOLLOWING CRITERIA ARE MET ON EACH CLAIM:
A. SAME PIC CODE
B. SAME PROVIDER NUMBER
C. SAME OR DUMMY PERFORMING PROVIDER NUMBER
D. OVERLAPPING DATES OF SERVICE
E. SAME PROCEDURE CODE

** REVIEW BOTH CLAIMS FOR MONTHLY LIMITATIONS AND PRIOR AUTHORIZATION NUMBERS-IF AUTH FILE ALLOWS ADDITIONAL UNITS-FORCE BOTH 100 & 102.

--NOTE: FORCE BOTH 100(AUTODENY) & 102 EXCEPTION WHENEVER BOTH FAIL TOGETHER ON THE SAME LINE AND 102 EXCEPTION IS TO BE FORCED.

1. IF SUSPENDED CLAIM APPEARS TO BE A REBILL TO AN ALREADY PAID CLAIM DENY W/102-189 EOBS (REVIEW HX CLAIM IN O4 SCREEN).

2. IF 444 OVERCODE OR STATEMENT "NOT A DUP"(ENTER 444 OVERCODE) - FORCE.

3. PHYSICAL THERAPY

   A. IF AUTHORIZATION NUMBER PRESENT REVIEW & PAY ACCORDINGLY.
   B. CONSECUTIVE CLAIMS - FORCE PROCEDURES WITH A 1 IN THE DUP CHECK IF IT APPEARS TO BE FOR MULTIPLE SERVICES, OTHERWISE DENY.
   C. ALL ELSE, DENY. NOTE: ANY UNUSUAL SITUATIONS OR QUESTIONS OL 83.

4. EYE EXAMS, VISUAL FIELD, REFRACTIONS, FITTING FEE IN COMBINATION - DENY ONLY EXACT DUPS & DUP SERVICES - ALL ELSE - FORCE. IF UNSURE AS

WHETHER TO FORCE OR DENY - SEE YOUR SUP.

5. 1002V (INTAOCULAR LENS), EACH. - ASSUME IT IS FOR RIGHT & LEFT LENS-
FORCE.

6. NON-PROFIT TRANSPORTATION
A. 0303A, 0304A - ALLOW ONE OF EACH, DENY ALL OTHERS.
B. 0301A AND 0302A - PAY BOTH WAYS UNDER EITHER CODE FOR SECOND TRIP, SAME DAY - FORCE.
C. BASE RATE, RETURN TRIP - FORCE. IF FOURTH TRIP, STAGE. EMC CLAIM - DENY WITH EOB 522.
D. IF BILLING ROUND TRIP UNDER 0301A - FORCE. SEND COPY TO PRU FOR PHONE CALL.
E. MECHANICAL LIFT - IF BILLING RETURN TRIP - FORCE. SEND COPY TO PRU FOR PHONE CALL.

7. GROUND AMBULANCE (PT 51)
NOTE: BRING UP HX CLAIM IN 4 SCREEN IF NECESSARY.
USE MODIFIERS TO IDENTIFY SEPARATE TRIPS. SEE TRAINER IF QUESTIONS.

*** CLAIMS WITH DATES OF SERVICE THROUGH 9/30/03 ADJUDICATE AS
AS FOLLOWS:
A. 0001A, 0002A, 0007A - DENY.
B. 0003A, 0004A, 0008A, 0015A, 0016A
1. DIFFERENT MODS - FORCE
2. SAME MODS AND 4TH TRIP INDICATED-FORCE
2. SAME MODS AND NO INDICATION OF ADDITIONAL TRIP-DENY
*** CLAIMS WITH DATES OF SERVICE 10/01/03 AND AFTER ADJUDICATE
AS FOLLOWS:
7. A A0426, A0427, A0433 OR A0434
B A0425, A0428, OR A0439
1. DIFFERENT MODS - FORCE
2. SAME MODS BUT INDICATION OF NEW TRIP - FORCE
3. SAME MODS AND NO INDICATION OF NEW TRIP - DENY

*** CLAIMS WITH DATES OF SERVICE THROUGH 9/30/03 ADJUDICATE
AS FOLLOWS:
C. 0044A (IV ADMINISTRATION - ALL INCLUSIVE, ALLOW ONLY 1 PER TRIP)
1. DIFFERENT TRIP - FORCE
2. SAME TRIP - DENY.
*** CLAIMS WITH DATES OF SERVICE 10/01/03 AND AFTER ADJUDICATE
AS FOLLOWS:
D. A0394 (ALLOW ONLY 1 PER TRIP - DENY ALL OTHERS)
1. DIFFERENT TRIP OR DIFFERENT MODS - FORCE
2. SAME TRIP OR SAME MODS - DENY

E. 0036A (DRESSINGS)
1. DIFFERENT TRIP - FORCE
2. SAME TRIP - DENY.

*** CLAIMS WITH DATES OF SERVICE THROUGH 9/30/03 ADJUDICATE
AS FOLLOWS:
F. 0010A (OXYGEN ADMIN 1 PER TRIP UNLESS OVER 50 MILES)
1. DIFFERENT TRIP - FORCE

2. SAME TRIP - DENY. EXCEPTION: ON TRIPS THAT EXCEED 50 MILES
(IE SPOKANE TO SEATTLE) - FORCE.

*** CLAIMS WITH DATES OF SERVICE 10/01/03 AND AFTER ADJUDICATE AS FOLLOWS:

G. A0422 (OXYGEN ADMIN 1 PER TRIP UNLESS OVER 50 MILES)
1. DIFFERENT TRIP(DIFFERENT MODS)-FORCE
2. SAME TRIP - DENY. EXCEPTION: ON TRIPS THAT EXCEED 50 MILES
(IE SPOKANE TO SEATTLE) - FORCE.

H. ALL ELSE - DENY

8. AIR AMBULANCE
A. PAY 2 LIFT OFFS AND 2 MILEAGES IF AN INDICATION ON CLAIM THAT IT IS A MULTIPLE TRANSPORT IN THE SAME DAY.
B. MULTIPLE CLIENTS TRANSPORTED:
1. PAY A LIFT OFF FEE FOR EACH CLIENT TRANSPORTED ON A SINGLE AIR AMBULANCE TRIP.
2. MILEAGE MUST BE DIVIDED EQUALLY BY THE NUMBER OF CLIENTS TRANSPORTED. FORCE IF MULTIPLE CLIENTS. ASSUME MILEAGE HAS BEEN DIVIDED UNLESS "TOTAL" MILEAGE IS INDICATED ON CLAIM OR BACKUP AND CONFLICTS WITH "DIVIDED" MILEAGE-IN THAT CASE PAY BOTH "LIFT OFFS" AND DENY ONE MILEAGE W/EOB 339.
C. ALL ELSE DENY.

09. ITA TRANSPORTATION- 0801A,S0215(ONE WAY RATE), 0802A(ONE WAY RETURN)
0803A,T2001(EXTRA ATTENDANT)

IF ABLE TO DETERMINE MORE THAN ONE TRANSPORT (FROM SITE TO COURT AND COURT TO ORIG SITE) AND/OR (SITE TO NEW DESTINATION (HOSPITAL) -- FORCE. IF USING 0801A OR S0215 MULTIPLE TIMES YOU CAN DETERMINE THERE ARE ACTUALLY RETURN TRIPS INVOLVED. DENY ONE OF THE 0801A OR S0215 WITH EOB 248.

10. DME (DURABLE MEDICAL EQUIPMENT) PT 26 & 39
(I.E. WHEELCHAIRS, BEDS, WALKERS, BATHROOM EQUIP, COMMODES, BLOOD GLUCOSE MONITORS, ALL EQUIPMENT ACCESSORIES, MODIFICATIONS AND REPAIRS)
A. IF AUTH # PRESENT - PAY ACCORDING TO AUTH FILE.
B. IF EXPEDITED AUTH # (BEGINNING WITH '87') & CLAIM IN IN HX PAID - DENY.
C. IF CLAIM APPEARS TO BE A REBILL DENY W/EOBS 102/189 (REVIEW HX CLAIM IN 04 SCREEN IF NECESSARY)
D. MONTHLY RENTAL CODES WITH FIRST OR LAST DATES OF SERVICE OVERLAPPING - FORCE.
E. DAILY RENTAL CODES WITH OVERLAPPING DAYS - SPLIT OUT AND PAY THOSE DATES NOT DUPPING.
F. FORCE THE FOLLOWING IF ON SAME OR CONSECUTIVE CLAIM:
1. GRAB BARS OR RAILS FOR BATH OR TOILET
2. BED PANS AND URINALS
3. POSITIONING BELT FOR SHOWER OR COMMODE CHAIR

11. NONDURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLIES (PT 26 OR 39)
A. AUTH # PRESENT - PAY ACCORDING TO AUTH FILE
B. L8210-IF PROVIDER INDICATES IT IS FOR A DIFFERENT BODY PART *DC

OR DIFFERENT LIMB-FORCE
C. IF CLAIM/LINE APPEARS TO BE A REBILL DENY W/EOBS 102/189. REVIEW HX CLAIM IN 4 SCREEN IF NECESSARY.
D. 4802A, T1999 W/EPA# 870000865(COMPLIANCE DEVICE/CONT)-DENY
E. FORCE THE FOLLOWING IF ON SAME OR CONSECUTIVE CLAIM
1. DRESSING, TAPES, GAUZE, BANDAGES, GLOVES
2. WOUND FILLERS, SKIN BARRIERS, LUBRICANT
3. SALINE OR WATER
4. FITTING FEE FOR VASCULAR SUPPORT
5. OSTOMY FILTERS
6. BRACES - RT VS LT
7. HEEL OR ELBOW PROTECTOR
8. CONDUCTIVE PASTE OR GEL
9. TENS (TRANSUTANEOUS NERVE STIMULATOR SUPPLIES) SUPPLIES & EQUIPMENT
10. METERED DOSE INHALER
11. MISC CODES
F. IF OVERLAPPING SPAN OF DATES AND SPAN OF DATES NOT REQUIRED FOR PROCEDURE CODE - FORCE.
G. ALL ELSE - DENY
H. ANY QUESTIONS SEE TRAINER/SUPERVISOR

12. P & O (PROSTHETICS AND ORTHOTICS) PT 38 OR 39
A. DUP OF SAME OR CONSECUTIVE CLAIM - FORCE.
B. AUTH # PRESENT - WORK ACCORDING TO AUTH FILE.
C. IF CLAIM/LINE APPEARS TO BE A REBILL DENY W/EOBS 102/189.
D. ALL ELSE - DENY

13. CHIROPRACTORS
A. SAME OR CONSECUTIVE CLAIM - FORCE.
B. DIFFERENT CLAIM - DENY.

14. OXYGEN
A. E0441-E0444 DOS PRIOR TO 1/1/00
1. SAME OR CONSECUTIVE CLAIM - FORCE
2. DIFFERENT CLAIM - DENY.
E0441-E0444 DOS 1/1/00 & AFTER - DENY.
B. E0450: VENTILATOR
1. MODIFIER 5B(BACK UP VENT) VS MODIFIER RR-KEY 5B IN FIRST MODIFIER FIELD AND FORCE.
2. MODIFIER U2(BACK UP VENT) VS MODIFIER RR-KEY U2 IN FIRST MODIFIER FIELD AND FORCE.
3. MODIFIER 5B VS NO MOD OR 1P MOD - FORCE
4. MOD 5B VS 5B - DENY
5. MOD U2 VS U2 - DENY

F. E0450, E0453, E0460 - DOS PRIOR TO 1/1/99
PAY UP TO 2 VENTS PER CLIENT IF BILLED ON THE SAME OR CONSECUTIVE CLAIM. DIFFERENT JULIAN DATE/BATCH - DENY.
G. E0600-ALLOWED 2 IN 5 YRS FORCE IF BILLED ON SAME OR CONSECUTIVE CLAIM. ALL ELSE O/L TO 83
H. IF NOT ADDRESSED ABOVE AND HX CLAIM IS CONSECUTIVE AND IT APPEARS TO BE ADDITIONAL SUPPLIES THEN CHECK PDDD FILE FOR '1' IN THE "DUP CHECK", IF A '1' - FORCE.

(CONSECUTIVE CLAIM = CLAIM THAT FALLS IN THE SAME JULIAN DATE AND THE SAME BATCH RANGE.)
I. ALL ELSE - DENY.

15. SPECIAL DUTY NURSES
DATES OF SERVICE OVERLAP - WORK ACCORDING TO THE AUTHORIZATION FILE.
EXCEPTION: ROBERT FISHER & DEBRA PAGET - FORCE. ALL ELSE OL TO 83.

16. ENTERAL THERAPY AND IV THERAPY
A. ANY CLAIM WITH 444 OVERCODE OR COMMENT "NOT A DUP" - FORCE.
B. SYRINGES, NEEDLES, SPONGES, DRESSINGS AND TAPES
SAME OR CONSECUTIVE CLAIM - FORCE.
C. MEDICAL NUTRITION FORMULAS ON SAME OR CONSECUTIVE CLAIM - FORCE.
D. ENTERAL PUMPS WITH STATEMENT "NOT A DUP"/"2 PUMPS"/"SCHOOL & HOME" - FORCE.
E. CASSETTES & EXTENSION SETS - SAME OR CONSECUTIVE CLAIM - FORCE.
F. IV SETS, FILTER SETS, INJECTION CAPS - SAME OR CONSECUTIVE - FORCE.
G. IF OVERLAPPING SPAN OF DATES AND SPAN OF DATES NOT REQUIRED FOR PROCEDURE CODE - FORCE.
H. MONTHLY RENTALS WITH BEGINNING OR ENDING DATE OVERLAPPING - FORCE.
I. ALL ELSE - DENY.

17. PARENTERAL
A. MONTHLY PUMP RENTALS WITH BEGINNING OR ENDING DATE OVERLAPPING - FORCE.
B. IF OVERLAPPING SPAN OF DATES AND SPAN OF DATES NOT REQUIRED FOR PROCEDURE CODE - FORCE.
C. ALL ELSE - DENY.

18. PODIATRISTS (PROVIDER TYPE 32) - 1600L - IF PROVIDER BILLS 1600L TWICE, LEFT & RIGHT FOOT - DENY 248. PROVIDER SHOULD BE BILLING 1601L FOR THE PAIR.

E. 00551,00580 - PAY UP TO 2 VISITS PER DAY IN ANY COMBINATION

19. CLOZARIL - CODES 0852J-0853J,0855J-0857J OR 90862- DENY DUPS.

20. NURSE DELEGATION (8900N-8903N)
A. SAME/CONSECUTIVE CLAIMS OR IN SAME BATCH - FORCE.
B. IF CLAIM IS A CARBON - DENY W/EOB 042.

21. IF NONE OF THE ABOVE DENY.

MED VENDOR (P) VS MEDICARE X-OVER (O) TOS 9 OR R OR VICE VERSA:

1. IF MONEY IS DIFFERENT - FORCE
2. IF MONEY IS THE SAME - RESEARCH.

DENTAL (K) VS. DENTAL (K)
1. THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF THE FOLLOWING DUP CRITERIA IS THE SAME ON EACH CLAIM
A. PIC CODE B. PROVIDER C. PROCEDURE CODE

D. TOOTH
2. IF ABOVE DUP CRITERIA IS MET BUT DETAIL DATES OF SERVICE ARE NOT THE SAME AS ANY OTHER DAY OF SERVICE WITHIN THE OVERLAPPING SPAN - FORCE.
3. IF ABOVE DUP CRITERIA IS MET AND DETAIL DATES OF SERVICE ARE THE SAME AS A DAY OF SERVICE WITHIN THE OVERLAPPING SPAN - DENY DUP, UNLESS ANY OF THE FOLLOWING APPLY:

NOTE: ENCOUNTER CODE 0200D OR T1015 BILLED BY PROV TYPE 27-GLOBAL CODES:
DENTAL ENC (0200D OR T1015) GLOBAL ISSUES CONTINUED:
DENTURES, CROWNS, ROOT CANALS, & SURGERIES. IF CLAIM LOOKS LIKE A REBILL AND:
(ANY QUESTIONS ASK SUPV/TRAINER/MMIS)
1. 102 IS FAILING ON BOTH THE PROCEDURE & THE ENCOUNTER - IF DENYING THE PROCEDURE ALSO DENY THE ENCOUNTER CODE.
2. 102 IS FAILING ONLY ON THE ENCOUNTER - CHECK HISTORY, IF GLOBAL PROCEDURE IS DIFFERENT - DENY W/EOB 910.
3. ALL ELSE - DENY.

A. 00230/D0230 - ALLOW UP TO 13 ON SAME DAY.
B. 00240/D0240 - ALLOW UP TO 4 ON SAME DAY.
C. 00270/D0270, 00272/D0272 - DENY WITH EOBS 041 AND 302.
D. 00501/D0501 - IF PROVIDER INDICATES NOT A DUP - FORCE.
E. 0200D (DENTAL ENCOUNTER) - FORCE.
NOTE: DENTISTS (PT27) WILL BILL THE FQHC DENTAL ENCOUNTER W/PROC CODE T1015 AS OF 10/01/03 FORWARD. THIS CODE IS LIMITED TO ONE ENCOUNTER PER DAY. MULTIPLE UNITS ARE ALLOWED(ON SAME CLAIM ONLY) WHEN BILLED IN COMBO W/GLOBAL DENTAL PROCEDURE CODES.
OTHERWISE, DENY ADDITIONALS W/ EOB 910.
F. 02110-02161, 02330-02335, 02380-02387, D2110-D2161, D2330-D2335, D2380-D2387 AMALGAM/COMPOSITE/RESIN RESTORATIONS
4480D-4488D & 4501D-4506D ENHANCED DENTAL PROJECT ADD-ONS
IF O (OCCLUSAL) & I(INCISAL) SURFACES ON SAME TOOTH - DENY.
IF B (BUCCAL) & F (FACIAL) SURFACES ON SAME TOOTH - DENY.
ANY OTHER COMBINATIONS - FORCE.
G. 03426/D3426, 03430/D3430 - IF TEETH # 1-5, 12-16, 17-21, 28-32 - FORCE.
H. 03950/D3950 -
1. DOS PRIOR TO 11-1-02 ALLOW UP TO 3 DOWEL POSTS PER TOOTH
2. DOS 11-1-02 OR AFTER - DENY.
I. 06010/D6010 - ALLOW UP TO 6.
J. 07110 - 07286, D7110-D7286 - STAGE. IF SUPERNUMERARY TOOTH-FORCE.
K. 0847D, 0849D, 0857D, 0859D, & 0861D - SHOULD NOT BE BILLING THESE CODES EVERY MONTH. IF NOT FOLLOWING DENTAL FEE SCHEDULE WHICH SAYS THEY ARE TO BILL ONCE FOR EACH 3 MONTH SEGMENT - DENY 957.
L. D9110 (PALLIATIVE TREATMENT)
1. DOS PRIOR TO 11-1-02 - ALLOW 2 TEETH PER QUADRANT, DENY EXTRAS WITH EOB 339.
2. DOS 11-1-02 OR AFTER - DENY.
M. 09220/D9220 - FORCE ON SAME CLAIM AND DIFFERENT TIMES INDICATED.
N. 09610/D9610 - FORCE IF ON SAME CLAIM.

0. 09630/D9630 - ALLOW MULTIPLES IF DIFFERENT MEDICATION.

P. CPT SURGERY PROCEDURE CODES (11100-64600) ON SAME OR CONSECUTIVE

CLAIM - IF PROCEDURE CAN BE DONE MORE THAN ONCE - FORCE 102 AND APPLY EXCEPTION 040 POLICY. EXCEPTION - THE FOLLOWING PROCEDURES HAVE A LIMIT ON THE NUMBER THAT CAN BE DONE - DENY ANY OVER THIS WITH EOB 339:
11100 - ALLOW 1
20605 29800, 29804, - ALLOW 2 OF EACH
41820, 41828 ALLOW UP TO 4 OF EACH.
41874 - ALLOW 1 PER QUADRANT

MED VENDOR (P) VS. MEDICARE X-OVER (O) TOS 9 OR R OR
MEDICARE X-OVER (O) VS. MED VENDOR (P)

1. IF MONEY IS DIFFERENT - FORCE
2. IF MONEY IS SAME - RESEARCH.

MEDICARE X-OVER (O) TOS 9 OR R VS. MEDICARE X-OVER (O) TOS 9 OR R

1. HARDCOPY VS HARDCOPY
   A. SAME OR CONSECUTIVE CLAIM - FORCE.
   B. DIFFERENT CLAIM
      1. DIFFERENT MONEY & '1' IN DUP CHECK ON PDDD FILE - FORCE
      2. SAME MONEY BUT ENDING DATE OF DATE SPAN IS DIFFERENT - DENY
      3. NOT ADDRESSED ABOVE - SEE MMIS FOR REVIEW & UPDATE.
      4. IF 102 IS POSTING INAPPROPRIATELY DUE TO UNNECESSARY DATE SPAN - FORCE.
2. HARDCOPY VS TAPE OR VICE VERSA
   A. IF 102 IS POSTING INAPPROPRIATELY DUE TO UNNECESSARY DATE SPAN - FORCE.
   B. ALL ELSE - DENY

MEDICARE X-OVER (O) TOS 3 OR Z VS. MEDICARE X-OVER (O) TOS 3 OR Z
(SEE PHYS POLICY)

PHYSICIANS NOTE: DUPE POSTS ON SAME PROVIDER, BUT ON X-OVER'S YOU MAY HAVE THE SAME PROVIDER AND TOTALLY DIFFERENT SERVICES. CHECK THE BILLED AMTS, TOS, UNITS, MODIFIERS. THESE ITEMS MAY ALERT YOU TO FORCE THE 102 EXCEPTION. SEE YOUR TRAINER FOR MORE INFORMATION.

PHYSICAN NOTE:
MODIFIER LT/RT OR E1/E3 OR E2/E4 PRICING (PHYSICIAN SERVICES)
ANY MEDIA
1. PF-4 UNDER PROCEDURE CODE ON SECOND LINE.
2. IF NOT A PROCEDURE WE ALLOW BILATERAL ON (N IN BILAT-FIELD) - FORCE 102.
3. IF PER PDDD DESCRIPTION BI-100% - PAY ONE PER EACH SIDE.
4. IF A PROCEDURE WE ALLOW BILATERAL ON (Y IN BILAT-FIELD)
   A. LOOK AT MAX ALLOWED FOR DOS.
   B. MULTIPLY MAX ALLOWED X 50% = NEW MAX ALLOWED AT 50%.
   C. COMPARE OUR NEW MAX ALLOWED TO MDCRS.
      1. IF OURS IS LESS - DENY DUPE W/EOB 030.
      2. IF OURS IS MORE:
         A. SUBTRACT MDCRS PAYMENT FROM NEW MAX ALLOWED & MANUAL PRICE LINE W/PAYMENT DUE, FORCE 102 AND 430.
         B. IF MDCR PD MORE THAN WE ALLOW - DENY 102 W/EOB 030.

1. TAPE VS HARD COPY - DENY 960. (EXCEPT)
   A. SURGEON VS ANESTHESIA (SEE 000 TEXT FOR MODS) VS ASC (TOS Z) VS ANESTHESIA VS ANESTHESIA (WITH DIFFERENT MODS) VS ASSIST (MOD 80, 81) OR ANY COMBINATION OF THE PRECEDING - FORCE.
   B. ANY SERVICE W/DIFFERENT MODS SHOULD BE REVIEWED FOR PAYING.
2. TAPE VS TAPE OR HARD COPY VS HARD COPY - DENY. (EXCEPT)
   A. SAME OR CONSECUTIVE CLAIM & MEDICARE PAID - FORCE.
   B. SEE TAPE VS HARD COPY ABOVE.
   C. DIFFERENT MONEY & "1" IN DUP CHECK ON PDDD FILE - FORCE.
   D. ANY SERVICE W/DIFFERENT MODS SHOULD BE REVIEWED FOR PAYING.

EPSDT (L) VS EPSDT (L)
1. THIS EXCEPTION WILL POST ON DETAIL LINES IF THE FOLLOWING DUP CRITERIA IS MET ON EACH CLAIM:
   A. SAME PIC CODE
   B. SAME PROVIDER NUMBER
   C. OVERLAPPING D.O.S.
   D. SAME OR DUMMY PERFORMING PROVIDER #
   E. SAME PROCEDURE CODE

2. IF ABOVE DUP CRITERIA IS MET DO THE FOLLOWING:
   A. CLAIM IS A REBILLING - DENY.
   B. 0252M, 99381-99395 (SCREENS) - DENY 910.
   C. LAB (80000-89999, 36415)
      1. 82947 GLUCOSE TEST - PAY MULTIPLES.
      2. IF BILLED ON SEPARATE CLAIMS, CHECK PDD FILE, IF "1" IN DUP CHECK - FORCE, OTHERWISE DENY WITH EOB 910.
      3. DENY MORE THAN 1 PER DAY WITH EOB 910.
   D. 90476-90749 (IMMUNIZATIONS) IF EXACT CODES DENY WITH EOB 910. EXCEPTION: IF CODE 90657-90660 OR 90724, ALLOW MULTIPLES IF DIFFERENT FLU STRAINS.
   E. MEDICAL ENCOUNTER CODE 9000M OR T1015 - DENY W/EOB 910. INCLUDING L(EPSDT) VS J(PHYSICIAN). FORCE THE 553 EXC ON THE E&M WHEN IT FAILS ONCE THE ENCOUNTER CODE IS DENIED, UNLESS DENYING THE E&M FOR ANOTHER EXCEPTION.
   F. ALL ELSE - FORCE.

3. IF ABOVE DUP CRITERIA IS MET & THE DETAIL DATES OF SERVICE ARE THE SAME AS A DAY OF SERVICE WITHIN THE OVERLAPPING SPAN - FORCE UNLESS ANY OF THE FOLLOWING APPLY-
   A. 0252M - DENY EOB 910.
   B. 36415, (HANDLING OR DRAWING FEE) - DENY MORE THAN 1 EACH PER DAY. EXCEPTION, IF CLAIM INDICATES MULTIPLE GLUCOSE TESTS PEFORMED, FORCE MULTIPLE DRAWING FEES.

PHYSICIAN (J) VS PHSICIAN (J)

NOTE: SEE PAGE 1 BEFORE EXAMING A DUPE CLAIM.

THE FOLLOWING IS A LIST OF DEFINITION, EXPLANATIONS AND PROCEDURE FOR USE IN THE FOLLOWING TEXT.

REBILL: A CLAIM OR SERVICE THAT HAS BEEN PAID AND BILLED AGAIN IN ERROR, BILLED AGAIN BEFORE PAYMENT WAS MADE ON THE ORIGINAL BILLING, OR WAS PAID AND THE PROVIDER IS TRYING TO CHANGE SOMETHING.

CARBON: A CLAIM THAT IS IDENTICAL TO THE ORIGINAL AND IS USUALLY THE FOLLOWING CLAIM. THIS IS AN ERROR ON THE PROVIDERS PART AND SHOULD NOT BE CONFUSED WITH PROVIDER ATTEMPTING TO BILL FOR MULTIPLE SERVICES. (SOMETIMES YOU CANNOT CLARIFY)

INTERMEDIARY PROBLEM (EMC): CLAIMS THAT WERE SUBMITTED IN ERROR IN SAME JULIAN DAY (USUALLY CLAIM FOR CLAIM IN SEPARATE BATCHES OR POSSIBLY DIFFERENT DAYS). THIS IS USUALLY CAUGHT IN RESOLUTIONS SORT, BUT BEWARE OF ANY CONSISTENCY OF REPETETIVE CLAIMS.

DUP CHECK (1): IF (1) IN THE (DUP CHK) FIELD ON THE PDDD FILE IT OVERIDES THE 101 AND ALLOWS MULTIPLE SERVICES ON SAME CLAIM. IF NO DUP CHK (1) ON THE PDDD - DO NOT ALLOW MULTIPLE SERVICES UNLESS TEXT INDICATES TO DO SO.

PAYMENT PROCEDURE: MULTIPLE SERVICES ARE BOTH SUSPENDING - ALLOW THE HIGHER OF THE TWO, OTHERWISE - DENY CURRENT W/EOB 910.

ADDITIONAL SERVICES IDENTIFICATION:
(NOTE) THE FOLLOWING INFORMATION MAY BE USED ON A REBILL - SEE YOUR TRAINER.
1. CLAIM STATES "NOT A DUPE" OR HAS AN OVERCODE OF (444)

2. SEPARATE CLAIMS - 2 SERVICES ON HX CLAIM, 1 PAID, 1 DENIED AND 1 IS BEING REBILLED AND SHOULD BE PAID.
3. DUP CHK IS (1) ON PDDD, MONEYS/UNITS ARE DIFFERENT

EOB (111): USE INFO EOB 111 ON PAID LINE WHEN TWO SERVICES ARE BILLED AND ONE OF THE SERVICES WILL BE DENIED BECAUSE NO DISTINGUISHABLE MODIFIERS IE. (RT & LT) WERE USED.

MULTIPLE SERVICES: SERVICES THAT WERE PERFORMED MORE THAN ONCE AND THE PROVIDER HAS BILLED MULTIPLE LINES OR MULTIPLE CLAIMS.
1. (HARDCOPY) - CONSIDER MULTIPLE SERVICE ATTEMPT IF IN SAME BATCH AND CLAIM IS NOT A MIRROR IMAGE.
2. (ELECTRONIC) - CONSIDER MULTIPLE SERVICE ATTEMPT IF ANY CLAIM IN THE SAME JULIAN DATE AND:
   A. CLAIM IS CONSECUTIVE
   B. CLAIM IS NOT A MIRROR IMAGE

NOTE: IF UNABLE TO DETERMINE MULTIPLE/ADDITIONAL SERVICES OR A REBILL- DENY W/EOB 102. THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF FOLLOWING DUP CRITERIA IS THE SAME:
1. PIC CODE
2. PROVIDER NUMBER
3. SAME OR DUMMY PERFORMING PROVIDER NUMBER
4. OVERLAPPING DATES OF SERVICE
5. PROCEDURE CODE - 5 DIGIT MATCH ON ALL CODES EXCEPT (92002 - 92014, 90800 - 90899) WHICH ARE A 2 - DIGIT MATCH ONLY.

--IF ABOVE CRITERIA IS MET A 102 WILL POST TO THE CLAIM. IT MAY POST

AGAINST SAME CLAIM OR ANOTHER CLAIM.

1. IF CLAIM IS A REBILL - DENY. SEE FOLLOWING EXCEPTIONS:
   A. FQHC ENCOUNTER CODES:
      1. 9001M, 5900M OR T1015 W/MOD TH:
         NOTE: GLOBAL PROCEDURES - DELIVERY AND PRENATAL CARE ONLY
         (59400, 59410, 59425, 59426, 59610-59614, 59618, 59622,
          5951M-5955M)
         A. 101 IS FAILING ON BOTH THE PROCEDURE & THE ENCOUNTER - DENY.
         B. 101 FAILING ONLY ON THE ENCOUNTER:
            1. IF A DIFFERENT GLOBAL PROCEDURE CODE - FORCE.
            2. ALL ELSE - DENY W/EOB 910.
      2. 9006M OR T1015 BILLED BY PT 35- CLAIM LOOKS LIKE A REBILL &:
         A. 102 IS FAILING ON BOTH THE PROCEDURE & THE ENCOUNTER (9006M
            OR T1015) - IF DENYING THE PROCEDURE CODE, ALSO DENY THE
            ENOUNTER CODE.
         B. 102 IS FAILING ONLY ON THE ENCOUNTER 9006M - CHECK HISTORY,
            IF PROCEDURE WAS DIFFERENT - FORCE THE ENCOUNTER.
         C. 102 IS FAILING ONLY ON ENCOUNTER T1015 (PT 35) - DENY
            WITH EOB 910.
   B. RADIOLOGY BILLED W/DX V59.0-V59.9, CLAIM OR COMMENTS INDICATE
      DONOR OR NOT A DUPE - FORCE EVEN IF IT APPEARS TO BE A REBILL.
   C. LAB BILLED W/DX OF V59.0-V59.9, CLAIM COMMENTS INDICATES DONOR OR
      NOT A DUPE - FORCE MULTIPLES EVEN IF IT APPEARS TO BE A REBILL.
   D. PROV TYPE 73 - IF PROVIDER STATES "NOT A DUPE, DIFFERENT STAFF,
      DIFFERENT TIMES", NAME OF PERFORMING PROVIDER IS DIFFERENT, OR IF
      CLAIM OR ADJUSTMENT STATES "SERVICE IS IN ADDITION TO PREVIOUSLY
      BILLED SERVICES" - FORCE.

   E. INTERPRETER SERVICES - AMERICAN SIGN LANGUAGE (ASL) -
      PT40 WITH SPEC. 60 OR 63 -

      PRIOR TO 100103 FOR 0997M AND/OR 0998M AND
      100103 AND AFTER FOR T1013 AND/OR S0215 -IF DIFFERENT REFERRING
      PROVIDER, DIFFERENT DOCTOR'S NAME LISTED, COMMENT ANYWHERE ON
      CLAIM STATING "NOT A DUPLICATE" OR SOMETHING SIMILAR, COMMENT ON
      CLAIM STATING "SECOND APPOINTMENT" OR "TEAM INTERPRETING FOR ASL",
      OR 444 OVERCODE - FORCE. BJS

   F. BEFORE DENYING A CLAIM AS A REBILL, REVIEW THE MULTIPLE SERVICES
      SECTION. IN SOME INSTANCES, WHAT LOOKS LIKE A REBILL MAY BE AN
      ATTEMPT AT MULTIPLE SERVICES AND MAY BE FORCEABLE IF CERTAIN
      CRITERIA IS MET. (IE) DIFFERENT TIME NOTED,DIFFERENT ANTIGENS OR
      UNRELATED DX, ETC.

2. IF CLAIM IS AN INTERMEDIARY PROBLEM (EMC) CONTACT CLAIMS CONTROL,
   THROUGH YOUR SUPERVISOR.

3. IF CLAIM IS FOR MULTIPLE SERVICES - SEE FOLLOWING GUIDELINES.
   IF NOT OTHERWISE SPECIFIED, REMEMBER TO APPLY DUP CHK (1)
   CRITERIA, OTHERWISE DENY ADDITIONALS W/EOB 910. NOTE: X-OVER
   CLAIMS - YOU MAY NEED TO REVIEW THE EOMB TO SEE HOW MDCR PAID/DENIED
   BEFORE YOU MAKE YOUR DECISION FROM THE FOLLOWING TEXT.
   A. RADIOLOGY - (70002-79999, 7612M, R0070, R0075)

NOTE: WHEN DENYING RADIOLOGY BECAUSE MULTIPLE SERVICES ARE NOT ALLOWED, TIMES NOT INDICATED, OR LT/RT NOT INDICATED - USE EOB 111, EXCEPT MRI/MRA OR VASCULAR GRAPHIES/GRAMS.

1. MOD 76/O'CODE 222 - DO NOT DENY MULTIPLE SERVICES AS A DUPE - FORCE, UNLESS OTHERWISE ADDRESSED IN THIS TEXT, EXCEPT MRI/MRA/CT, VASCULAR GRAPHIES/GRAMS OR 72295.
2. CAT SCANS:
   A. DIFFERENT TIMES - FORCE.
   B. LT VS RT MOD - FORCE.
   C. 76375 W/MOD 76 - FORCE.
   D. ALL ELSE - DENY W/EOB 111.
3. MRI -
   A. DIFFERENT TIME SESSIONS - FORCE.
   B. LT VS RT MOD - FORCE.
4. PROCEDURE 78990 (PROVISION OF DIAGNOSTIC RADIOPHARMACEUTICAL) DONE FOR DIFFERENT TESTS - FORCE.
5. MEGAVOLTAGE (77401-77416 & 77419-77430):
   A. (77401 - 77416) DAILY TREATMENT DELIVERY - MULTIPLE TREATMENTS ARE PAYABLE ON THE SAME DAY IF CLAIM/COMMENTS/ OR BACKUP INDICATE A DISTINCT BREAK OF AT LEAST 6 HRS, OTHERWISE - PAY 1 & DENY ADDITIONLS W/EOB 910.
   B. (77419 - 77430) WEEKLY THERAPY MANAGEMENT - EACH CODE IS EQUAL TO 2 OR MORE TREATMENT SESSIONS & SHOULD BE COMPLETED IN 1 WK. MULTI SESSIONS IN 1 DAY MAY BE COUNTED IN THE TOTAL SESSIONS FOR THAT WEEK, BUT CAN ONLY BE BILLED ONCE PER WK. DENY ADDITIONALS W/EOB'S 910/339.
6. LOCALIZATION OF BREAST NODULE (76096) - ALLOW 2 (1 FOR EACH BREAST), DENY ADDITIONALS W/EOB 339.
7. ULTRASOUND ECHOGRAPHY/ULTRASONIC GUIDANCE
   A. YEAR 2003 FOR 76801-76828
      1. 76801, 76805, 76811, 76825, 76827 - PAY 1 AND DENY ALL OTHERS W/EOB 302 TO BILL "FOLLOW UP OR REPEAT STUDY" CODE.
      2. 76802, 76810, 76812, 76826, 76828 - PAY 1 PER EACH ADDTL FETUS (TWINS, TRIPLETTS, ETC) - DENY ALL OTHERS W/EOB 111.
      3. 76815, 76816, 76817, 76818, 76819 - ALLOW 1 PER EACH FETUS AND DENY ALL OTHERS W/EOB 111.
   B. YEAR 2001-2002 FOR 76805-76828:
      FETUS AND DENY ALL OTHERS W/EOB 302.
      1. 76805 BILLED MULTIPLES WITH DX/COMMENTS OF TWINS, TRIP-LETTS, ETC - DENY ALL W/EOB 302 TO BILL 76810 FOR MULTIPLE GESTATION UNDER ONE CODE.
      2. 76805 BILLED MULTIPLES FOR SINGLE FETUS - PAY 1 AND DENY ALL OTHERS W/EOB 302 TO BILL "FOLLOW UP OR REPEAT STUDY" CODE.
      3. 76810, 76815, 76818, 76819, 76825, 76827 - PAY 1 AND DENY ALL OTHERS W/EOB 302 TO BILL FOR "FOLLOW UP OR REPEAT STUDY" CODE.
      4. 76816, 76826, 76828 - PAY 1 FOR EACH ADDTL FETUS (TWIN, TRIPLETTS, ETC) AND DENY ALL OTHERS W/EOB 111.
8. RADIOLOGY BILLED W/DX (V59.0-V59.9) - CLAIM OR COMMENTS INDICATE DONOR OR NOT A DUPE - FORCE.
9. RT/LT MODS & MULTIPLE BODY PARTS - ALLOW 1 EACH. NOTE:

2 BILATERAL PROCEDURES (BY PDDD/CPT DESCRIPTION) DO NOT FALL INTO THIS CATEGORY - DENY W/EOB 324.
10. COMPARISON STUDIES - ALLOW 1 UNLESS TIME OR JUSTIFICATION IS STATED FOR ADDITIONALS, IE. (1 IN MORN & 1 IN AFTERNOON, X-RAY BEFORE REPAIR & X-RAY AFTER REPAIR)
11. ANY RADIOLOGY PROCEDURE WITH UNILATERAL DESCRIPTION AND CPT LISTS A BILATERAL CODE: IF BILLED ON MULTIPLE LINES, DENY ALL LINES WITH EOB 302.
12. MAMMOGRAPHY (76090) - IF BILLED ON MULTIPLE LINES, DENY ALL LINES W/EOB 302.
13. VASCULAR GRAPHIES/GRAMS ONLY (75600 - 75898)
A. DESCRIPTION IS UNILATERAL & NO BILATERAL CODE AVAILABLE PER PDDD/CPT - ALLOW 2 & DENY ALL OTHERS W/EOB'S 800/373.
B. DESCRIPTION IS UNILATERAL & BILATERAL CODE AVAILABLE PER PDDD/CPT - DENY ALL OF SAME CODE W/EOB 302.
C. DESCRIPTION IS BILATERAL - ALLOW 1 & DENY ALL OTHERS W/EOB'S 800/373.
D. ANY SITUATIONS OTHER THAN THE ABOVE - SEE TRAINER.
14. 72295 - DENY W/EOB 910.

B. LAB (80000-89999,8000M,8001M,8720M,0065M & 36415)
1. IF POS 1 - FORCE.
2. DRAWING/HANDLING FEES:
A. DRAWING FEE IS BILLED IN CONJUNCTION W/(82951 OR 82952) - FORCE.
B. CLAIM INDICATES RUNNING MULTIPLE GLUCOSE TESTS OR DX IS FOR DIABETES, IE(DX IS 250) - FORCE.
3. LAB BILLED W/DX OF V59.0-V59.9, CLAIM OR COMMENTS INDICATES DONOR OR NOT A DUPE -FORCE.
4. SAME TEST AND DIFFERENT TIMES INDICATED - FORCE.
5. 83018 - CLAIM INDICATES TEST RUN ON DIFFERENT SPECIMENS, IE. BLOOD, HAIR, URINE, SERUM -FORCE.
6. STAT CHARGES (8949M/S3600) ALLOW ONLY 1 PER DAY, ALL ALL OTHERS W/EOB 339.
7. MOD QR/91 OR O'CODE 221 - FORCE.
8. MOD 76 OR O'CODE 222 - DOES NOT APPLY TO LAB PROCEDURES

C. MISCELLANEOUS:
ALLOW SPECIFIC LIMITS FOR THE FOLLOWING PROCEDURES.
1. SPEECH THERAPY (92507 OR 92508) ALLOW 1 PER DAY.
2. ELECTROCARDIOGRAPHY (9301M-9303M) - FORCE.
3. SLEEP STUDIES (95819-95830 & POS IS 1 - FORCE.
4. EYE SERVICES:
A. 92225 - SEE 061 AUDIT.
B. DUP CHECK ON PDDD FILE - FORCE.
C. "Y" IN BI-SURG FIELD OR DESCRIPTION OF BI-100% - PAY UP TO 2 - DENYING ALL OTHERS W/EOB 339.
D.ALL ELSE:
1. DESCRIPTION OF UNILATERAL - DENY W/EOB 111.
2. ALL ELSE - ALLOW 1, DENY ADDITIONAL W/EOB 324.
5. AUDIOMETRIC TESTS (92551-92599) ALLOW 1, DENY ADDITIONAL TESTS W/EOB 324.
6. CRITICAL CARE (99291/99292) & PROLONGED SERVICES (99355/

99357)
A. CRITICAL CARE:
99291 - PAY ONE, DENY ADDITIONALS W/EOB 302.
99292 - PAY UP TO 4, DENY ADDITIONALS W/EOB 339.
B. PROLONGED SERVICES:
99354/99356 - PAY 1, DENY ADDITIONALS W/EOB 302.
99355/99357 - PAY UP TO 4, DENY ADDITIONALS W/EOB 339.

7. IMPRESSION CASTING (1602L) - ALLOW 2, 1 FOR EACH FOOT, DENY ADDITIONALS W/EOB 339. IF 2 1600L'S - DENY BOTH W/EOB 302, PROVIDER SHOULD BE BILLING 1601L FOR THE PAIR.
8. FLU IMMUNIZATION (90724) ALLOW MULTIPLES IF DIFFERENT STRAINS.NOTE: IF 90724 BILLED IN COMB W/90657-90660 - DENY 90724 W/EOB 365.
9. SURGICAL ASSISTANT (MOD 80,81 OR 82) - ALLOW 1 PER SURGERY, DENY ADDITIONALS W/EOB 366.
10. SERVICES W/DX OF MULTIPLE BIRTHS (V31-V37):
A. IDENTIFIED - FORCE AND OVERCODE APPROPRIATELY
B. UNIDENTIFIED - DENY W/EOB 779 AND OVERCODE 886
11. CLAIM INDICATES PATIENT IS ON A VENTILATOR OR MOD 76 IS BILLED (94010-96462,94652,94660-94662,94680-94750, 94770-94799) - FORCE.
12. VARIOUS INITIAL PROCEDURES - 30905,31645,33010,46940,49080 53600,53620,53660,61000,92225,93561,94650,94656,94664, 94667 - PAY 1 - SEE 061 AUDIT.
13. ANTIGENS:
A. 95125 - PT 93 - DIFFERENT ANTIGENS -FORCE
B. 95117,95125,95144-95199- PT OTHER THAN 93 - FORCE.
14. STERILE TRAY - (A4550) - IF COMMENT/DESCRIPTION INDICATES CVC OR IV TRAY - ALLOW 1 OF EACH
15. CASTING/SPLINTING/BRACES - ALLOW 2 IF LT & RT IS INDICATED.
16. IV INFUSION:
A. 90780 - ALLOW 1, DENY ADDTIONALS W/EOB'S 302/158.
B. 90781 - ALLOW UP TO A MAX OF 8, DENY ADDITIONALS W/EOB 339.
17. SPECIAL HANDLING (9018M) OR SPECIAL MAILING (9019M) FAILING AGAINST EACH OTHER OR ANY OTHER 90---SERIES - FORCE.
18. CRITICAL CARE (99291-99292) (DO NOT USE-AUDIT PURPOSES ONLY)
A. C.C. VS C.C - PAY 1, DENY CURRENT CLAIM W/EOB 825.
B. C.C. VS ADMIT - FORCE.
C. C.C VS ANYTHING ELSE -
1. UNRELATED DX - FORCE, EXCEPT FOR NICU
2. OTHERWISE, PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 825. IF HX IS PAID, DENY OR RECOUP & DENY THE LESSER W/EOB 825.
19. INTRAOCULAR LENS (V2630, V2631, V2632) - ASSUME 1 FOR LEFT AND 1 FOR RIGHT - FORCE.
20. CHEMOTHERAPY INFUSION:
A. 96410 - PAY 1, DENY ADDITIONALS W/EOB'S 302/158.
B. 96412 - ALLOW TO A MAX OF 7 UNITS, DENY ADDITIONALS W/EOB 339.
C. 96414 - PAY 1, DENY ADDITIONALS W/EOB 339.

21. IMUNIZATION ADMINS (90471 OR 90472)
    A. BILLED IN COMBO W/EACH OTHER:
       1. PRIOR TO 7/1/00 DOS - DENY W/EOB 910.
       2. 7/1/00 DOS & AFTER - ALLOW 1 EACH PER SESSION.
    B. BILLED IN COMBO W/VACCINES (90476-90749) & THERE IS OR SHOULD BE A MOD 1H/SL ON ALL OF THE VACCINES ON THE CLAIM - DENY THE ADMIN W/EOB 365.
    C. IF THERE IS AT LEAST 1 VACCINE THAT DOES NOT REQUIRE THE MOD 1H/SL - FORCE THE ADMIN.
22. VACCINES/IMMUNOGLOBULINS (90281-90470, 90473-90699 POSTING AGAINST EACH OTHER - FORCE.
23. MIFEPRISTONE/MISOPROSTOL (RU-486)
    A. S0190 - ALLOW UP TO 3, DENY ALL OTHERS W/EOB 339.
    B. S0191 - ALLOW UP TO 2, DENY ALL OTHERS W/EOB 339.
24. DOPPLER COLOR FLOW VELOCITY MAPPING (93325) - BILLED IN COMBO W/(76825-76828), ALLOW 1 FOR EACH FETUS.
25. 95860-95875:
    A. 95860-95863, 95867 - DENY ALL BILLED W/EOBS 302/158.
    B. 95864 AND 95868-95870 - DENY MULTIPLES W/EOB 324.
    C. 95875 - DENY, UNLESS JUSTIFICATION OF SEPARATE LIMBS.

26. MSS/ICM - PT 35 (0400M-0405M, 0420M & 0421M)
    DATES OF SERVICE 9/30/03 & BEFORE - ALLOW 1 PER DAY.
    DATES OF SERVICE 10/1/03 & AFTER - ALLOW MULTIPLES.
    NOTE: ALLOW MULTIPLES ON T1017 W/MOD HD AS OF 10/1/03.

27. FQHC ENCOUNTER CODES:
    A. 9000M, T1015 J(PHYS) VS L(EPSDT) - ALLOW 1 PER DAY, DENY ADDITIONALS W/EOB 910. FORCE 553 EXC ON E&M WHEN IT FAILS ONCE THE ENCOUNTER CODE HAS BEEN DENIED, UNLESS DENYING THE E&M FOR ANOTHER EXCEPTION.
    B. 9001M, 5900M & T1015 W/MOD TH

NOTE: GLOBAL PROCEDURE CODES - DELIVERY AND PRENATAL CARE ONLY (59400,59410,59425, 59426, 59610-59614, 59618, 59520, 59622, 5951M-5955M).

1. MULTIPLE LINES OF FQHC ENCOUNTER CODE BILLED WITH ANY GLOBAL PROCEDURE CODE ON SAME DOS - FORCE ALL FQHC ENCOUNTER CODES.
2. FQHC ENCOUNTER CODE BILLED WITH GLOBAL PROCEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH DIFFERENT GLOBAL PROCEDURE CODE - FORCE.
   EXCEPTION: AS OF 10/01/03 DATES OF SERVICE FORWARD, (T1015 W/MOD TH) - DENY W/EOB 910.
3. FQHC ENCOUNTER CODE BILLED WITH GLOBAL PROCEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH SAME GLOBAL PROCEDURE CODE - DENY MULTIPLE FQHC ENCOUNTER CODE W/EOB 910.
4. FQHC ENCOUNTER CODE BILLED WITH GLOBAL PROCEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH NON-GLOBAL PROCEDURE CODE - DENY MULTIPLE FQHC ENCOUNTER CODE BILLED WITH THE NON-GLOBAL PROCEDURE CODE W/EOB 910.
5. FQHC ENCOUNTER CODE BILLED WITH NON-GLOBAL PRO-CEDURE CODE VS FQHC ENCOUNTER CODE BILLED WITH SAME OR DIFFERENT NON-GLOBAL PROCEDURE CODE -

DENY MULTIPLE FQHC ENCOUNTER CODES W/EOB 910.
6. FQHC ENCOUNTER CODE PAID IN HX WITH A NON-GLOBAL PROCEDURE CODE VS CURRENT FQHC ENCOUNTER CODE WITH MULTIPLE UNITS BILLED WITH GLOBAL PROCEDURE CODE - PAY CURRENT FQHC ENCOUNTER CODE WITH GLOBAL PROCEDURE CODE THEN REC AND DENY HX FQHC ENCOUNTER W/EOB 339.

ANY QUESTIONS SEE SUPV/TRAINER/MMIS

C. 9006M OR T1015 BILLED BY PROV TYPE 35:
1. DIFFERENT FEE FOR SERVICE PROCEDURE ON SAME DOS, ALLOW 1 9006M PER EACH FEE FOR SERVICE PROCEDURE. OTHERWISE, DENY W/EOB 910.
2. T1015 FOR DATE OF SERVICE 10/01/03 & AFTER, DENY WITH EOB 910.

D. SURGERIES (10000-69999,92975-92984,92986-92998,93501-93533, 0001T-0002T,0005T-0009T,0012T-0014T,0016T-0017T)
NOTE: IF 053,087 NOT POSTING - O'LOC TO 36.
NOTE: IF NOT LISTED BELOW AND 053 EXC POSTING - O'LOC TO 36.
1. MULTIPLE DIAGNOSTIC, THERAPEUTIC, SELF-LIMITING OR UNILATERAL PROCEDURES DONE BILATERALLY - FORCE. UNILATERAL PROCEDURES DONE BILATERALLY & PER ANATOMY ONLY 2 ALLOWED - PAY UP TO 2 - DENY ALL OTHERS W/EOB 800/589.
2. MOHS SURGERY(17304-17310) - FORCE MULTIPLES AT SAME OP SESSION PER DR. NICOLAUS. EXCEPTION: CLAIM OR REPORT INDICATES SAME TUMOR - DENY W/EOB 302.
3. CRYOTHERAPY (17340) - ALLOW 1 PER DAY
4. DESTRUCTION OF LESIONS (17100-17104) SEE 053
5. X-OVER SURGERY CLAIMS (MOD LT/RT) - SEE 368 EXCEPTION (MOD 50) FOR PRICING.

E. INDIAN HEALTH (PT 15) -
1. 5999M - ALLOW ONE MEDICAL CALL AND ONE DENTAL CALL PER DAY. IF THEY BILL MORE THAN ONE MEDICAL CALL OR ONE DENTAL CALL PER DAY - DENY WITH EOB 339.
EXCEPTION - IF EMERGENCY AND DIFFERENT DX ON SAME DAY, A SECOND ENCOUNTER IS ALLOWED.
2. 5988M - ALLOW ONE PER DAY. IF MORE THAN ONE BILLED - DENY 339
EXCEPTION - IF EMERGENCY AND DIFFERENT DX ON SAME DAY, A SECOND ENCOUNTER IS ALLOWED.

F. THERAPIES, AUDIOLOGY & VARIOUS TESTING PROCEDURES BILLABLE BY PROVIDER TYPES 18 20 36 37 40 93:
1. (0701M) OCCUPATIONAL THERAPY INIT. 30 MIN-IF BILLING SPANS OF DATES WITH 1 UNIT, DENY W/EOB'S 910/417, ALL ELSE DENY 910.
2. (0002M)-CUSTOM SPLINTS-ALLOW 2, DENY ADDITIONALS W/EOB 339.
3. 92543 - ALLOW 1 UNIT PER IRRIGATION, UP TO 4 UNITS FOR EACH EAR. PAY UP MAX OF 8 W/EOB 101. DENY ALL OTHERS W/EOB 339.
4. 92546 - ALLOW 1 UNIT PER VELOCITY/PER DIRECTION, UP TO 3 UNITS FOR EACH DIRECTION. DENY ADDITIONAL W/EOB 339.
5. 97504 - ALLOW MAX OF 2 PER DAY W/INFO EOB 101, & FORCE 102 EXCEPTION. DENY ADDITIONAL W/EOB 339.
6. 97703 - ALLOW MAX OF 2 PER DAY W/INFO EOB 101, & FORCE 102 EXCEPTION. DENY ADDITIONAL W/EOB 339.

7. 97803 - ALLOW UP TO 4 PER DAY. DENY ALL OTHERS W/EOB 339.
8. 97804 - DOS PRIOR TO 7/1/02: ALLOW 2 PER DAY. DENY ALL OTHERS W/EOB 339.
DOS 7/1/02 AND AFTER: ALLOW 4 PER DAY. DENY ALL OTHERS W/EOB 339.

G. AMBULATORY SURGERY CENTER (PT 22) - FORCE MULTIPLE SERVICES.
--0501L -PAY MULTIPLES AS JUSTIFIED BY REVIEW OR REPORTS, INVOICES (W/SHIPPING, TAX AND 2ND EOB 552), OR OTHER BILLINGS ON CLAIM. IF UNCERTAIN - ROUTE TO CHRISTINE C/MMIS REVIEW/45564.
--NOTE: IF 053 EXCEPTION NOT POSTING - SEE YOUR SUP.
FYI: PROSTHETIC DEVICES, COLLAGEN IMPLANTS, COCHLEAR IMPLANTS, INTRAOCULAR LENSES, OR CORNEAL PROCESSING DO NOT POST 053.

H. ANESTHESIA SERVICES (00100 - 01999 OR 5911M - 5915M) PT 48/49-
- O'LOC TO 12.

I. SCHOOL SERVICES (PT 58)
(0110S - 0170S) - FORCE, EVEN IF IT APPEARS TO BE A REBILL.
NOTE: (0110S - 0150S) - IF HX LINE PAID AT $0.00 - O'LOC TO 83.

J. INTERPRETER SERVICES - AMERICAN SIGN LANGUAGE (ASL) ONLY - PT 40
SPEC. 60 OR 63 - PRIOR TO 100103 - 0997M AND/OR 0998M OR
100103 AND AFTER - T1013 AND/OR S0215 - IF CLAIMS ARE WITHIN
SAME JULIAN DATE - FORCE. BJS

K. COMMUNITY MENTAL HEALTH (PT 73) - 9701M - FORCE.

L. SUBSTANCE ABUSE (PT 75-INTAKE PROCESSING, GROUP THERAPY OR CASE MANAGEMENT)
1. 0159M - THROUGH DOS 6/30/03 - FORCE. DENY AS OF 7/1/03.
2. 0155M, 0156M - AS OF 7/1/03 FORWARD - FORCE.
3. 0143M, 0153M, 95155 W/MODIFIER HF OR HZ - AS OF DOS 10/01/3 FORWARD - FORCE.
4. 0141M, 0149M, 0151M, 0161M, 0169M, 0341M, 0369M, 2131M, 2135M, 2141M, 2149M, 2151M, 2159M, 2165M, 2166M, 2171M, 2179M, 2182M, 2185M, 2189M, & 2195M - FORCE ANY DOS.
5. DENY ALL OTHER PT 75 (DASA) CODES.

M. RURAL HEALTH (PT 88) - ALLOW ONE, DENY OTHERS W/EOB 910.

N. ER CALLS VS ER CALLS (99281-99285)
1. UNRELATED DX - FORCE
2. TIMES INDICATED - FORCE

O. CALLS (99201-99285, 99341-99353,99231-99239,99301-99333,90801-90871, 9011M-9014M,9020M,9083M,9084M-9089M,0252M, ADMITS (99221--99223), CONSULTS (99241-99263) AND PROLONGED SERVICES (99354, 99356)
1. ADJ/RES ONLY - IF UNRELATED DX AND CLAIM SPECIFICALLY INDICATES DIFFERENT TIMES OR HAS JUSTIFICATION FOR 2 CALLS-FORCE, EXCEPTION: PSYCH, SEE BELOW.
2. PSYCH PROCEDURE VERSUS PSYCH PROCEDURE (908XX) SEE EXCEPTION 015.
3. ADMITS/PSYCH EVALUATIONS/THERAPY VS COURT TESTIMONY (9085M-

9087M) - FORCE.
4. PSYCH EVAL (90801,90802 VS 9089M) - FORCE.
5. ADMIT & PSYCH EVAL (9084M) VS PSYCHIATRIC ITA PHYSICAL EXAM (9083M) - FORCE.
6. ADMIT VS ADMIT (99221-99223), INCLUDING CODES (99201-99215 IN POS 2) - FORCE IF UNRELATED DX, OTHERWISE PAY 1 PER PATIENT PER DAY - DENY CURRENT W/EOB 181 IF HX IS PAID. EXCEPTION: HOSP/CLINICS DOING DIAGNOSTIC WORKUP FOR CHILDREN IE (AUP/COH/CHILDRENS UNIV MED GRP)- BILLING (99201-99215) IN COMBINATION (POS 2) - FORCE.
7. ITA PHYSICAL EXAM (9083M) VS PSYCH EVAL (90801,90802,90820)- FORCE.
8. HOSPITAL DISCHARGE (99238/99239) VS NURSING FACILITY (99301-99333) - FORCE.
9. HOSPITAL CALLS (99231-99239) BILLED BY AN ANESTHESIOLOGIST- (PT 48/49) - PAY UP TO 2 ON SAME DAY, DENY ALL OTHERS W/EOB 757.
10. TB TREATMENT SERVICES (9011M, 9012M) VS AIDS COUNSELING SERVICES (9020M) - FORCE.
11. ER (99281-99285) VS ADMIT (99221-99223) AND CLAIM/COMMENTS INDICATE "PHYSICIAN/DR IN CHARGE ADMITTED CLIENT - FORCE.
12. AIDS COUNSELING (9020M) PAY 2 (1 FOR PRE AND 1 FOR POST), DENY ADDITIONALS.
13. CONSULTS (99241-99245) VS ER (99281-99285) - FORCE.

4. IF PROCEDURES POSTING AGAINST EACH OTHER ARE NOT THE SAME CATEGORY, (IE) CALL (9020M) VS IMMUNIZATION (9069M), PSYCH CALL (90807) VS MED MANAGEMENT (90862) - FORCE.

TEXT KEY TEXT DESC

103 POSSIBLE CONFLICT - IF THE CLAIM IN HISTORY WAS PAID AT $0.00 OR IS TO BE PAID AT $0.00 - FORCE.

EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) FOR QRS/PIP AND CAMERA/REEL # IS (77) - SEE YOUR SUP BEFORE PROCESSING.

--IF SUSPENDED CLAIM OR HISTORY CLAIM IS A HOSPICE PROVIDER (PT 63) OVERLOC SUSPENDED CLAIM TO LOC 67.

--MED VENDOR (P) AND MED VENDOR X-OVER (O) - SEE PAGE 16

--DENTAL (K) VS. DENTAL (K)
1. THIS EXCEPTION WILL POST ON DETAIL IF FOLLOWING DUP CRITERIA IS MET ON EACH CLAIM:
   A. PIC CODE
   B. OVERLAPPING DATES OF SERVICE
   C. PROCEDURE CODE
   D. TOOTH #
   E. TOOTH SURFACE
2. IF ABOVE DUP CRITERIA IS MET & THE PROCEDURE IS NOT FILLING OR EXTRACTING THE SAME TOOTH - FORCE.
3. DIFFERENT PROVIDERS - STAGE IF IT APPEARS TO BE A DUPLICATE - DENY.

HOSPITALS - GENERAL INFORMATION

1. CONSECUTIVE ICN'S - STAGE
2. IF CLAIM STATES "DONOR CHARGES" - FORCE.
3. BABY ON PARENTS PIC VS CLAIM FOR PARENT -- FORCE.

DRG (R) VS INPATIENT (S) OR "S" VS "R"
1. CLAIMS APPEAR TO BE TRANSFERS AND DATE OF DISCHARGE/ADMIT DATE OVERLAP - FORCE.

2. OVERLAPPING DATES OF SERVICE - STAGE. VERIFY DAYS BILLED. IF NOT BILLING DUPLICATE DAYS - FORCE. IF BILLING DUPLICATE DAYS OR UNABLE TO DETERMINE DAYS BILLED - DENY.

3. SAME DATES OF SERVICE - DETERMINE APPROPRIATE CLAIM TYPE. DENY/RECOUP AS NECESSARY.

4. MOMS CLAIM AGAINST BABYS CLAIM - FORCE.

DRG (R) VS OUTPATIENT (M) OR "M" VS "R"
1. DIFFERENT PROVIDERS - IF SERVICE ON ADMIT OR DISCHARGE DATE - FORCE.

2. KIDNEY CENTERS OR KIDNEY DIALYSIS SERVICES - FORCE.

3. SAME PROVIDER - IF PROVIDED WITHIN 24 HOURS OF ADMIT OR DISCHARGE - DENY OR RECOUP OUTPATIENT CLAIM WITH EOB 504.

4. DRG VS OUTPATIENT PT 44 (HOME HEALTH) - IF HOME HEALTH DATES OF

SERVICE ARE OUTSIDE OF THE DRG DATE SPAN, FORCE THE HOME HEALTH CLAIM.
ANY OTHER PROVIDER - IF PROVIDED DURING A HOSPITAL STAY (OTHER THAN KIDNEY DIALYSIS) DENY OR RECOUP OUTPATIENT CLAIM W/EOB 504.

5. ANY PROVIDER - IF MOM'S CLAIM AGAINST BABY'S CLAIM - FORCE.

OUTPATIENT (M) VS OUTPATIENT (M)

1. KIDNEY CENTERS OR KIDNEY DIALYSIS SERVICES - FORCE
2. HOME HEALTH (PT 44) - DENY.
3. DIFFERENT PROVIDERS W/DIFFERENT DOLLAR AMOUNTS-FORCE. OTHERWISE DENY.

4. SAME PROVIDERS:

A. IF SUSPENDED CLAIM APPEARS TO BE AN ADJUSTMENT - DENY, GIVE 189 AS AN INFORMATIONAL EOB IN THE SECOND SLOT.
B. CLAIMS APPEAR TO BE DUPLICATES - VERIFY HOUR OF CARE (HOUR 00 CONSIDER HOUR NOT GIVEN). IF DIFFERENT HOURS - FORCE. IF SAME, DENY WITH EOB 041. IF HOUR NOT GIVEN DENY WITH EOB 595.
C. IF CLAIM INDICATES "LATE CHARGES" "NOT A DUP" OR "SEEN TWICE IN SAME DAY" - FORCE. (OVERCODE 444).
D. IF THE PROVIDER IS BILLING DIFFERENT THERAPY REVENUE CODES (42X/43X/44X/47X) ON DIFFERENT CLAIMS - FORCE. *SR
E. OUT-OF-STATE - STAGE TO VERIFY CHARGES/REVENUE CODES -IF DIFFERENT HOUR OF CARE (HOUR 00, CONSIDER HOUR NOT GIVEN) OR LATE CHARGES - FORCE. OTHERWISE DENY WITH EOB 041.

INPATIENT X-OVER (V) VS INPATIENT X-OVER - DIFFERENT PROVIDERS
1. DISCHARGED AND READMITTED ON THE SAME DAY, CLAIMS APPEAR TO BE TRANSFERS - FORCE
2. OVERLAPPING OR SAME DATES OF SERVICE - DENY.

DRG (R) VS INPATIENT X-OVER (V) OR "V" VS "R".
DENY DRG CLAIM WITH APPROPRIATE EOB (918/937).

INPATIENT (S) VS IN-PT X-OVER (V) OR "V" VS "S"
IF INPATIENT CLAIM IS BILLING MEDICARE NON-COVERED SERVICES (SEE 259 TEXT FOR LIST OF MEDICARE NON-COVERED SERVICES) FORCE. OTHERWISE DENY INPATIENT CLAIM WITH APPROPRIATE EOB (918/937)

DRG (R) VS OUTPATIENT X-OVER (W) OR "W" VS "R".
1. SAME PROVIDER - DENY WITH EOB 504 & SEND DEAD WORKSHEET TO DUS/MRS, 5510, AUDREY FINNIGAN.
2. DIFFERENT PROVIDERS - ADMIT OR DISCHARGE DATE OVERLAP - FORCE.
3. OTHERWISE DENY OR RECOUP X-OVER WITH EOB 504.

INPATIENT (S) VS OUTPATIENT X-OVER (W) OR "W" VS "S",
SAME OR DIFFERENT PROVIDERS - IF INPATIENT CLAIM DOES NOT INCLUDE PART B CHARGES (SEE TEXT 259 FOR LIST) - FORCE. IF PART B CHARGES INCLUDED - DENY WITH EOB 292 & SEND DEAD WORKSHEET TO DUS/MRS, MS 5510 AUDREY FINNIGAN. ("S" VS "W") IDENTIFIES THAT MEDICARE PART B IS AVAILABLE AND SHOULD BE BILLED TO MEDICARE OR A DENIAL IS NECESSARY TO INCLUDE AS PART OF INPATIENT CLAIM.

OUTPATIENT (M) VS INPATIENT X-OVER (V) OR "V" VS "M" - IF OP CLAIM IS FOR MEDICARE NON-COVERED SERVICES OR HAS MEDICARE DENIAL ATTACHED - FORCE. IF NO INDICATION ON CLAIM - DENY WITH EOB 918.

OUTPATIENT (M) VS OUTPATIENT X-OVERS (W) OR "W" VS "M".
IF SERVICES ARE LISTED IN THE 261 TEXT AS NOT COVERED BY MEDICARE- FORCE. OTHERWISE DENY WITH EOB 918.

1.IF OUTPATIENT CLAIM IS FOR A KIDNEY CENTER BILLING NON-COVERED CHARGES
  A. REVENUE CODES 260, 303, 304, 825, 835, 845, 855, 880, 881, & 889 - FORCE
  B. ALL ELSE - DENY WITH EOB 918.

2.KIDNEY CENTERS/OH DIALYSIS - PHARMACY REVENUE CODE 250
  A. IF CLAIM IS FOR DIALYSIS, RENAL OR KIDNEY PATIENT
     1. DATES OF SERVICE PRIOR TO 010194 - FORCE.
     2. DATES OF SERVICE AFTER 123193 - DENY WITH EOB 918.
  B. IF CLAIM IS NOT FOR DIALYSIS,RENAL OR KIDNEY PATIENT-DENY 918.

3. IF OUTPATIENT CLAIM OF LESS THAN 24 HOURS SAYS NO PART A IT'S BECAUSE MEDICARE HAS NO 24 HOUR RULE, AND CONSIDERS IT INPATIENT. IF PART B CHARGES INCLUDED ON OUTPATIENT CLAIM, DENY. IF NO PART B CHARGES, FORCE. IF IN QUESTION - STAGE.

4. IF OUTPATIENT CLAIM IS FOR WEIGHT LOSS PROGAM (OBESITY) OR WEIGHT LOSS PROGRAM PROVIDER # - FORCE.

OUTPATIENT (M) VS INPATIENT (S) OR "S" VS "M"
1. DIFFERENT PROVIDER -
   A. IF SERVICE ON ADMIT OR DISCHARGE DATE - FORCE.
   B. CAT SCANS & MRI'S - CHECK CLAIMS AGAINST EACH OTHER
      1. IF DUPS (SAME REV. CODE VS. REV. CODE OR REV CODE VS. PROCEDURE CODE) - DENY.
      2. IF NOT DUP - FORCE.
2. KIDNEY CENTERS OR KIDNEY DIALYSIS SERVICES - FORCE.
3. SAME PROVIDER - IF PROVIDED WITHIN 24 HOURS OF ADMIT OR DISCHARGE - DENY OR RECOUP OUTPATIENT CLAIM WITH EOB 515.
4. ANY PROVIDER -
   A. IF PROVIDED DURING A HOSPITAL STAY - DENY OR RECOUP OUTPATIENT CLAIM WITH EOB 515.
   EXCEPTION: WHEN INPATIENT CLAIM IS FOR CUP SERVICES (REV CODE 168) (REV CODE 168) VS. OUTPATIENT (M) CLAIM - FORCE.
   B. IF MOMS CLAIM AGAINST BABY'S CLAIM - FORCE.

INPATIENT (S) VS INPATIENT (S) APPLY APPROPRIATE CRITERIA FOR R VS R SITUATIONS ALSO.
1. DISCHARGE AND READMITTED ON THE SAME DAY, CLAIMS APPEAR TO BE TRANSFERS - FORCE.
2. OVERLAPPING OR SAME DATES OF SERVICE - STAGE. VERIFY DATES BILLED. IF UNABLE TO VERIFY DENY.
3. CLAIM APPEARS TO BE FOR LATE CHARGES -IF SAME PROVIDER NUMBER, FORCE. IF DIFFERENT PROVIDER NUMBERS, DENY. (IF FOR LATE CHARGES THEY NEED TO BILL USING THE SAME PROVIDER NUMBER OF THE ORIGINAL BILLING.)

4. BABY (BILLED ON MOTHER'S PIC, ONLY UNTIL AGE 1) DUPING AGAINST MOM'S CLAIM - FORCE. OVER AGE 1 - DENY.
5. DETOX CENTER (PROVIDER SPECIALTY 93) VS DETOX CENTER - IF ADMIT/ DISCHARGE DATE OVERLAP - FORCE. OTHERWISE - DENY.
6. DETOX CENTER VS INPATIENT HOSPITAL CLAIM
   A. ADMIT/DISCHARGE DATE OVERLAP - FORCE
   B. IF DATES OVERLAP-STAGE.VERIFY DATES BILLED.IF UNABLE TO VERIFY DENY.

INPATIENT (S) OR DRG (R) VS NURSING HOME (T)
1. ADMIT/DISCHARGE DATE OVERLAP
   A. CLAIMS FROM NH TO HOSPITAL OR HOSPITAL TO NH - FORCE.
   B. ADDITIONAL DAYS OVERLAP - FORCE HOSPITAL CLAIM AND RECOUP DUPLICATE DAYS FROM NURSING HOME. ATTACH WORKSHEET TO ADJUSTMENT REQUEST AS BACK-UP.
2. CLAIM INDICATES "SWING BED AT ICF LEVEL" OR IS FOR ANCILLARY CHARGES ONLY AND NH PROVIDER NUMBER BEGINS WITH "42";
   A. DRG'S (R): DENY 333 AND REPROCESS IN AN 'S' BATCH.
   B. INPATIENT (S): FORCE.

(T) NURSING HOME VS. (T) NURSING HOME
1. DIFFERENT PROVIDERS
   A. NH (T) VS. NH (T)
      1. IF CLAIMS APPEAR TO BE TRANSFERS AND THE DATE OF DISCHARGE AND DATE OF ADMIT OVERLAP - FORCE.
      2. OVERLAPPING OR SAME DATES OF SERVICE STAGE.
         A. CLAIM HAS VALID AWARD LETTER - FORCE. RECOUP DAYS FROM DISCHARGING NH.
         B. OTHERWISE DENY USING EOB 492 IN THE SECOND SLOT.
   B. NH (T) VS. INPATIENT (S) OR DRG (R)
      1. CLASS 26 (SWING BED) AGAINST INPATIENT CLAIM (ANCILLARY CHARGES ONLY) - FORCE.
      2. CLAIMS APPEAR TO BE TRANSFERS, AND DATE OF DISCHARGE AND DATE OF ADMIT OVERLAPS - FORCE
      3. OVERLAPPING OR SAME DATE OF SERVICE - DENY.
2. SAME PROVIDER - DENY WITH EOB 189. CHANGE RECIPIENT FILE TO MATCH PAID CLAIM IN HISTORY.
3. IF NONE OF THE ABOVE APPLY - DENY.

PHYSICIAN (J) VS. PHYSICIAN (J) &
PHYSICIAN (J) VS. MEDICARE X-OVER (O) TOS 3 OR Z

NOTE: CLAIM IN HX PAID AT $0.00 OR IS TO BE PD AT $0.00 - FORCE.
EXCEPTION: CLAIM IN HX IS HX ONLY ADJ (BATCH RANGE 953-957) AND DETAIL LINE PROCEDURE/MONEY/UNTIS ARE EXACT MATCH:
1. CARRIER CODE ON HX CLAIM IS (1111) - FORCE.
2. ADJ-REASON (ADJ-R) IS "E" - FORCE.
3. OTHERWISE - DENY W/EOB 830.

(J) VS (J)

1. IF 2 DIFFERENT PROV BILL THE FOLLOWING CODES FOR MOD 26 AND BLANK MOD IN COMBINATION - FORCE. REASON: THE TECH (TC) SEGMENT HAS BEEN REMOVED FROM PAYMENT FIELD ON PDDD AND BILLING THE BLANK MOD PROCEDURE IS THE ONLY WAY THEY CAN RECEIVE THE TECHNICAL PORTION. (83020, 83912, 84165, 84181, 84182, 85390, 85576, 86255, 86256, 86320

86325, 86327, 86334, 87164, 87207, 88151, 88157, 88371, 88372, 89060)

2. PT 43 VS PT 43 - FORCE IF DIFFERENT PROVIDER, PER MED CONSULTANT.

(EXCEPTION PROV # 7097793 VS PROV # 7063852)- DENY SUSPENDED CLAIM W/EOB'S 280/544. IF BOTH SUSPENDED, PAY 7097793 & DENY 7063852.

(EXCEPTION MOD 90) LAB WAS SENT TO A REFERENCE LAB.
A. IF HX PD W/MOD 90 - DENY CURRENT.
B. IF CURRENT BILLED W/MOD 90 - FORCE AND R/DENY HX CLAIM W/EOB 280.
C. IF BOTH CLAIMS ARE SUSPENDING - PAY THE CLAIM W/MOD 90 AND DENY THE OTHER CLAIM.

NOTE: THE OBJECT IS TO PAY THE MOD 90 OVER ANOTHER PROVIDER BILLING.

3. PT 43 VS ANY OTHER PT OR ANY OTHER PT VS 43
A. ALWAYS FORCE THE PT 43.
B. IF OTHER PROV TYPE STATES (HE IS PROV OF SERVICE) - FORCE AND OVERCODE W/318 IF CURRENT. DO NOT RECOUP. ROUTE DEAD CLAIM OR WORKSHEET TO LINDA AYERS/DMM/MPMU/45506 INDICATING LAB PAID & PHYSICIAN INDICATING "HE IS PROVIDER OF SERVICE".

NOTE: INDICATE ON THE WORKSHEET THE PROVIDER NUMBER, NAME, ADDRESS, AND PHONE # FOR BOTH THE CURRENT CLAIM AND HX CLAIM, CLIENT NAME, DOS & A BRIEF NOTE INDICATING BOTH PROVIDERS CLAIM THEY ARE PROVIDER OF SERVICE. ALSO INDICATE,ANY QUESTIONS CALL SANDY A/MMIS/360 7251133.

C. OTHER PT- CHECK PERF PROV - IF PT 43 OR SPECIALITIES ARE 22 OR 69 - FORCE.
D. ALL ELSE - DENY W/EOB 318 OR R/D W/EOB 318.

4. ALL OTHER PT VS ALL OTHER PT
A. IF ONE OF THE PROV STATE (HE IS PROV OF SERVICE) - FORCE AND OVERCODE W/318.
B. ALWAYS CHECK PERF PROV ON BOTH. IF PERF PROV IS PT 43 OR SPECIALTIES ARE 22 OR 69 ON BOTH - PAY BOTH.
C. IF ONE IS PT 43 OR SPECIALTIES ARE 22 OR 69 - PAY THAT ONE AND DENY W/EOB 318 OR R/D W/EOB 318.

5. OTHERWISE - DENY CURRENT. IF BOTH SUSPENDED PAY THE OLDEST ICN.

ANY QUESTIONS OR UNUSUAL CIRCUMSTANCES - SEE YOUR SUP FOR POSSIBLE TEXT UPDATE.

(J) VS (O)

(J) CLAIM POSTING AGAINST (O) CLAIM

1. SAME PROVIDER:
A. IF 261 POSTING - PROCEDURE CODES 90800-90899
1. DIFFERENT CODE - FORCE.
2. SAME CODE:
A. PROV # 7095975(COLUMBIA RIVER MENTAL HLTH)(PT 19) - DENIAL REASON CODE CO-B15 ON CURRENT CLAIM MDCR BU AND COMMENTS STATE (ONLY SVC THIS PERF PROV/BU SENT) OR (1 SVC BY PERF PROV) - FORCE. (THERE IS A BACKUP LETTER IN MMIS FILE INDICATING THE PSYCH SERVICE THEY

ARE BILLING MAA IS THE ONLY SERVICE BY THE PERF PROV ON THE CLAIM. EVEN THOUGH THERE MAY BE MULTIPLE SVCS ON THE MDCR EOMB. MAA CANNOT DISTINGUISH DIFFERENT PERF PROV ON THE EOMB, BUT BECAUSE THEY ARE DIFF MAA WILL PAY, WHEN MDCR WOULD NOT.

B. ALL ELSE - DENY W/EOB 960 IF MDCR PD/APPLIED TOWARD THE DEDUCTIBLE.

B. 261 NOT POSTING - DENY W/EOB 960 IF MDCR PD/APPLIED TOWARD THE DEDUCTIBLE & O'CODE 111 FOR AUDREY FINNIGAN REVIEW.

2. DIFFERENT PROVIDER -
   A. IF TOS (Z) ON BOTH CURRENT & HX - DENY W/EOB 960.
   B. IF TOS (Z) VS SURGEON/ASSIST/ANESTHESIA - FORCE.
   C. IF SURGEON VS ANESTHESIA CLAIM - FORCE.
   D. IF TC MOD VS 26 MOD - FORCE.
   E. CHECK BILLING PROV FILES:
      1. IF SAME NAME OR # - DENY W/EOB 960.
      2. IF DIFFERENT #, SAME CODE AND SAME BILLED $ - DENY W/EOB'S 960/280.
   F. IF MEDICARE DID NOT PAY OR APPLY TO DEDUCTIBLE - FORCE.
   G. IF 103 ONLY POSTING & NO 261 - STAGE TO SEE WHY NOT POSTING MEDICARE. ROUTE TO 83 FOR DETERMINATION IF NECESSARY.
   H. ALL ELSE - OVERLOC TO 83. (IF 261 POSTING - DO NOT WORK)

ANY QUESTIONS OR UNUSUAL CIRCUMSTANCES - SEE YOUR SUP FOR POSSIBLE TEXT UPDATE.

CROSS-OVER (O) VS PHYSICIAN (J)

THIS EXCEPTION WILL POST ON DETAIL LINE(S) IF THE FOLLOWING DUPE CRITERIA IS MET ON EACH CLAIM:
1. SAME PIC CODE
2. OVERLAPPING DATES OF SERVICE

IF THE ABOVE DUP CRITERIA IS MET, FORCE THE CURRENT CLAIM AND ROUTE THE DEAD WORKSHEET TO AUDREY FINNIGAN, MS 5570 FOR REVIEW AND POSSIBLE RECOUPMENT OF THE PAID HISTORY CLAIM.

NOTE: 5/10/99 EXCEPTION SET TO PAY AND REPORT W/DETAILED WORKSHEET SENT TO AUDREY FINNIGAN.

MED VENDOR (P) VS. MED VENDOR (P)
MED VENDOR (P) VS. MEDICARE X-OVER (O) TOS 9 OR R

1. PROVIDER TYPE 33: IF OVERLAPPING DAYS LESS THAN 15 - FORCE. IF 16 OR MORE OVERLOC TO 83.

2. PROVIDER TYPE 34:
   (P VS P ONLY) IF DATES OF SERVICE, PROCEDURE CODES AND MONEY ARE SAME - DENY. CLAIM FOR MULTIPLE SERVICES - FORCE.

   ANY UNUSUAL SITUATIONS OR P VS O OVERLOC TO 83.

3. PT 26, 38, 39, 40, 78 OR 79
   NOTE: CAN REVIEW PROVIDER NUMBER & COMPANY NAME ON 8 SCREEN.
   NOTE: IF HISTORY CLAIM IS CASH CONTROL ADJUSTMENT (BATCH RANGE 951-957 & 969) REVIEW CLAIM IN 4 SCREEN AND IF MONEY WAS RECOUPED - FORCE 103 EXCEPTION(S) ON SUSPENDING CLAIM.

   A. OVERLAPPING DATES
      1. IF PROCEDURE CODE IS NOT A RENTAL, SAME OR DIFFERENT COMPANIES - FORCE.
      2. IF PROCEDURE CODE IS A RENTAL & SAME COMPANY - DENY.
      3. IF PROCEDURE CODE IS A RENTAL & DIFFERENT COMPANIES
         A. AND ONLY BEGINNING OR ENDING DATE OVERLAPPING - FORCE.
         B. MORE THAN BEGINNING OR ENDING DATES OVERLAPPING - FORCE & OVERCODE 112.

   B. SAME DATES
      1. IF SAME COMPANY - DENY
         NOTE: PACIFIC MEDICAL SYSTEM & PACIFIC MOTHERS SUPPORT ARE THE SAME COMPANY.
      2. IF DIFFERENT COMPANY - FORCE & OVERCODE 112.

4. PT 26, 38, 39, 40, 78 OR 79 P CLAIM VS O CLAIM
   1. DIFFERENT MONEY AMOUNT - FORCE
   2. SAME MONEY AMOUNT - DENY.

5. PT 51 & 53 (GROUND & AIR AMBULANCE)
   A. IF DIFFERENT MODIFIERS
      1. DIFFERENT COMPANY - FORCE
      2. SAME COMPANY - DENY.
   B. IF SAME MODIFIERS
      1. DIFFERENT COMPANY - FORCE
      2. SAME COMPANY - DENY.

TEXT KEY TEXT DESC

104 CALLS DURING FOLLOW-UP PERIOD ARE INCLUDED IN THE SURGICAL FLAT FEE IF THE CALL IS RELATED TO THE SURGERY.

-NOTE-
EFF 09/01/01 PER CSR 3804 - DIFFERENT PROVIDER/PERFORMING PROV NO LONGER POSTS. SURGICAL FOLLOW UP DX HAVE BEEN ADDED TO 3 DIGIT MATCH CRITERIA AND SURG FU WILL POST AGAINST ANY DX.

- NOTE -
WHEN THIS TEXT STATES TO RECOUP OR DENY, IT REFERS ONLY TO THE E & M, YOU WILL ALWAYS PAY THE SURGICAL PROCEDURE.

- NOTE -
WHEN THIS TEXT INDICATES FOR YOU TO DENY THE CALL AS INCLUDED IN THE FOLLOW UP PERIOD OF THE SURGERY/PROCEDURE AND FOR SOME REASON, YOU ARE NOT PAYING THE SURGERY - DENY THE CALL ANYWAY. (IT IS A GLOBAL FEE)

- NOTE -
PROVIDERS SHOULD BE BILLING THE APPROPRIATE SURGICAL PROCEDURE W/MOD 55. HOWEVER SOME PROVIDERS WILL CONTINUE TO BILL E&M CODES. DENY ALL CALLS FOR FOLLOW-UP UNLESS SPECIFICALLY NOTED IN THE FOLLOWING TEXT.

- NOTE -
WHEN CARE HAS BEEN TRANSFERRED FROM THE SURGEON TO ANOTHER PHYSICIAN IMMEDIATELY AFTER SURGERY, THE PHYSICIAN OTHER THAN THE SURGEON BILLS FOR POST DISCHARGE CARE W/MOD 55. WHEN THE CARE IS TRANSFERRED IN THE MIDDLE OF POST OP PERIOD, THE PHYSICIAN OTHER THAN THE SURGEON MAY BILL AN APPROPRIATE E & M CODE.

IF THE FOLLOWING CODES ARE BILLED BY THE SAME PHYS USING MOD 24 - DENY, UNLESS FOLLWING TEXT INDICATES TO FORCE. (PER MDCR MOD 24 MUST BE ACCOMPANIED BY AN UNRELATED DX, BUT 104 ONLY POSTS ON SAME DX & EFF 9/1/01 SOME SURGICAL FOLLOWUP DX WILL POST)

EYE EXAMS (92012,92014), OFFICE OR OUTPATIENT (99211-99215), HOSPITAL OBSERVATION (99217-99223), SUBSEQUENT HOSPITAL CARE (99231-99233), OBSERVATION/INPATIENT CARE (99234-99236), DISCHARGE (99238), CONSULTATION (99241-99245,99251-99255,99261-99263,99271-99275) CRITICAL CARE (99291-99292), NURSING FACILITY (99301-99303,99311-99316), REST HOME (99331-99333), HOME SERVICES (99347-99353), CARE PLAN OVER-SIGHT (99378, G0064-G0066), INDWELLING CATHETER (G0002).

MOD 24: E&M POSTING AGAINST SURGERY & CLAIM/COMMENT/MODIFIER INDICATE THAT E&M IS FOR DIFFERENT SITE, SIDE, LIMB, ETC THAN THE SURGERY - FORCE.

MOD 55:
1. E & M VS SURGERY W/DIFFERENT PROVIDER OR PERFORMING PROVIDER - FORCE.
2. E & M VS SURGERY W/ SAME PROVIDER - DENY W/EOB 587.
NOTE: MULTIPLE MOD 55'S FOR SAME SURGERY BY SAME OR DIFFERENT PROVIDER OR PERFORMING PROVIDIER - PAY FIRST PROCEDURE BILLED. DENY OR

R/D ALL OTHERS W/EOB 587.

MOD 78:
E & M VS SURGERY W/SAME/DIFFERENT PROVIDER OR PERFORMING PROVIDER -FORCE

MOD 54:
1. E & M VS SURGERY W/DIFFERENT PROVIDER OR PERFORMING PROVIDER - FORCE.
2. E & M VS SURGERY W/SAME PROVIDER - DENY W/EOB 587.

IF MAX ALLOWED FOR POST OP NOT PAID ON ONE LINE - DENY OR REC AND
DENY W/EOBS 587/189.

A. FORCE UP TO 2 E & M CALLS (99231-99239) BILLED BY AN ANESTHESIOLOGIST (PT 48/49) AGAINST SAME OR DIFFERENT PROVIDER. DENY ALL OTHERS W/EOB 757.

B. FOLLOW UP CALLS AGAINST DIFFERENT PROV OR PERFORMING PROVIDER - FORCE

C. CHEMOTHERAPY PROCEDURE CODES ON SAME CLAIM AS CALLS - FORCE.

D. SOME MEDICAL CONDITIONS MAY BE ON GOING OR INCURABLE AND THE SURGERY WILL NEVER FIX THE PROBLEM - FORCE. THE FOLLOWING IS A PARTIAL LIST OF SUCH CONDITIONS AND DIAGNOSES. FORCE THE FOLLOWUP FOR THE FOLLOWING CONDITIONS AND DIAGNOSES.
   1. AIDS
   2. ARTHRITIS, EXCEPTION: DENY IF FOR PYOGENIC
   3. BURNS (906.5-906.9, 940-949.9)
   4. CEREBRAL PALSY (343-343.9)
   5. CIRRHOSIS OF LIVER (571, 571.2, 571.5, 571.6)
   6. CROHNS DISEASE
   7. CYSTIC FIBROSIS (277.0)
   8. DIABETES (250-250.9, 648.0), DIABETIC RETINOPATHY (362.02)
   9. EMPHYSEMIA (492-492.8)
   10. EMPYEMA (510)
   11. EPILEPSY (345-345.9)
   12. GLAUCOMA (365 & 365.1-365.9)
   13. ISCHEMIC HEART DISEASE (414-414.9)
   14. LEPROSY (030-030.9)
   15. LUPUS
   16. MALIGNANCY (140-208.9, 230-234)
   17. MENIER'S DISEASE (386.0-386.04)
   18. MULTIPLE SCLEROSIS (340)
   19. MUSCULAR DYSTROPHY (359.0, 359.1, 359.2)
   20. MYASTENIA GRAVIS (358.0)
   21. PARKINSON'S DISEASE (332-332.1)
   22. RENAL FAILURE (584-586) EXCEPTION: DENY AFTER KIDNEY TRANSPLANT
   23. SICKLE-CELL ANEMIA (282.6)
   24. SPINA BIFIDA
   25. SYRINGOMYELIA (336.0)
   26. TUBERCULOSIS (010-018)
   27. WERMER'S DISEASE (258.0)
   NOTE: ANY QUESTIONS - SEE YOUR TRAINER OR SUPERVISOR.

E. 1600L-1604L (PODIATRY) DATES OF SERVICE PRIOR TO 6/1/92- FORCE.

6/1/92 AND AFTER APPLY EXCEPTION. (IF THE DX IS FOR A MEDICAL PROBLEM, AND NOT FOR FOLLOWUP TO CHECK THE ORTHOTICS - FORCE).

F. FOLLOWUP FAILING AGAINST RADIOLOGY SERIES (70000) - IF RADIOLOGY PROCEDURE IS BILLED W/MOD 26 - FORCE, OTHERWISE - APPLY THE TEXT.

G. IF THE PROCEDURE PERFORMED WAS DIAGNOSTIC OR LIFESAVING (E.G. TRACH EOSTOMY) AND CALLS WERE FOR THE PRIMARY ILLNESS - PAY, UNLESS THE CALLS ARE FOR PROBLEMS RESULTING FROM THE DIAGNOSTIC OR LIFE SAVING PROCEDURE. THIS APPLIES TO ENDOSCOPIC PROCEDURES.

TEXT KEY TEXT DESC

105 PROCEDURE CODE, DIAGNOSIS CODE CONFLICT
IF PROCEDURE AND DIAGNOSIS ARE UNRELATED (E.G. 0141M CHEMICAL DEPENDENCY INTAKE VS DIAGNOSIS CODE 466.0 BRONCHITIS) - DENY.

IF YOU HAVE A PROCEDURE THAT IS SPECIFICALLY LISTED IN THE SECTION AT THE END OF THIS TEXT, FOLLOW THE DIRECTION GIVEN THERE. DO NOT CONSIDER AN ENCOUNTER CODE A FEE FOR SERVICE.

EXCEPTION 105 WILL POST IF AT LEAST ONE OF THE DX FIELDS ON THE CLAIM CONTAINS AN EXCLUDED DX. CHECK THE DX CODES SECTION 1ST FOR BOTH OF THE DX & IF STILL NOT FOUND, LOOK AT THE PROCEDURE SECTION.

**IF AUTH # PRESENT - O'LOC TO 23 TO REVIEW FOR POSSIBLE PAYMENT - UNLESS YOU ARE ABLE TO FORCE PER THE FOLLOWING TEXT.

**IF YOU FEEL THERE IS NO DIRECTION IN THIS TEXT OR A QUESTION ON ADJUDICATION ARISES, O'LOC TO 83 W/COMMENTS.

DIAGNOSES CODES
---

290 - 319.99 - PSYCHIATRIC RELATED DIAGNOSIS
PROCEDURE CODES (99201 - 99215, 99241 - 99245, 99281 - 99288, 99301- 99316, 99321 - 99333, 99360)
1. PT/PP IS 19 OR PP SPECIALTY IS 36 - DENY.
2. ALL OTHER PT - FORCE, UNLESS 303.5 & DIRECTION ON NEXT PAGE.
ALL OTHER PROCEDURES - FORCE, UNLESS 303.5 & DIRECTION ON NEXT PAGE.

303.5 - DETOX - THIS IS THE DUMMY DIAGNOSTIC CODE FOR DETOX SERVICES.
THIS WILL SUSPEND IF CODES 99201-99215,99221-99239,99281-99285, 9011M-9013M,9021M OR 9022M ARE BILLED
1. CLAIMS FOR HOSPITALIZATION OR OUTPATIENT SERVICES WITH A PRIMARY DIAGNOSIS OF ALCOHOLISM OR A MEDICAL I.D. CARD INDICATING DETOX OR A NOTE ON THE CLAIM ARE NOT TO BE DENIED, HOWEVER, IF THE CLAIM IS FOR ALCOHOLISM AND THERE IS NO MENTION OF "DETOX" OR THE PROVIDER HAS NOT USED THE PROPER PROCEDURE CODES (0025M, 0026M) - DENY 301.
   A. EXCEPTION: WE WILL PAY FOR THE DIAGNOSIS OF ALCOHOLISM FOR A NEWBORN CHILD - FORCE.
   B. EXCEPTION: WE WILL PAY FOR CHILDREN IF THE SERVICE IS MEDICALLY JUSTIFIED (E.G. ACUTE INGESTION) - FORCE.
   C. EXCEPTION: IF DIAGNOSIS 648.33 APPEARS ON CLAIM - FORCE.
2. CLAIMS FOR SERVICES RENDERED IN THE OFFICE WITH A PRIMARY DIAGNOSIS OF ALCOHOLISM ARE TO DENIED USING EOB 325.
   A. EXCEPTION: WE WILL PAY FOR SOBRIETY MAINTENANCE FOR ANTABUSE TREATMENT--FORCE.
   B. EXCEPTION: IF DIAGNOSIS 648.33 APPEARS ON CLAIM - FORCE.

367.0-367.9 REFRACTIONS - IF CODES 99201-99215, 99218-99220,
99241-99275, 99281-99285, 99301-99333, 99341-99353,
- DENY W/EOB 761. ALL OTHER PROCEDURES - FORCE.

696.1 - PSORIASIS
IF ANY OTHER DX IS USED WITH 0100J - DENY 325/373.
V20-V20.2, V30-V39.2 HEALTHY LIVEBORN INFANT
1. IF CODES 99221-99223,99231-99233,99295-99298 - DENY W/EOB 249.
2. IF 99281-99285 (ER CALLS) - FORCE.
3. IF 99238/99239 BILLED SAME CLAIM AS 99431/99433/99345 - FORCE.
4. IF 99238/99239 BILLED BY ITSELF OR W/ENCOUNTER CODE ONLY- FORCE. (BY ITSELF MEANS ONLY SERVICE ON CLAIM OR ONLY SERVICE FOR SAME DOS)
5. 99201-99215,0252M,LAB,RAD,&/OR IMMUNIZATIONS, FORCE IF;
A. ANY OF THE ABOVE CODES ARE THE ONLY SERVICES ON THE CLAIM FOR THE SAME DOS OR;
B. IF THERE ARE OTHER SERVICES ON THE SAME DOS THAT HAVE A DX OF OTHER THAN V20-V20.2 OR V30-V39.2.
C. SEE SANDY A. IN MMIS IF QUESTIONS *S
6. IF CODE 99150 & DIAGNOSIS V31 THRU V37 - FORCE; OTHERWISE - DENY.
7. ANYTHING ELSE - DENY.

V22 - V23.9 ROUTINE PREGNANCY
PRIOR TO 7/1/03 DOS:
1. PROCEDURE CODES 99201-99215 OR 99281-99285 - DENY W/EOB 303.
EXCEPTION: IF CLAIM INDICATES PATIENT REFERRED TO ANOTHER PHYS, PATIENT MOVED, PATIENT TRANSFERRED, PATIENT SEEN ONLY ONCE, CHANGED HEALTH CARE PLANS OF 617 O'CODE - FORCE.
2. ALL OTHER PROCEDURE CODES - FORCE.
DOS 7/1/03 & AFTER:
1. PROCEDURE CODES 99201-99205, 99211-99215
A. IF BILLED W/MOD TH - FORCE.
B. IF NO MOD TH - DENY W/EOB 036.
2. ALL OTHER PROCEDURE CODES - FORCE.

V24 - V24.2 POSTPARTUM CARE & EXAM - (99201 - 99215, 99281 -99285) -
DENY W/EOB 303. ALL OTHER PROCEDURES - FORCE.
EXCEPTION: IF DX IS MEDICALLY RELATED & NOT RELATED TO MATERNITY & IN PRIMARY FIELD - FORCE. *S

V25.0 - V25.9 FAMILY PLANNING & CONTRACEPTIVE MANAGEMENT - IF
BILLING J1050, J1051 FOR DEPO PROVERA
OR MEDROXYPROGESTERONE - DENY W/EOB 302.
NOTE: PROCEDURES (00800-00884, 00920-00955) SEE PAGE 12.
V30-V39.2 - SEE V20-V20.2

V53.1 REFRACTION - IF CODES 99201-99215, 99218-99220, 99241-99275,
99281-99285, 99301-99333, 99341-99353 - DENY W/EOB 761.

V589 - (DUMMY DIAG) - SEE INSTRUCTIONS ON PAGES 14-20

V709 - UNSPECIFIED GENERAL MEDICAL EXAM (DUMMY ANES. CODE)
1. FOLLOWUP HOSPITAL CALLS (99231-99233) BILLED BY AN ANESTHESIOLOGIST (PT 48) - FORCE.
2. UNDER 21 YEARS OF AGE:
A. 99361,99362,99371,99372,99373 - DENY W/EOB 341.
B. ALL ELSE - DENY W/EOB 352.
3. 21 YEARS AND OLDER - DENY WITH EOB 341 (NOTE: IF BABY ON MOM'S PIC - DENY WITH EOB 352, EXCEPT FOR CODES IN B.1 ABOVE)

V726 - LABORATORY EXAMINATION (DUMMY LAB CODE) - DENY 341.

V728 - OTHER SPECIFIED EXAMINATIONS. (DUMMY RADIOLOGY CODE) - DENY 341
EXCEPTION - IF BILLING IS FOR RADIATION THERAPY OR NUCLEAR MEDICINE & THEY ARE BILLING FOR A CALL OR CONSULT - FORCE.

V960 - EPSDT/HEALTHY KIDS - WELL BABY CARE
1. FORCE 99211,0252M,LAB, RAD. AND/OR IMMUNIZATIONS IF ONLY SERVICES ON CLAIM FOR SAME DATE OF SERVICE (DO NOT CONSIDER OTHER DOS ON CLAIM) OR IF OTHER SERVICES ON SAME DATE OF SERVICE HAVE A DIAGNOSIS OF OTHER THAN HEALTHY CHILD.
2. IF NEWBORN CARE IN THE HOSPITAL (99431-99433) - DENY.
3. ALL ELSE - DENY.

PROCEDURE CODES:

OUTPATIENT (M) CLAIMS - 87534-87539 (HIV VIRAL LOAD):
1. DX 042 OR V08 ANYWHERE ON THE CLAIM - FORCE.
2. ALL ELSE - DENY W/EOB 325

HOME HEALTH (PT 44), HIGH RISK OBSTETRICAL NURSING CARE.
1. IF BILLING REVENUE CODE 558 W/DX CODES 630 - 670 OR V23 - FORCE. ANY OTHER DX CODE - DENY.
2. DOS PRIOR TO 10/16/03, IF BILLING DX CODES 630 - 670 OR V23 W/ANY REVENUE CODE OTHER THAN 558 - DENY W/EOB 744. 10/16/03 DOS & AFTER - FORCE IF BILLED W/REV CODE 551. ANY OTHER REV CODE - DENY W/744
3. ALL ELSE - OVERLOC TO 67.

PHYSICIAN CLAIMS (J)
1. 00800-00884, 00920-00955 (CPT ANESTHESIA) - DX V25.2, V26.5-V26.52
FOR STERILIZATION:
A. DOS PRIOR TO 01/01/02 - DENY W/EOBS 302/327.
B. DOS 01/01/02 AND AFTER:
1. 00851 AND 00869 - FORCE.
2. ALL ELSE - DENY W/EOBS 302/327.

2. 00800-00884, 00920-00955 (CPT ANESTHESIA) - DX 635 - 639.9, V61.7
FOR ABORTION - DENY W/EOB 302.

3. 0100J (OXSORALEN 1%) - DX OTHER THAN 696.1 - DENY.

4. 0310M (DD ANNUAL EXAM) - DX OTHER THAN V79.3-V79.9, V93.0 - DENY.

5. 0470M,0471M,0472M, (HIV/AIDS):
   DOS PRIOR TO 10/01/03 - FORCE ANY DX
   DOS 10/01/03 & AFTER - MUST BE DX V08 OR 042 - ALL ELSE DENY

6. 11960,11970-11971,19160,19162,19180,19182,19316,19340,19342,19350,
   19357,19361.19364,19366-19371 OR 19380 (TISSUE EXPANDERS) - IF
   APPROVED - FORCE, OTHERWISE, DENY W/EOB 325/017.

7. 51715,L8603,G0025 (COLLAGEN IMPLANT, CONTIGEN) - IF OTHER THAN DX
   599.82 - DENY W/EOB 834.

8. 54150-54152,54160-54161 (CIRCUMCISION) IF DX OTHER THAN 605,607.1,
   607.81 - DENY W/EOB 331.
   NOTE: IF STERILE TRAY (A4550) IS ALSO ON THE CLAIM - DENY W/EOB 331.

9. 58673/58770 - SALPINGOSTOMY - IF FOR TUBAL PREGNANCY (633.1,633.10,
   633.11) - FORCE, OTHERWISE, IF AUTH # CHECK TO SEE IF APPROVED. IF
   APPROVED. IF APPROVED - FORCE. IF NOT APPROVED OR NO AUTH # - DENY
   W/EOB 325. *S

10. 5941M & 5959M - HIGH RISK DELIVERIES. THESE CODES ARE ONLY PAYABLE
    TO THE DELIVERING PHYSICIAN OR IF PROCEDURE CODE 5959M, WE WILL PAY
    AN ASSISTANT SURGEON ALSO.
    A. IF PRIOR AUTH # OR APPROVAL - FORCE.
    B. IF 618 IN THE OVERCODE - FORCE. (RES-EMC) IF ANY DX OTHER THAN
       650 OR V22 - V22.2 FOR SAME DOS - FORCE AND OVERCODE 618.
    C. ALL ELSE - DENY WITH EOB 337.

11. 5953M, 5954M, & 5955M - HIGH RISK TRIMESTER MANAGEMENT.
    A. PATIENT AGE 15 & UNDER - FORCE.
    B. IF PRIOR AUTH # OR APPROVAL - FORCE.
    C. IF 618 IN THE OVERCODE - FORCE. (RES-EMC) IF ANY DX OTHER THAN
       650 OR V22-V22.2 FOR SAME DOS - FORCE AND OVERCODE 618.
    D. ALL ELSE - DENY WITH EOB 337.

12. 5960M, 5961M, AND 5962M - DENY WITH EOB 325.

13. 61862 (CRANIAL NEUROSTIM) - DX OTHER THAN 333.1 OR 332.0 - DENY.
    (CODE ENDED 1/31/04) REPLACED BY CODES THAT REQUIRE AUTH.

14. 9011M-9012M (TUBERCULOSIS CARE CODES) - ANY DIAGNOSIS OTHER THAN
    010 - 018.9, V74.1, 795.5, DENY W/EOB 302.

15. 90804 - 90827, 90845, 90847, 90853 - 90871, 90899 - DX OTHER THAN
    290 - 319.99 - DENY. (LOC 23 - IF APPROVAL ON CLAIM, IT MUST
    BE FOR THE ABOVE PSYCH VISITS) ANY QUESTIONS, SEE TRAINER.

16. 92081, 92082, 92083 (VISUAL FIELDS) - DENY W/EOB 762.
    EXCEPTION: IF CLAIM INDICATES TUMOR BEHIND EYE, OR RULING OUT TUMOR-
               FORCE.
    EXCEPTION: IF VISUAL FIELDS APPROVED - FORCE.

17. 99078 (DIABETES/ASTHMA GRP COUNSELING) - DX OTHER THAN 250.00 -

250.93 OR 493.00 - 493.92 - DENY.

18. 99201-99215,99231-99239,99241-99275,99281-99285,99291-99298,99301-99316,99321-99333,99341,99347,99360 BILLING DX 010-018.9,795.5,V74.1

A. PT 24 BILLING FOR E&M CODES ABOVE.
1. 6/30/03 DOS & PRIOR TO - DENY W/EOB 302. PT (7810302) - DENY W/EOB'S 711/302.
2. 7/01/03 DOS & AFTER - E&M CODES (99201-99215,99341,99347) - FORCE. ALL OTHER PROCEDURES - DENY.

B. ALL OTHER PROV TYPES - FORCE THE ABOVE DX.

19. 96910 (PHOTOCHEMO LIGHT THERAPY) - DX IS 709.01 (VITILIGO) - DENY.

20. 99401-99402 (SMOKING CESSATION COUNSELING, AIDS COUNSELING OTHER THAN DX 648.43-648.44, V65.44 - DENY.

21. 99431,99433,99435 OTHER THAN WELL BABY CARE (V20-V20.2, V30-V39.2
A. IF BABY ON PARENT'S PIC & DIAGNOSIS CLEARLY INDICATES MOM - FORCE. (SINCE CLAIM NOT BILLED W/A SICK DX FOR BABY, WE GIVE THEM THE BENEFIT OF DOUBT)
B. IF USING V960 - DENY.
C. ALL ELSE DENY WITH EOB 184.

22. G0100, 87534-87539, (HIV VIRAL LOAD) DX OTHER THAN V08 OR 042 - DENY W/EOB 325. EXCEPTION - IF PT 71 AND DX V25-V25.9 - FORCE.

23. G0101 (CERVICAL/VAGINAL CANCER SCREEN) - DX IS OTHER THAN (FAMILY PLANNING) V25.01, V25.02, V25.09, V25.1, V25.2, V25.40 - V25.43, V25.49, V25.5, V25.8, V25.9 OR MALIGNANT NEOPLASM V76.2 - DENY. EXCEPTION: DX (V99.9) - DENY ALL OTHER LINES ON THE CLAIM W/V99.9 W/EOB 017.

24. G0103, G0104, G0106, G0107, G0121, G0122 (CANCER SCREEN) - DX 555.0-555.2, 555.9, 556.0-556.6, 556.8-556.9, 558.2, 558.9, V10.05-V10.06, V12.72, V16.0 - DENY.

25. G0105, G0120 (COLORECTAL CANCER SCREEN) - DX OTHER THAN 555.0-555.2 555.9, 556.0-556.6, 556.8-556.9, 558.2, 558.9, V10.05-V10.06, V12.72, V16.0 - DENY.

26. H0010, H0011
0025M-0026M, 0028M-0029M, 0130M-0135M, 0140M-0149M, 0150M-0159M, 0160M-0169M, 0171M- 0179M, 0180M-0189M, 0190M-0199M, 0341M, 0369M, 2050M-2051M, 2130M-2139M, 2140M-2149M, 2150M-2159M, 2160M-2169M, 2170M-2197M (CHEMICAL DEPENDENCY) - DENY
NOTE: PROCEDURE CODES 0341M, 0140M, 0141M, 0143M, 0149M, 0190M OR 96155 WITH MODIFIER HF OR HZ:
FOR DATES OF SERVICE 10/01/03 AND AFTER, IF CLIENT IS AGE 9 THROUGH 20 & THE DIAGNOSIS CODE IS 305.0 OR 305.9 - FORCE

27. J0637 (CASPOFUNGIN ACETATE) - DX OTHER THAN 117.3 - DENY.

28. J1055 DEPO PROVERA IF DIAGNOSIS OTHER THAN V25 - V25.9 OR V99.9-

DENY WITH EOB 509. (IF V25-V25.9 OR V99.9 IS ON SAME DETAIL LINE OR ON ANOTHER LINE FOR SAME DOS - USE O'CODE 619 & FORCE. NOTE:CLIENT IS A MALE & DX IS RELATED TO CANCER - FORCE, IF NO DENY & USE INFO EOB 373 IN SECOND EOB SLOT, UNLESS AUTH, THEN REVIE FOR POSSIBLE PAYMENT.

29. J1212 (DMSO, DIMETHYL SULFOXIDE) - DENY W/EOB 939.

30. J1595 (GLATIRAMER) - DX OTHER THAN 340 - DENY.

31. J1756 (IRON SUCROSE INJ), J2501 (PARICALCITOL), J2916 (NA FERRIC GLUCONATE CMPLX) - DX OTHER THAN 585 - DENY.

32. J3395 (INJ, VERTEPORFIN) DX OTHER THAN 362.52 - DENY.

33. J3420 (VITAMIN B12) - IF OTHER THAN DX 123.4,151-154.8,157-157.9 197.4-197.5,266.2,281.0-281.3,281.9,284.0,284.8,555.9,579.0,648.2 - DENY.

34. J3465 (VORICONAZOLE)- DX OTHER THAN 117.3 - DENY.

35. J3487 (ZOLEDRONIC ACIG) - DX OTHER THAN 198.5,203-203.01,275.42 - - DENY.

36. J7315/J7316/J7317 (HYALGAN) & J7320 (SYNVISC) DX OTHER THAN 715.16 715.18, 715.26, 715.28, 715.36, 715.38, 715.96, 715.98 - DENY.
NOTE: IF DENYING EITHER CODE ABOVE & 20610 ON CLAIM - DENY
20610 W/EOB 757.

37. Q0163 - Q0181 (ANTI-EMETICS) - IF DX IS OTHER THAN 140.0-208.9, 230-239.9, V58.1 - DENY.

38. Q3013 (INJ, VERTEPORFIN) DX OTHER THAN 362.52 - DENY.

39. Q3025, Q3026 (INJ INTERFERON) - DX OTHER THAN 340 - DENY.

40. Q4077 (TREPROSTINIL) - DX OTHER THAN 416-416.9 - DENY.

41. S0115 (BORTEZOMIB) - DX OTHER THAN 203.00-203.01 - DENY.

42. S0130 (INJ GONADOTROPIN) - DX OTHER THAN 752.51 - DENY.

43. S0139 (MINOXIDIL) - DX OTHER THAN 401-401.9 - DENY.

44. S0189 (TESTOSTERONE PELLETS) & 11980 (IMPLANTATION) - DX OTHER THAN 257.2, 174-174.9 - DENY.

45. T1023 (DDD PHYSICAL EXAM) - DX OTHER THAN V79.3-V79.9,V93.0-DENY.

MEDICAL VENDOR (P)

MEDICAL NUTRITION PT 26,39-ANY OF THE FOLLOWING CODES BILLED REGARDLESS OF SERVICE DATE-DENY.

0000B, 0001B, 0002B, 0003B, 0004B, 0005B, 0006B, 0007B, 0008B, 0009B
MEDICAL NUTRITION CODES CONTINUED:
0010B, 0011B, 0012B, 0013B, 0014B, 0015B, 0016B, 0017B, 0019B, 0021B,
0023B, 0025B, 0027B, 0028B, 0029B, 0030B, 0031B, 0032B, 0033B, 0034B,
0035B, 0036B, 0037B, 0038B, 0039B, 0040B, 0041B, 0042B, 0043B, 0044B,
0045B, 0046B, 0047B, 0048B, 0049B, 0050B, 0051B, 0052B, 0053B, 0054B,
0055B, 0056B, 0057B, 0059B, 0061B, 0063B, 0064B, 0065B, 0066B, 0067B,
0068B, 0069B, 0071B, 0073B, 0075B, 0077B, 0079B, 0081B, 0083B, 0085B,
0087B, 0089B, 0091B, 0093B, 0095B, 0097B, 0100B, 0102B, 0103B, 0104B,
0105B, 0106B, 0107B, 0108B, 0109B, 0110B, 0111B, 0113B, 0114B, 0115B,
0116B, 0117B, 0118B, 0119B, 0120B, 0121B, 0122B, 0123B, 0124B, 0125B,
0126B, 0127B, 0128B, 0129B, 0130B, 0131B, 0132B, 0133B, 0134B, 0135B,
0136B, 0137B, 0138B, 0139B, 0140B, 0141B, 0142B, 0143B, 0145B, 0147B,
0149B, 0159B, 0160B, 0164B, 0166B, 0167B, 0168B, 0169B, 0170B, 0178B,
0179B, 0180B, 0181B, 0182B, 0183B, 0184B, 0188B, 0189B, 0190B, 0194B,
0195B, 0196B, 0197B, 0198B, 0199B, 0200B, 0203B, 0204B, 0205B, 0209B,
0210B, 0217B, 0218B, 0219B, 0220B, 0365B, 0370B, 0371B, 0376B, 0377B,
0380B, 0381B, 0382B, 0383B, 0384B, 0385B, 0386B, 4041B, 4085B, B4034,
B4035, B4036, B4081, B4082, B4083, B4086, B9002, B9998, E0776, E1340,

P & O- PT 38- SERVICES PRIOR TO 11/1/02 FORCE, AFTER 11/1/02-DENY.

DURABLE MEDICAL EQUIPMENT/NON-DURABLE MEDICAL EQUIPMENT- PT 26, 39
CLAIMS WITH DATES OF SERVICE PRIOR TO 11/1/02 FORCE, AFTER 11/1/02
DENY.

0001E, 0090A, 0094A, 0095A, 0098A, 0100A, 0100E, 0110E, 0112E, 0113E,
0114E, 0115E, 0116E, 0118E, 0119E, 0121E, 0123E, 0124E, 0126E, 0127E,
0128E, 0131E, 0132E, 0133E, 0134E, 0135E, 0136E, 0137E, 0138E, 0142E,
0143E, 0144E, 0145E, 0146E, 0147E, 0148E, 0149E, 0150E, 0152E, 0153E,
0154E, 0155E, 0157A, 0157E, 0158E, 0159E, 0167E, 0168E, 0169E, 0170E,
0172E, 0173A, 0173E, 0175E, 0176E, 0178A, 0178E, 0179A, 0181A, 0182E,
0185E, 0186E, 0187E, 0189E, 0191E, 0196E, 0197E, 0200E, 0201E, 0202E,
0203E, 0204E, 0205E, 0206E, 0207E, 0209E, 0210E, 0211E, 0213E, 0214E,
0215E, 0216E, 0217E, 0218E, 0219E, 0224E, 0225E, 0226E, 0227E, 0230E,
0231E, 0232E, 0233E, 0234E, 0235E, 0243E, 0244E, 0245E, 0246E, 0293E,
0294E, 0295E, 0296E, 0297E, 0298E, 0301E, 0302E, 0307E, 0323E, 0324E,
0325E, 0326E, 0328E, 0329E, 0330E, 0331E, 0332E, 0333E, 0335E, 0336E,
0337E, 0338E, 0339E, 0341E, 0348E, 0349E, 0350E, 0351E, 0352E, 0353E,
0354E, 0355E, 0356E, 0357E, 0360E, 0361E, 0363E, 0364E, 0366E, 0367E,

DURABLE MEDICAL EQUIPMENT CONTINUED:

0368E, 0371E, 0372E, 0373E, 0376E, 0378E, 0379E, 0380E, 0382E, 0385E,
0389E, 0392E, 0393E, 0394E, 0396E, 0397E, 0400E, 0404E, 0405E, 0407E,
0408E, 0410E, 0414E, 0416E, 0417E, 0421E, 0425E, 0427E, 0428E, 0429E,
0430E, 0433E, 0434E, 0508E, 0626E, 0662E, 0667E, 0686E, 0687E, 0693E,
0695E, 0700E, 0701E, 0702E, 0703E, 0705E, 0708E, 0711E, 0712E, 0713E,
0714E, 0716E, 0717E, 0719E, 0722E, 0723E, 0724E, 0725E, 0726E, 0727E,
0729E, 0730E, 0731E, 0733E, 0735E, 0736E, 0738E, 0739E, 0742E, 0744E,
0745E, 0746E, 0747E, 0748E, 0749E, 0750E, 0751E, 0753E, 0755E, 0756E,
0757E, 0760E, 0762E, 0763E, 0770E, 0772E, 0775E, 0777E, 0778E, 0781E,
0782E, 0788E, 0791E, 0792E, 0793E, 0794E, 0795E, 0799E, 0801E, 0802E,
0815E, 0825E, 0840E, 0845E, 0851E, 0852E, 0853E, 0854E, 0858E, 0859E,

0865E, 0899E, 0900E, 0903E, 0904E, 0905E, 0906E, 0907E, 0908E, 0912E,
0913E, 0914E, 0916E, 0917E, 0918E, 0920E, 0921E, 0922E, 0923E, 0924E,
0931E, 0936E, 0937E, 0960E, 0973E, 0974E, 0976E, 0977E, 0978E, 1016E,
1020E, 1107E, 1109E, 1111E, 1113E, 1211E, 1212E, 1213E, 1214E, 1219E,
1222E, 1223E, 1270E, 1271E, 1272E, 1273E, 1274E, 1275E, 1276E, 1277E,
1278E, 1323E, 1416E, 1417E, 1427E, 1428E, 1465E, 1482E, 1499E, 1503E,
1504E, 1505E, 1530E, 1533E, 1535E, 1610E, 1613E, 1614E, 1625E, 1631E,

DURABLE MEDICAL EQUIPMENT CONTINUED:

1635E, 1636E, 1639E, 1705E, 1706E, 1799E, 1820E, 1821E, 1822E, 1824E,
1828E, 1912E, 1957E, 1960E, 1961E, 1962E, 1972E, 1997E, 1998E, 4350A,
4460A, 4461A, 4462A, 4463A, 4464A, 4465A, 4466A, 4467A, 4468A, 4469A,
4470A, 4471A, 4472A, 4473A, 4474A, 4475A, 4476A, 4477A, 4478A, 4479A,
4480A, 4481A, 4482A, 4512A, 4513A, 4521A, 4529A, 4530A, 4555A, 4560A,
4570A, 4580A, 4585A, 4595A, 4610A, 4611A, 4612A, 4616A, 4617A, 4618A,
4619A, 4620A, 4621A, 4625A, 4630A, 4640A, 4760A, 4761A, 4762A, 4763A,
4764A, 4765A, 4766A, 4767A, 4768A, 4769A, 4771A, 4790A, 4791A, 4792A,
4795A, 4796A, 4799A, 4800A, 4801A, 4802A, 4803A, 4804A, 4805A, 4991A,

A4206, A4207, A4208, A4209, A4210, A4214, A4215, A4244, A4245, A4246,
A4247, A4253, A4254, A4256, A4258, A4259, A4310, A4311, A4312, A4313,
A4314, A4315, A4316, A4320, A4322, A4323, A4324, A4325, A4326, A4330,
A4331, A4332, A4335, A4338, A4340, A4344, A4346, A4351, A4352, A4353,
A4354, A4355, A4356, A4357, A4358, A4359, A4361, A4362, A4364, A4365,
A4367, A4368, A4369, A4370, A4371, A4372, A4373, A4374, A4375, A4376,
A4377, A4378, A4379, A4380, A4381, A4382, A4383, A4385, A4386, A4387,
A4388, A4389, A4390, A4391, A4392, A4393, A4397, A4398, A4399, A4402,
A4404, A4421, A4450, A4452, A4455, A4462, A4490, A4495, A4500, A4510
A4521, A4522, A4523, A4525, A4526, A4527, A4528, A4529, A4530, A4531
A4532, A4533, A4535, A4536, A4637, A4538, A4539, A4554, A4556, A4558

DURABLE MEDICAL EQUIPMENT CONTINUED:

A4565, A4570, A4572, A4595, A4630, A4635, A4636, A4637, A4640, A4649,
A4660, A4663, A4670, A4927, A4930, A5051, A5052, A5053, A5093, A5102,
A5105, A5112, A5113, A5114, A5119, A5121, A5122, A5123, A5126, A6021,
A6022, A6023, A6024, A6154, A6196, A6197, A6198, A6199, A6200, A6201,
A6202, A6203, A6204, A6205, A6206, A6207, A6208, A6209, A6210, A6211,
A6212, A6213, A6214, A6215, A6216, A6217, A6218, A6219, A6220, A6221,
A6222, A6223, A6224, A6228, A6229, A6230, A6234, A6245, A6246, A6247,
A6248, A6251, A6252, A6253, A6254, A6255, A6256, A6257, A6258, A6259,
A6260, A6261, A6262, A6263, A6264, A6402, A6403, A6404, A6405, A6406,
A6410, A6411, A6440, A9901

E0100, E0105, E0110, E0111, E0112, E0113, E0114, E0116, E0130, E0135
E0142, E0143, E0144, E0146, E0148, E0153, E0155, E0157, E0158, E0159,
E0163, E0164, E0165, E0166, E0167, E0168, E0176, E0180, E0181, E0182,
E0185, E0186, E0188, E0189, E0190, E0191, E0192, E0194, E0197, E0199,
E0200, E0202, E0241, E0111, E0242, E0243, E0244, E0245, E0246, E0271,
E0275, E0276, E0292, E0293, E0294, E0295, E0296, E0297, E0305, E0310,
E0325, E0326, E0372, E0602, E0603, E0604, E0607, E0609, E0621, E0630,
E0635, E0650, E0655, E0660, E0665, E0666, E0700, E0730, E0747, E0748,
E0840, E0860, E0870, E0890, E0910, E0920, E0930, E0935, E0940, E0942,

DURABLE MEDICAL EQUIPMENT CONTINUED:

E0943, E0944, E0945, E0946, E0947, E0958, E0959, E0961, E0962, E0963, E0964, E0965, E0971, E0972, E0974, E0977, E0992, E1031, E1060, E1161, E1225, E1228, E1229, E1230, E1232, E1233, E1237, E1238, E1296

K0001, K0003, K0004, K0005, K0006, K0007, K0009, K0011, K0012, K0014, K0015, K0016, K0020, K0024, K0026, K0027, K0028, K0030, K0031, K0032, K0033, K0034, K0035, K0036, K0037, K0040, K0041, K0045, K0048, K0049, K0052, K0054, K0058, K0059, K0062, K0063, K0064, K0065, K0066, K0067, K0068, K0069, K0070, K0071, K0072, K0073, K0074, K0075, K0076, K0077, K0078, K0082, K0083, K0088, K0104, K0106, K0108, K0115, K0538, K0539, K0540, K0541, K0542, K0543, K0544, K0546, K0547, K0549, K0550, K0620, L8210, S8431, S8470, S9445, T1999

MEDICAL VENDOR (P)--GLASSES/LENSES

WHEN 105 IS POSTING FOR ANY GLASSES OR LENS PRODUCT - DENY W/ 762.
THE REMAINING TEXT IS FOR HISTORICAL PURPOSES ONLY.

0174V, 0175V, 1175V-1178V(POLYCARONATE LENSES)--DENY W/EOB 762

0075V-0076V, 1140V-1141V (TINTED LENSES)-DATE OF SERVICE PRIOR TO 7/1/00 AND ONE OF THE FOLLOWING DX CODES: 017.3, 036.81, 053.22, 054.44, 090.3, 090.49, 091.50, 094.0, 094.84, 098.41, 130.2, 250.5, 345.5-345.8, 360.11 363.13, 363.20, 364-364.3, 364.42-364-59, 366.17-366.9, 367.99-F0RCE. ALL ELSE DENY W/EOB 762.

0069V, 0073V, 0219V, 1131V, 1134V, 1138V (EXECUTIVE BI/TRI-FOCAL) DENY W/EOB 762.

0174V, 0175V, 1175V-1178V(POLYCARBONATE LENSES)--DENY W/EOB 762

0222V-0223V, 1168V, 1169V (PHOTCHROMATIC LENSES) DATE OF SERVICE PRIOR TO 7/1/00 AND ONE OF THE FOLLOWING DX CODES: 036.81, 090.49, 09430, 094.84 FORCE. ALL ELSE DENY W/EOB 762.

0079V-0080V, 0164V-0165V, 1144V-1147V, 1183V-1186V (ASPHERIC/LENTICULAR LENSES) DENY W/EOB 762.

TEXT KEY TEXT DESC

106 THE AMOUNT PAID BY MEDICARE, THE DEDUCTIBLE MEDICAID IS TO PAY & THIRD PARTY PAYMENT IS GREATER THAN THE TOTAL BILLED TO MEDICARE.

MEDICARE NON-INST. X-OVERS (O)
NOTE: IF EXCEPTION 107 IS ALSO POSTING, SEE IT FIRST, IF NO DIRECTION IS GIVEN, GO BACK TO 106 AND WORK.

1. HARD COPY CLAIMS
   A. CHECK THE CLAIM TO SEE IF THE THIRD PARTY PAYMENT IS CORRECT OR IF IT WAS ACTUALLY THE MEDICARE PAYMENT ENTERED IN THE WRONG PLACE. IF IT IS NOT A TPL PAYMENT - DELETE THE AMOUNT.
   B. IF AN RA IS ATTACHED, CHECK TO SEE IF THE DEDUCTIBLE AMD MEDICARE PAYMENT ARE CORRECT. IF NOT, CORRECT PER MEDICARE RA.
   C. IF THE BILLED AMOUNTS OR DATES OF SERVICE ON THE CLAIM DO NOT MATCH MEDICARE'S RA DENY WITH EOB 105.
   D. IF MEDICARE'S PAYMENT PLUS DEDUCTIBLE AND/OR COINSURANCE AMOUNTS DO NOT BALANCE WITH TOTAL CHARGE AND NO RA IS ATTACHED DENY WITH EOB 335.
   E. AMBULATORY SURGERY (TOS Z), MOD SG OR PT 22 - FORCE. MEDICARE HAS CONTRACTED SET RATES WITH THE ASC'S AND SOME ASC'S ARE BILLING UNDER THE SET RATE.
2. TAPE CLAIMS
   A. IF INSURANCE IS INDICATED - OVERLOC TO 05.
   B. IF PT 22 (ASC) OR TOS Z (ASC) - FORCE. (MEDICARE PAYS ASC'S LIKE DRG'S).
   C. IF PROCEDURE IS (ZZZZZ) - FORCE.

3. ALL ELSE - O'LOC TO 83.

MEDICARE X-OVERS (V & W)

HARD COPY CLAIMS:
1. RURAL HEALTH CLAIMS (FAILING 106 & 310) FORCE 106, WORK 310.
2. IF MEDICARE'S RA IS ATTACHED:
   A. IF CLAIM DOES NOT MATCH BACKUP - DENY WITH EOB 105.
      --NOTE: YOU MAY USE NON-COVERED AND CONTRACTUAL ADJUSTMENT AMOUNTS TO CREATE A MATCH. IF MEDICARES PAID AMOUNT EXCEEDS THE BILLED TO MEDICARE AMOUNT - FORCE.
   B. IF CLAIM DOES MATCH BACKUP - FORCE.
3. IF MEDICARES REMITTANCE NOT ATTACHED - AND CLAIMS NON-COVERED CHARGES BALANCE - FORCE. OTHERWISE DENY.

TEXT KEY TEXT DESC

107 MEDICARE ALLOWED AMOUNT FOR A SERVICE IS GREATER THAN AMOUNT BILLED.

NOTES: MEDICARE NON-INST. X-OVERS (O)

1. HARD COPY CLAIMS
   A. IF AN RA IS ATTACHED TO THE CLAIM, CORRECT THE MEDICARE ALLOWED AMOUNTS ON THE CLAIM TO THE ALLOWED AMOUNTS ON THE RA.
      IF UNABLE TO CORRECT MEDICARE ALLOWED AMT DUE TO AMBULANCE SVS & PART A/B HOSPITAL RA - EE: PA2 RES: SEE EXCEPT 856.
   B. IF THE BILLED AMOUNTS ON THE CLAIM DO NOT MATCH THE BILLED AMOUNTS ON THE RA - DENY 105.
   C. IF THE DATES OF SERVICE ON THE CLAIM DO NOT MATCH THE DATES OF SERVICE ON THE RA - DENY 105.
   D. IF AMBULATORY SURGICENTER (TOS Z) OR MOD SG - FORCE. MEDICARE HAS CONTRACTED SET RATES WITH THE ASC'S & SOME ASC'S ARE BILLING UNDER THE SET RATE.)
   E. IF NO RA IS ATTACHED - DENY 335.

2. TAPE X-OVERS
   A. IF AMBULATORY SURGICENTER (TOS Z)- FORCE. (MEDICARE HAS CONTRACTED SET RATES WITH THE ASC'S & SOME ARE BILLING UNDER THE SET RATE.)
   B. IF PHYSICIAN PSYCH (TOS 3) - FORCE.
   (ITS USUALLY ONLY A PENNY OR TWO MORE IN MDCR PD, & WE NOW PRICE OFF MDCR/MDCD ALLOWED, WHICHEVER IS LESS)
3. DME X-OVERS - (MED VENDOR) - TAPE & HARDCOPY OVERLOC TO 83.

TEXT KEY TEXT DESC
109 EXCEEDS PAS LENGTH OF STAY CRITERIA.

NOTE: IF YOUR SITUATION IS NOT ADDRESSED IN THE 4-LINE OR IN THIS TEXT FILE - SEE YOUR TRAINER FOR POSSIBLE TEXT FILE UPDATE.

NOTE: IF AUTH NUMBER ON CLAIM BEGINNING WITH "64" - O'LOC TO 72. *SH

1. PAS ALLOWANCE DOES NOT APPLY TO THE FOLLOWING (ADJUDICATE PER INDIVIDUAL INSTRUCTIONS):

A. MADIGAN (3318904) BILLING PER DIEM CHARGES W/REV CODE 160 -FORCE.

B. PAIN CLINIC - REVENUE CODE 511. ST. JOSEPH (3309309) IS THE ONLY APPROVED PAIN CLINIC.
1. IF BILLING FOR 21 DAYS OR LESS - FORCE.
2. IF BILLING FOR MORE THAN 21 DAYS - DENY W/EOB 339.

C. PM&R LEVEL A - (TO IDENTIFY LOOK FOR 1 OR MORE OF THE FOLLOWING: AUTH # BEGINS WITH 57/REVENUE CODE 128/PRIMARY DX V57.X/ PROVIDER NUMBER BEGINS WITH 32).
1. EE: OVERLOC TO 23.
2. RES: WORK PER INSTRUCTIONS IN 343 TEXT (DX CODES V57.X).

D. PM&R LEVEL B - REVENUE CODES 101 & 128 - OVERLOC TO 72.

E. LTAC (LONG TERM ACUTE CARE - REGIONAL HOSPITAL (3200326) AND KINDRED HOSPITAL (3200318) ARE THE ONLY APPROVED LTAC PROVIDERS:
1. IF NO PRIOR AUTH # ON THE CLAIM - DENY W/EOB 023.
2. IF PRIOR AUTH #:
A. CLAIM DATES OF SERVICE ARE NOT COVERED UNDER THE AUTH # - DENY W/EOB 216.
B. CLAIM DATES OF SERVICE ARE COVERED UNDER THE AUTH # - FORCE W/OVERCODE 647.

F. CUP (CHEMICALLY USING PREGNANT) WOMEN PROGRAM-REV CODE 129 OR 168:
--NOTE: REV CODE 129 REPLACES REV CODE 168 BEGINNING 06/01/03, BUT PROVIDERS CAN BILL REV CODE 168 UNTIL 08/01/03.
1. IF DAYS BILLED ARE 26 OR LESS - FORCE.
2. PRIOR TO 11/01/02 AND DAYS BILLED ARE MORE THAN 26:
A. IF NO APPROVED EXTENSION LETTER OR COMMENTS INDICATING # OF EXTENDED DAYS & DATES OF SERVICE APPROVED - DENY AT HEADER LEVEL W/EOB 339.
B. IF APPROVED EXTENSION LETTER OR COMMENTS INDICATING # OF EXTENDED DAYS & DATES OF SERVICE APPROVED:
1. IF PROVIDER IS BILLING DAYS OVER 26 WITH REVENUE CODE CODE 169 - FORCE.
2. IF PROVIDER IS NOT BILLING DAYS OVER 26 WITH REVENUE CODE 169 - SPLIT OUT DAYS OVER 26 AND KEY ON A SEPARATE LINE WITH REV CODE 169. ADJUST THE UNITS AND BILLED AMOUNT ACCORDINGLY. ENTER 126 IN THE 2ND EOB.
3. AFTER 11/01/02 AND DAYS BILLED ARE OVER 26:
A. IF NO APPROVED EXTENSION LETTER OR COMMENTS INDICATING # OF

EXTENDED DAYS & DATES OF SERVICE APPROVED - DENY AT HEADER LEVEL W/EOB 339.

B. IF APPROVED EXTENSION LETTER OR COMMENTS INDICATING # OF EXTENDED DAYS & DATES APPROVED:
1. IF EXTENDED DAYS HAVE BEEN APPROVED FOR REV CODE 169 AND PROVIDER IS BILLING REV CODE 169 - FORCE.
2. IF EXTENDED DAYS HAVE BEEN APPROVED FOR REV CODE 129 OR 168 & PROVIDER IS BILLING REV CODE 129 OR 168 - FORCE.
3. ALL ELSE - OVERLOC TO 72.

2. ALL ELSE:
INFO: THE MAXIMUM NUMBER OF DAYS FOR EACH ICD.9 DIAGNOSES CODE IS LOADED ON SCREEN 10 UNDER "INSTITUTIONAL CRITERIA". KEY AN "I" IN THE "TYPE FACILITY:" FIELD AND THE DIAGNOSES CODE IN THE "DIAG-CD:" FIELD. --NOTE: USE THE PRIMARY (DISCHARGING) DX CODE (NOT THE ADMITTING DX CODE) AND THE DATE OF ADMISSION (EVEN IF YOU HAVE AN INTERIM BILLING). PF 1 TO FIND THE PAS ALLOWANCE FOR THE ADMITTING DATE ON YOUR CLAIM.

PAS IS DETERMINED BY AGE (OR BIRTH WEIGHT IF NEWBORN), SINGLE OR MULTIPLE DX CODES (SYMPTOMS SUCH AS FEVER, FATIGUE, EDEMA, ETC. DO NOT CONSTITUTE A MULTIPLE DX), AND OPERATED OR NOT OPERATED (PROCEDURES SUCH AS MRI'S, THERAPIES, ETC. DO NOT CONSTITUTE OPERATED).

CHECK TO MAKE SURE ALL DX CODES, SURGICAL PROCEDURES, AND THE SURGERY DATE HAVE BEEN KEYED. IF ANY OF THIS INFO HAS NOT BEEN KEYED, THE SYSTEM CANNOT MAKE THE CORRECT LENGTH OF STAY DETERMINATION. ENTER ANY MISSING INFO & LET THE CLAIM CYCLE.

--- ALL CLAIMS FOR PSYCH ADMITS THAT ARE BEYOND PAS LENGTH OF STAY MUST BE APPROVED BY THE RSN (REGIONAL SUPPORT NETWORK), NOT MAA.

A. IF THE NUMBER OF DAYS IN THE FILE ARE 0 (ZERO) - OVERLOC TO 72.

B. IF THE LENGTH OF STAY IS BEYOND THE PAS ALLOWANCE AND AN EXTENSION REQUEST IS NOT ATTACHED.
1. IN STATE PROVIDERS:
A. PSYCH ADMITS - DENY W/EOB 993.
B. IF PROV IS BILLING DAYS BEYOND PAS AS "NON-COVERED" - FORCE.
C. ALL ELSE - DENY.
2. OUT OF STATE PROVIDERS:
A. PSYCH ADMITS - DENY W/EOB 993.
B. ALL ELSE:
1. IF NO MEDICAL RECORDS - DENY.
2. IF MEDICAL RECORDS ARE ATTACHED - ROUTE CLAIM, MEDICAL RECORDS, AND PAS COVER SHEET TO QRS (MS 45506). INDICATE "OUT OF STATE PROVIDER" ON THE COVER SHEET. WHEN CLAIM IS RETURNED - DENY W/EOB 333 AND RE-ICN.

C. IF THE LENGTH OF STAY IS BEYOND THE PAS ALLOWANCE AND AN APPROVED EXTENSION REQUEST IS ATTACHED:

--IMPORTANT NOTES - ALL CLAIMS WHEN FORCING EXC 109:

-- IF EXTENSION REQUEST APPROVED BY QRS - USE 373 IN 2ND EOB.
-- IF EXTENSION REQUEST APPROVED BY RSN - USE 839 IN 2ND EOB.
-- ALWAYS ENTER THE # OF EXTENSION DAYS APPROVED IN THE "EXT-DAYS:" FIELD (INCLUDE ADMIN DAYS) AND A "Y" IN THE LMC FIELD. IF MULTIPLE EXTENSIONS ATTACHED - TOTAL ALL DAYS.

1. THE CLIENT & ADMIT DATE ON THE CLAIM MUST MATCH THE PAS EXTENSION AND THE ACTUAL DATES OF SERVICE & DAYS BILLED MUST BE COVERED BY THE PAS EXTENSION:
--THE FOLLOWING RULES APPLY TO INTERIM BILLINGS. BE SURE TO COUNT PAS DAYS FROM THE DATE OF ADMIT.
A. IF THE CLIENT &/OR ADMIT DATE DO NOT MATCH - DENY W/EOB 016.
B. IF THE ACTUAL DATES OF SERVICE &/OR DAYS BILLED ARE NOT COVERED BY THE PAS EXTENSION -OR- THE RSN/NCC DENIED ANY OF THE REQUESTED EXTENSION DAYS - DENY W/EOB 755. USE 373 IN 2ND EOB IF REVIEW BY NDD. USE 839 IN 2ND EOB IF REVIEWED BY RSN.
C. IF THE CLAIM INFO MATCHES THE PAS EXTENSION AND THE DATES OF SERVICE & DAYS BILLED ARE COVERED - FORCE. EXCEPTION: IF ANY OF THE DAYS WERE APPROVED FOR "ADMIN DAYS" - SEE BELOW.
2. ADMINSTRATIVE (ADMIN) DAYS MUST BE BILLED W/REV CODE 169:
A. IF DAYS HAVE BEEN SPLIT OUT - FORCE W/126 IN 2ND EOB.
B. IF DAYS HAVE NOT BEEN SPLIT OUT - ADJUST CLAIM BY SUBTRACTING THE # OF ADMIN DAYS FROM THE ROOM CODE WITH THE LOWEST DAILY ROOM RATE. ADJUST THE BILLED AMT ACCORDINGLY. ADD A NEW LINE WITH REV CODE 169 & THE # OF DAYS APPROVED AS ADMIN. FORCE W/126 IN 2ND EOB.

D. IF ATTACHED EXTENSION HAS BEEN DENIED:
1. IF DENIED BY QRS - DENY W/EOB'S 754/373. EXCEPTION: IF NCC INDICATES ON THE PAS COVER SHEET THAT A DECISION CANNOT BE MADE DUE TO INCOMPLETE MEDICAL RECORDS - DENY W/EOB'S 048/373.
2. IF DENIED BY RSN - DENY W/EOB'S 754/839.

E. IF EXTENSION REQUEST IS ATTACHED, BUT HAS NOT BEEN APPROVED:
1. PSYCH ADMITS - DENY W/EOB 993.
2. ALL ELSE:
A. IF MEDICAL RECORDS ARE NOT ATTACHED - DENY.
B. IF MEDICAL RECORDS ARE ATTACHED (SEE NOTE) ATTACH A PAS COVER SHEET AND ROUTE CLAIM WITH ALL MEDICAL RECORDS (OR INDICATE ON COVERSHEET THAT MEDICAL RECORDS ARE IN ART) AND ROUTE TO QRS - MS: 45506
**NOTE - MEDICAL RECORDS MUST INCLUE:
1. HISTORY AND PHYSICAL
2. PROGRESS NOTES & DOCTOR'S ORDERS FOR THE ENTIRE LENGTH OF STAY; AND
C. WHEN THE CLAIM IS RETURNED FROM QRS - DENY W/EOB 333, ATTACH COVER SHEET & EXTENSION REQUEST AND RESUBMIT CLAIM FOR PROCESSING. ELECTRONIC CLAIMS: IF UB-92 NOT SUBMITTED WITH BACKUP - PRINT A COPY OF THE SCREEN (BE SURE TO PRINT ALL PAGES INCLUDING THE PF6 PAGE) AND SUBMIT FOR PROCESSING.

TEXT KEY TEXT DESC

114

MEDICARE DEDUCTIBLE AMOUNT IS GREATER THAN THE SUM OF MEDICARE ALLOWED AMOUNTS IN LINE ITEMS.

NOTES: MEDICARE NON-INST. X-OVERS (O)

1. HARD COPY CLAIMS
   A. IF AN RA IS ATTACHED TO THE CLAIM, CORRECT THE MEDICARE ALLOWED AMOUNTS AND/OR DEDUCTIBLE ON THE CLAIM TO THE AMOUNT SHOWN ON THE RA.
   B. IF THE BILLED AMOUNTS ON THE CLAIM DO NOT MATCH THE BILLED AMOUNTS ON THE RA - DENY 105.
   C. IF THE DATES OF SERVICE ON THE CLAIM DO NOT MATCH THE DATES OF SERVICE ON THE RA - DENY 105.
   D. IF NO RA IS ATTACHED - DENY.

2. TAPE CLAIMS - IF CLAIM HAS ONLY ONE LINE AND MEDICARE PAYMENT IS ZERO, CORRECT THE ALLOWED AMOUNT TO THE DEDUCTABLE.

END

TEXT KEY TEXT DESC

115 THIS EXCEPTION WILL POST WHEN THE TOTAL DAYS BILLED DO NOT EQUAL THE DATES OF SERVICE. WHEN DETERMINING THE TOTAL DAYS BILLED DO NOT COUNT THE DAY OF DISCHARGE UNLESS THE CLAIM HAS A PATIENT STATUS 30 (STILL A PATIENT).

EXAMPLE: 01/01/02 TO 01/10/02 = 9 DAYS
01/01/02 TO 01/10/02 = 10 DAYS WITH PATIENT STATUS 30

1. IF NO ACCOMODATION CODES ARE BILLED:
   A. DELIVERY/LABOR ROOM CHARGES - FORCE.
   B. SWING BED (ANCILLARY CHARGES) AT SNF LEVEL - FORCE.
   C. LATE AND/OR ADDITIONAL CHARGES (MUST BE STATED ON THE CLAIM OR IN THE COMMENT FIELD):
      EE: ENTER 444 IN THE OVER-CODE AND PA-2.
      RES: IF NO RELATED CLAIM IN HISTORY - DENY W/EOB 790.
           IF RELATED CLAIM IN HISTORY IS AN "S" CLAIM - FORCE.
           IF RELATED CLAIM IN HISTORY IS AN "R" CLAIM - DENY W/EOB 798.

2. IF EXC 367 IS ALSO POSTING (ON ACCOMODATION CODE ONLY) AND THE TOTAL DAYS BILLED ARE CORRECT - FORCE EXC 115 AND WORK EXC 367 PER 4-LINE/ TEXT FILE INSTRUCTIONS. IF TOTAL DAYS BILLED ARE NOT CORRECT- DENY.

3. CLAIMS THAT ARE 24 HOURS OR LESS WILL POST EXC 115 IF THE "FROM-DT" IS THE SAME AS THE "TO-DT" - FORCE.

4. IF THE TOTAL DAYS BILLED ARE INCORRECT BECAUSE THE CLIENT WAS IN THE ER (REV CODE 450), OBSERVATION ROOM (REV CODE 76X), SHORT STAY (REV CODE 490), OR LABOR/DELIVERY (REV CODE 72X), ON THE FIRST DATE OF SERVICE - FORCE.

5. LEAVE OF ABSENCE (LOA) - REVENUE CODE 180. IF THE TOTAL DAYS BILLED PLUS THE LOA DAYS ARE CORRECT - FORCE. NOTE: DENY EXC 369 THAT POSTS ON THE REVENUE CODE - PA2 EXC. 184.

6. SPLIT CLAIMS - IF THE TOTAL DAYS BILLED ON ALL RELATED CLAIMS IS CORRECT (IF THE ROOM CHARGES ARE ON MORE THAN ONE CLAIM YOU MUST ADD ALL THE DAYS) - FORCE ALL RELATED CLAIMS. IF THE TOTAL DAYS ARE NOT CORRECT - DENY W/EOB 387 IN THE 2ND SLOT.

7. PM&R LEVEL B - BILLING REVENUE CODES 101 & 128 OVERLOC TO 72.

8. LONG TERM ACUTE CARE (LTAC) - REGIONAL HOSPITAL (3200326) AND KINDRED HOSPITAL (3200318) BILL REVENUE CODE 128 IN CONJUNCTION WITH REVENUE CODE 100. THEY BILL THEIR USUAL AND CUSTOMARY CHARGE AS NON-COVERED UNDER REVENUE CODE 128. THEY BILL THEIR PER DIEM CHARGE UNDER REVENUE CODE 100.

   FYI: EFFECTIVE 04/01/03, LTAC PROVIDERS ARE NO LONGER REQUIRED TO BILL THEIR USUAL & CUSTOMARY CHARGES UNDER REVENUE CODE 128. ALL ROOM & BOARD CHARGES CAN BE BILLED UNDER REVENUE CODE 100. IF THEY DO NOT BILL REVENUE CODE 128 & THE DATES OF SERVICE DO NOT EQUAL THE TOTAL DAYS BILLED - DENY. IF THEY BILL BOTH REV CODES

100 & 128 - SEE A, BELOW.

**NOTE: LTAC REQUIRES PRIOR AUTHORIZATION. IF NO PRIOR AUTH # ON THE CLAIM - DENY EXC 115 WITH EOB 023. IF AUTH #: EE - OVERLOC TO 23. RES: IF CLAIM DOS DO NOT MATCH THE AUTH # - DENY W/EOB 216.

A. IF THE DAYS BILLED UNDER BOTH REV CODES ARE NOT THE SAME - OVER-LOC TO 72.
B. IF THE CHARGES BILLED UNDER REVENUE CODE 128 ARE NOT LISTED IN THE NON-COVERED FIELD - OVER-LOC TO 72.
C. ALL ELSE - ONLY COUNT THE DAYS BILLED UNDER ONE OF THE REVENUE CODES. IF THE TOTAL DAYS BILLED ARE CORRECT - FORCE. OTHERWISE - DENY.

09. ALL ELSE - DENY

TEXT KEY TEXT DESC

117 PROCEDURE CODE MODIFIER INVALID

PHYSICIANS (J)

1. OUT OF STATE - FORCE.
2. MODIFIER Q1 - CONVERT TO QI.
3. PROVIDER TYPE 41,88 - DENY
4. MOD 60,GU,QQ,QV, GT - FORCE.
5. MOD SL - DOS 07/01/02 AND AFTER O'LOC TO 83.
6. MODS 5A/5B - DENY FOR DOS 7/31/03 & AFTER.
7. MODS U1/U2 - DENY FOR DOS PRIOR TO 7/1/03.
8. ALL ELSE - DENY.

EPSDT (L)

VACCINES: CORRECT PAYMENT MOD FOR DOS LISTED BELOW MUST BE BILLED IN
1ST MOD FIELD, IF NOT DENY.
1. MOD SL - DOS 7/1/02 & AFTER
2. MOD 1H - DOS PRIOR TO 7/1/02
ALL ELSE: DENY.

MEDICARE X-OVER (O) PHYSICIAN SERVICES: TOS (3) OR (Z)

1. TAPES (2 MEDIA) FORCE.

2. HARDCOPY
   A. DENY THE FOLLOWING: AE,AF,AG,AL,AK,AN,AV,AW,BC,DM,GH,L4,L5,ME OD,OP,OS,OU,QJ,QO,QQ,QR,RL,WL,XO,YB,YE,YF,YG,YL,ZG,ZK,5C,10,11, 29,30,35,73,5A/5B(07/01/03 AND AFTER).
   B. FORCE THE FOLLOWING: GU,QQ,QS,QV,GT,60,5A/5B(PRIOR TO 7/1/03 FOR PT 22 ONLY).
   C. PT 22 ONLY, 5A AND 5B 7/1/03 AND AFTER - DENY.
   D. ALL ELSE- O'LOC TO 83.

MEDICARE X-OVER (O) - (TOS 9 OR R)

1. TAPE (2 MEDIA) FORCE.

2. MEDICAL NUTRITION (0000B - 0387B) - DENY W/EOB 903.

3. IF THERE IS A MOD ON CLAIM BUT NO MOD ON MCARE BACKUP - DENY.

4. 1P MODIFIER BILLED AFTER DATE OF SERVICE 10/15/03-DENY

4. ALL ELSE - OVERLOC TO 83.

MED VENDOR (P)
NOTE: HIT ENTER FIRST AND 117 MAY DROP OFF.
(PER CONSULTEC - IF THE CLAIM IS BILLED BY PROVIDER WITH A 'TOS 3' IT MAY POST A 117 THINKING THE CLAIM IS A J & THAT THE MOD IS INVALID - AFTER IT GOES THRU A 'FRONT-LINE' EDIT IT MAY CORRECT

TOS TO 9. BECAUSE ALL EDITS ARE HELD, ONCE THE 117 POSTS - EVEN WHEN IN ERROR, IT REMAINS UNTIL SOMEONE HITS ENTER.)
--IF 117 DOES NOT DROP OFF CONTINUE THROUGH THE TEXT.

1. SINGLE DIGIT MODIFIERS - I.E. 'V' 'H' - DENY.

2. PROV TYPE 51 (GROUND AMBULANCE)
   A. SINGLE DIGIT MODS - DENY
   B. THE LETTERS IN THE FOLLOWING LIST ARE THE ONLY ONES VALID FOR MAKING UP THE 2 LETTER AMBULANCE CODES. IF NOT LISTED - DENY.
      D, E, G, H, I, J, N, P, R, S, X.
   C. ANY MODIFIER ENDING IN 'S'(SCENE OF INCIDENT) - DENY.
      NOTE: IF RETURNING CLIENT BACK HOME AFTER AN ACCIDENT IN THE HOME - 'R' (RESIDENT) IS THE APPROPRIATE MOD, NOT 'S' - DENY.
   D. ALL ELSE- REVIEW CLAIM & FORCE IF APPROPRIATE USE OF MODS.

3. PROV TYPE 33 (NURSE SVCS/DELEGATION) OR 87 (DAY HEALTH) - DENY.

4. PROV TYPE 34 (PHYSICAL THERAPY) - "L" OR "R" - DENY.

5. MEDICAL NUTRITION - DOS 10/16/03 AND AFTER - DENY. ALL ELSE OL TO 83.

6. "MS" MODIFIER- OVERLOC TO 83.

7. 1P MODIFIER BILLED WITH DATE OF SERVICE BEFORE 10/16/03-FORCE

8. ALL ELSE-DENY

TEXT KEY TEXT DESC

118 MISSING PLACE OF SERVICE
EFFECTIVE 10/16/03 - KEY POS AS INDICATED ON CLAIM.

PHYSICIAN (J), EPSDT (L), MED VENDOR (P) OR X-OVER (O) WITH 2 DIGIT
POS OF SERVICE - 10/15/03 AND PRIOR - CONVERT AS FOLLOWS.

01 TO 1		
02 TO 2		
03 TO 3	34 TO 2	81 TO 3
11 TO 3	41 TO 9	99 TO 9
12 TO 4	42 TO 9	
15 TO 9	50 TO 3	
20 TO 3	51 TO 1	
21 TO 1	52 TO 2	
22 TO 2	53 TO 3	
23 TO 5	54 TO 7	
24 TO 3 PRIOR TO 07/01/01 DOS	55 TO 9	
24 TO 6 07/01/01 & AFTER DOS	56 TO 9	
25 TO 3	60 TO 9	
26 TO 9	61 TO 1	
31 TO 8	62 TO 2	
32 TO 8 MORE NEXT PAGE	65 TO 2 MORE NEXT PAGE	
33 TO 6 PRIOR TO 07/01/01 DOS	71 TO 3	
33 TO 9 07/01/01 & AFTER DOS	72 TO 3	

CLAIM TYPE O (TOS 3 OR X):
1. MEDIA 2(TAPE) - NO POS - O'LOC TO 83.
2. MEDIA 0(HARDCOPY) - NO POS - DENY 118 EXC TO OVERRIDE
430 EXC.

TEXT KEY TEXT DESC

121 PROVIDER NUMBER MISSING ON CLAIM:

OUT-OF-STATE PROVIDER - DO AN ALPHA, SSN, OR TAX NUMBER SEARCH FROM PF5

1. IF ACTIVE NUMBER FOUND - ENTER IT WITH INFO EOB 510.
2. IF TERMINATED, PENDING, OR ID ONLY NUMBER FOUND - ENTER IT WITH EOB 510 (OTHER EXCEPTIONS WILL POST).
3. IF NO NUMBER, OR CANNOT DETERMINE THE CORRECT NUMBER (AN EXACT MATCH CANNOT BE FOUND) - OVER LOC TO LOCATION 69.

PROVIDER ENROLLMENT (LOCATION 73)

DO AN ALPHA, SSN, OR TAX NUMBER SEARCH FROM PF5 SCREEN TO DETERMINE THE CORRECT PROVIDER NUMBER.

1. IF NUMBER FOUND - ENTER IT WITH INFO EOB 510
2. IF TERMINATED, PENDING OR ID ONLY NUMBER FOUND - ENTER IT WITH INFO EOB 510 (OTHER EXCEPTIONS WILL POST).
3. IF NO NUMBER FOUND - KEY IN 9999905 THEN ENTER THE CLAIM AND ADJUDICATE PER THE 416 FOUR LINE.
   A. START A FILE
   B. MAKE A COPY OF THE CLAIM
   C. ISSUE A PENDING NUMBER
   D. MAIL OUT A CORE PROVIDER AGREEMENT

INFORMATION ONLY: ELECTRONIC CLAIMS POSTING 121 WILL HAVE THE DUMMY NUMBER PLUGGED (0011601) AND THEN AUTO DENIED.

TEXT KEY 122

TEXT DESC

INVALID PROVIDER NUMBER ON CLAIM:

OUT-OF-STATE PROVIDER - DON AN ALPHA, SSN, OR TAX NUMBER SEARCH FROM PF5

1. IF ACTIVE NUMBER FOUND - ENTER IT WITH INFO EOB 510.
2. IF TERMINATED, PENDING, OR ID ONLY NUMBER FOUND - ENTER IT WITH EOB 510 (OTHER EXCEPTIONS WILL POST).
3. IF NO NUMBER, OR CANNOT DETERMINE THE CORRECT NUMBER - (AN EXACT MATCH CANNOT BE FOUND) - OVERLOC TO LOC 69.

PROVIDER ENROLLMENT

DO AN ALPHA, SSN, OR TAX NUMBER SEARCH FROM PF5 SCREEN TO DETERMINE THE CORRECT PROVIDER NUMBER.

1. IF NUMBER FOUND - ENTER IT WITH INFO EOB 510.
2. IF TERMINATE, PENDING, OR ID ONLY NUMBER FOUND - ENTER IT WITH INFO EOB 510 (OTHER EXCEPTIONS WILL POST).
3. IF NO NUMBER FOUND - KEY IN 9999905, ENTER THE CLAIM AND ADJUDICATE PER THE 416 FOUR LINE.
   A. START A FILE
   B. MAKE A COPY OF THE CLAIM
   C. ISSUE A PENDING NUMBER
   D. MAIL OUT THE CORE PROVIDER AGREEMENT.

INFORMATION ONLY: ELECTRONIC CLAIMS POSTING 122 WILL HAVE THE DUMMY NUMBER PLUGGED (0011601) AND THEN AUTO DENIED.

TEXT KEY	TEXT DESC
124	MISSING "FROM" DATE OF SERVICE

DENTAL & MED VENDOR

1. IF CLAIM IS INCOMPLETE AND APPEARS TO BE A REQUEST FOR APPROVAL (E.G. NO DATES OF SERVICE)

   A. IF PROCEDURE REQUIRES AUTHORIZATION - DENY AT HEADER LEVEL WITH EOB 155. INDICATE D-155 AND QUS ON CLAIM AND BATCH COVER AND PLACE IN ROUTING SLOT IN EXAM ENTRY UNIT AREA.
   B. IF THE PROCEDURE DOES NOT REQUIRE AUTHORIZATION - DENY EXC. 124 - ENTER EOB 166 IN THE 2ND LINE EOB.

2. IF CLAIMS WITH APPROVAL AND NO DATES OF SERVICE ON ENTIRE CLAIM - DENY AT HEADER LEVEL W/EOB 969 & SEND CLAIM BACK TO PROVIDER WITH GREEN COVER LETTER, MAKE NOTE ON BATCH COVER, AND PUT IN OUTGOING MAIL.

3. ALL ELSE - DENY.

TEXT KEY TEXT DESC
125 CLAIM PAST TIMELY BILLING LIMIT OF 1 YEAR (365 DAYS)

NOTE: IF MORE THAN ONE ICN IS REFERENCED ON THE CLAIM, KEY THE ICN WITH THE OLDEST JULIAN DATE IN THE R-ICN FIELD.
NOTE: EXCEPTION TO POLICY - SEE YOUR SUPERVISOR.
NOTE: IF THERE IS MORE THAN 3 YRS FROM THE DOS ON THE CLAIM TO THE CURRENT ICN (JULIAN DATE) - DENY W/EOB 967. (OUR SYSTEM CANNOT DETERMINE THE ORIGINAL DISPOSITION) EXCEPTION SEE # 1 BELOW.
NOTE: IF CLAIM HAS "COB MEDICARE SECTION OVERPAYMENT INFORMATION FORM" AS BACKUP, DENY WITH EOB 968 & ROUTE TO COB - MEDICARE MS/45570. FYI: THE COB MEDICARE FORM IS FROM MAA, NOT A EOMB.

NOTE: DENY UNLESS EXCEPTION LISTED BELOW:

1. IF A MANAGED CARE/HEALTHY OPTIONS OR BHPP CLIENT'S PREMIUM HAS BEEN RECOUPED BY MAA, PROVIDERS MAY BILL FEE FOR SERVICE. THE TIME LIMIT IS 365 DAYS FROM THE DATE OF RECOUPMENT BY THE PLAN.
   A. IF STATEMENT ON CLAIM OR B/U INDICATES A PREMIUM HAS BEEN RECOUPED FORCE IF 1 YEAR (365) DAYS OR LESS FROM THE RECOUPMENT OR REFUND DATE TO THE CURRENT ICN.
   NOTE: THE RECOUPMENT OR REFUND DATE IS THE DATE THE MANAGED CARE PLAN EITHER RECOUPED THE MONEY FROM THE PROVIDER OR THE DATE THE PROVIDER REFUNDED THE MONEY TO THE MANAGED CARE PLAN.

   NOTE: 3 YR RECOUPMENT RULE STARTS FROM THE DATE OF RECOUPMENT.

2. IF INSURANCE INFORMATION ATTACHED INDICATING RETRO-DISENROLLMENT, AND CLAIM IS NOT BEING DENIED, OL TO LOCATION 05 FOR TPL REVIEW.

3. NURSING HOME CLAIMS (T) - AWARD LETTERS CAN BE USED TO JUSTIFY TIMELINESS.

4. LOCAL CSO ISSUED CARD COVERING DATE OF SERVICE ATTACHED & INDICATES RETRO/DELAYED CERT/ISSN DATE: FORCE IF 1 YEAR (365 DAYS) OR LESS FROM THE DELAYED CERT/ISSN DATE TO THE ICN THAT ESTABLISHES TIMELINESS. NO CERTIFICATION DATE ON CARD, COMMENTS OR BACKUP:
   1. EMC - DENY W/EOB 382.
   2. HARD COPY - O'LOC TO 65. (LOC 65 - CHECK ACES SYSTEM TO FIND RETRO/DELAYED CERT DATE).

5. OUT OF STATE PROVIDERS - DATES OF SERVICE ARE PRIOR TO APPLICATION DATE (APPL-DTE) ON PROVIDER FILE - FORCE.

6. INPATIENT HOSPITAL (S) CLAIMS THAT ARE INTERIM BILLINGS OR DRG INTERIM OUTLIERS WITH PATIENT STATUS 30 (STILL A PATIENT) - FORCE.

7. FAIR HEARING - O'LOC TO 81.(FSU/PRU SPECIAL HANDLING).

8. TRIMESTER CARE (5951M, 5952M, 5953M, 5954M, 5955M), LAB OR RADIOLOGY W/CODE DESCRIPTION OR DIAGNOSIS RELATED TO OB CARE/PREGNANCY - ALLOW 1 YR (365 DAYS) FROM EDC (EXPECTED DATE OF CONFINEMENT) OR

DELIVERY DATE NOTED ON CLAIM, COMMENTS OR BACKUP TO CURRENT ICN.
A. IF EDC PROVES TIMELY - FORCE.
B. IF NO EDC - DENY W/EOB 276.
--NOTE - IF ANY OF THE SERVICES MENTIONED ABOVE ARE TIMELY - FORCE THE ENTIRE CLAIM.

-- NOTE - PRENATAL ASSESSMENT IS EXCLUDED FROM THIS EXCEPTION.
-- NOTE - TRIMESTER CARE "TO DATE" SHOULD BE USED TO CALCULATE 1 YR.

9. MAA IN-DATE STAMP, MUST BE IDENTIFYING, E.G. (COB,DPS,MEDS,MMIS,ETC) OR DATED "RETURN TO PROVIDER" LETTER ATTACHED. IF UNSURE - SEE YOUR TRAINER/LEAD/SUP.
10. MEDICARE OR MEDICARE MANAGED HEALTH CARE RECIPIENTS W/EOMB OR HMO/MHC EOMB ATTACHED AND MEDICARE HAS PAID:
A. LESS THAN 6 MONTHS FROM EOMB OR HMO/MHC EOMB PAID DATE TO THE ORIGINAL OR REF ICN - FORCE.

B. MORE THAN 6 MONTHS FROM EOMB OR HMO/MHC EOMB PAID DATE TO THE ORIGINAL ICN - DENY W/EOB 546.

11. REBILLINGS:
A. CLAIM INDICATES REBILL, BUT RA IS NOT ATTACHED OR PREVIOUS ICN NOT REFERENCED ON CLAIM OR IN REMARKS/COMMENTS FIELD TO VERIFY RESUBMISSION TIMELINESS - DENY.
B. RA IS ATTACHED OR ICN REFERENCED (EMC SEE REMARKS FOR RA DATE OR REFERENCE ICN):
1. VERIFIES CLAIM WAS ORIGINALLY BILLED WITHIN 1 YR (365 DAYS) OF DATE OF SERVICE - FORCE. (NOTE: MANAGED CARE CODES 0351M OR 0357M & REFERENCED ICN BEGINS W/"4", JULIAN DATE OF REFERENCE ICN MAY BE IN THE MONTH PRIOR TO DOS ON CLAIM.)
2. VERIFIES CLAIM WAS NOT BILLED WITHIN 1 YR (365 DAYS) FROM THE DATE OF SERVICE - DENY.

3. CLAIM & RA DOES NOT MATCH:
A. SURGICAL CODES 10000-69999 VS 00100-01999 AND MODS MATCH O'LOC TO 12
RES LOC 12 - REVIEW DESCRIPTION, IF SAME/SIMILAR OR IN THE SAME ANATOMICAL AREA, WORK THE 125 EXC PER TEXT AS MATCH.
B. ALL ELSE - DENY & USE EOB 535 IN SECOND SLOT.

- NOTE - REFERENCE ICN ON CLAIM OR BACKUP IS PRIOR TO JULIAN DATE (99162) - ALLOW THROUGH THE END OF THE MONTH.

- NOTE - IF MANAGED CARE (PT 90) USE THE TO DATE TO CALCULATE 1 YR (365 DAYS).

- NOTE - TO CALCULATE 1 YR (365 DAYS) USING RA OR REF ICN, SEE JULIAN DATE CALENDAR AT END OF THIS TEXT.

- NOTE - REBILLED LINE HAS OBVIOUS CHANGES FROM THE ORIGINAL PAID LINE DENY WITH EOB 189.

- NOTE - RA/REMARKS/REFERENCE ICN/ETC MAY BE USED FOR JUSTIFYING TIMELINESS UNLESS THERE IS AN INDICATION THE ORIGINAL CLAIM WAS

DENIED FOR TIMELINESS. (RA ATTACHED INDICATES SERVICES NOT PREVIOUSLY DENIED FOR TIMELINESS).

-- SEE NEXT PAGES FOR JULIAN DATE CALENDAR

JULIAN DATE CALENDAR - FOR NORMAL YEARS ONLY

DAYS | MONTHS-->>												
VVV	01	02	03	04	05	06	07	08	09	10	11	12
1	01	32	60	91	121	152	182	213	244	274	305	335
2	02	33	61	92	122	153	183	214	245	275	306	336
3	03	34	62	93	123	154	184	215	246	276	307	337
4	04	35	63	94	124	155	185	216	247	277	308	338
5	05	36	64	95	125	156	186	217	248	278	309	339
6	06	37	65	96	126	157	187	218	249	279	310	340
7	07	38	66	97	127	158	188	219	250	280	311	341
8	08	39	67	98	128	159	189	220	251	281	312	342
9	09	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350

JULIAN DATE CALENDAR (CONTINUED) - FOR NORMAL YEARS ONLY

DAYS | MONTHS-->>												
	01	02	03	04	05	06	07	08	09	10	11	12
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29		88	119	149	180	210	241	272	302	333	363
30	30		89	120	150	181	211	242	273	303	334	364
31	31		90		151		212	243		304		365

TEXT KEY	TEXT DESC
129	

TEXT KEY TEXT DESC
150 INVALID ITA INDICATOR.

M,R,S CLAIMS:

1. OUT OF STATE PROVIDERS (ALSO POSTING EXCEPTION 317) MUST BE PAID AS VOLUNTARY.
   A. IF "V" INDICATOR IN ITA FIELD - FORCE.
   B. IF "I" INDICATOR IN ITA FIELD - CHANGE INDICATOR TO "V" AND FORCE.

2. DETOX PROVIDERS (PROV BEGINS W/34 OR 36) - IF "I" OR "V" - DENY. OTHERWISE REMOVE INDICATOR & ENTER.

3. ALL ELSE - REMOVE THE INDICATOR AND ENTER.

J CLAIMS:
IF ITA EQUAL TO I OR V AND PT IS OTHER THAN 18, 19, 20, 26, 31, 51, 55, 59, 64, OR 65 - DENY W/EOBS 228/711.

TEXT KEY TEXT DESC

164

MISSING/INVALID REFERRING PROVIDER #-NAME.

MED VENDOR (P):
1. PROVIDER SELF-REFERRAL/CLIENT SELF-REFERRAL ON DME OR PROSTHETIC /ORTHOTIC REPAIRS (PARTS/LABOR) - FORCE
2. CRUTCHES - "SELF-REFERRAL" - FORCE
3. IF NO NAME OR NUMBER ON ALL OTHER SERVICES - DENY

PHYSICIAN (J) (RETAIN FOR FUTURE CSR USE)
1. PROVIDER TYPE 20 W/SPECIALTY 30 - DENY.
2. NO REFERRING PHYSICIAN AND BILLING ONE LINE - DENY.
3. MULTIPLE LINES BILLED;
   A.PF-4 UNDER PROCEDURE CODE'S TO DETERMINE IF A CONSULT.
     (IF ALL PROCEDURES ARE CONSULTS - DENY THE 164 AT HEADER)
   B.REMOVE UNITS ON THE CONSULT PROCEDURE CODE LINE AND ENTER EOB 038 IN FIRST EOB SLOT.
   C.ENTER THE CLAIM, DENY THE 183 AND FORCE THE 164 EXCEPTION.
   D.PUT UNITS BACK IN & ENTER THE CLAIM.
ALL ELSE - DENY.

TEXT KEY TEXT DESC
165 POSSIBLE HEALTH INSURANCE.

TPL (LOC. 04)

1. IF PROVIDER IS TO BILL INSURANCE - DENY.
2. IF PART PAID BY INSURANCE - FORCE USING EOB 031.
3. IF FULLY PAID BY INSURANCE - DENY WITH EOB 032.
4. IF CLAIM STATES INSURANCE EOB ATTACHED BUT NONE WAS ATTACHED - DENY WITH EOB 980.
5. IF INVALID DENIAL - PATIENT RESPONSIBILITY - DENY WITH EOB 981.
6. IF INVALID DENIAL - INSURANCE REQUESTS NOT MET - DENY WITH EOB 982.
7. IF RECOMMEND PAY - FORCE.
8. ITA COURT HEARINGS, REQUIRED BY STATE, ARE NOT COVERED BY INSURANCE-FORCE.
9. WHEN THE INSURANCE EOB DENIAL IS IN ERROR - DENY WITH EOB 291.
10. WHEN THE INSURANCE EOB IS ATTACHED BUT INSURANCE PAYMENT IS NOT INDICATED ON THE HCFA 1500 - DENY WITH EOB 987
11. WHEN THE INSURANCE EOB'S BILLED AMOUNT, PAID AMOUNT OR OTHER DOLLAR AMOUNTS DO NOT MATCH THE CLAIM - DENY WITH EOB 551.

12. WHEN THE INSURANCE PAYMENT ON THE EOB DOES NOT MATCH INSURANCE AMOUNT ON CLAIM - DENY WITH EOB 557.
13. WHEN THE INSURANCE COMPANY HAS DENIED THE CLAIM AND WE VERIFIED WITH INSURANCE COMPANY THAT THE PROVIDER BILLED IN ERROR - DENY WITH EOB 516.
14. WHEN THE INSURANCE EOB'S PATIENT NAME, DATE OF SERVICE OR OTHER FIELDS DO NOT MATCH THE CLAIM - DENY WITH EOB 487.
15. IF INSURANCE INFORMATION ON THE CLAIM BUT NO TPL INSURANCE SCEEN ON ELIGIBILITY FILE - DENY WITH EOB 485.
16. IF "HM" IS NOT ON COUPON FOR DOS ON CLAIM - FORCE USING EOB 541.
17. IF PROCEDURE CODES ARE 5970M-5976M (1ST STEPS DISCRETIONARY ADD-ON FEE) &:
    EXCEPTION CODES 248, 254, 258 OR 270 IS SUSPENDING AND BACKUP INDICATES HEALTHY OPTIONS, REMOVE "Y" FROM TPL. IF INSURANCE BACKUP IS ATTACHED, APPLY NORMAL TPL POLICY.
18. IF A VALID INSURANCE DENIAL IS ATTACHED, FORCE WITH APPLICABLE EOB.
19. IF THE CLAIM IS ELECTRONIC BILLING AND EXCEPTION 165 POSTS AND THERE NO "I" IN THE TPL INDICATOR FIELD - FORCE.
    IF THE DOCUMENTATION SUPPORTS TPL PAYMENT ADJUST ACCORDINGLY.
20. IF CLAIM NEEDS TO BE SEEN BY A CASE MANAGER IN THE FBI OR IRS UNITS, (I.E. STATUS 2 EXSISTS ON TPL DATA SCREEN OR SUPPORT ENFORCEMENT IS INVOLVED) - OVERLOC TO LOC 05 & FORWARD LIVE CLAIM AND BACKUP TO CASE MANAGER.

21. IF CHAMPUS DENIAL IS ATTACHED TO CLAIM &:
    A. EOB IS 026, 046, 107, 108 OR 110 - DENY WITH EOB 868.
    B. EOB IS 075, 077, OR 079 - PAY WITH INFO EOB 869.

22. IF CO-PAY & EXCEPTIONS 251 OR 254 POSTING - (TPL) VERIFY IF DUAL COVERAGE IS IN EFFECT &:
    A) IF DUAL COVERAGE IS IN EFFECT - FORCE EXCEPTIONS 165, 251/254,

263.
B) IF DUAL COVERAGE IS NOT IN EFFECT - DENY EXCEPTION 251/254 WITH EOB 151.

TEXT KEY TEXT DESC
166

TPR VS MEDICARE/HMO EXCEPTIONS:

1. NO BACKUP, AND;
   A. ONLY 166 POSTING - PA-2.
   B. IF CLAIM INDICATES DSHS PD AND 134 NOT POSTING - DENY W/EOB'S 831/293.
   C. 166 AND 261/247 POSTING - DENY 166 W/EOB 335 & PA-2 ALL OTHER EXCEPTIONS OTHER THAN ELIGIBILITY AND TIMELINESS.
   D. 166 AND HMO/MHC EXCEPTION POSTING - DENY 166 W/EOB 835 AND PA-2 THE HMO/MHC.
   E. 166 AND 263 POSTING - PA-2.
   F. 166 POSTING W/ANY 2 OF THE FOLLOWING: MEDICARE (261/247), HMO/MHC (552) OR 263 - DENY THE 166 W/EOB 831.

NOTE: IF 103 POSTING (IT MAY BE A PAID X-OVER) WORK 103 FIRST.

2. BACKUP, AND;
   A. BACKUP VERIFIES MEDICARE HAS ALLOWED/PAID - PA-2 166 AND WORK THE MEDICARE EXC. IF NO MEDICARE EXC POSTING, DENY PER APPROPRIATE SECTION OF INFO TEXT BY CLAIM TYPE.
   B. IF RA ATTACHED SHOWING DSHS PAID ON SOME DETAIL LINES AND 134 EXC IS NOT POSTING, DENY THE 166 EXC W/EOBS 831/293
   C. 166 EXC POSTING WITH 552 EXC - PA-2 THE 166 EXC.
   D. 166 EXC POSTING WITH 552 & 263 EXC'S - PA-2 THE 166 EXC, WORK 552 EXC, IF DENYING USE INFO EOB 572.

3. CROSSOVER (O) PHYSICIAN AND MED VENDOR CLAIMS
   NO INSURANCE BACKUP/263 POSTING AND $ IN BOX 32 AND MEDICARE EOMB/RA VERIFIES MEDICARE PAID COINSURANCE AND/OR DEDUCTIBLE, REMOVE $ FROM INSURANCE FIELD, RETOTAL NET AND USE INFO EOB 482.

4. ALL ELSE - PA-2.

TEXT KEY	TEXT DESC
167	

TEXT KEY TEXT DESC
169 --MODIFIER INVALID WITH PROCEDURE.

NOTE: IF ANOTHER EXCEPTION IS ALSO FAILING ON THE SAME LINE, WORK THE OTHER EXCEPTION. IF DENYING THE OTHER EXCEPTION, PA 2 THE 0169 EXCEPTION. IF NOT DENYING THE OTHER EXCEPTION, ADJUDICATE PER THE 0169 TEXT. *BJS

MED VENDOR (P) - SEE PAGE 11.

X-OVER (O) TOS 9 OR R - FORCE.

PHYSICIAN (J) - SEE BELOW
X-OVER (O) TOS 3 OR Z - FORCE

NOTE: MODIFIERS LISTED BELOW APPLY TO THE LINE EXCEPTION 169 IS POSTING ON.
NOTE: FOR THE FOLLOWING MODS TEMPORARILY - 60,GU,QQ,QV,GT - FORCE.

1. MODIFIER 20 - DENY.

2. MODIFIER 22 - DO NOT ALLOW ADDITIONAL SLICES NOR THE USE OF MOD 22 - DENY.

3. MODIFIER 26:
   A. PROCEDURE IS (6) NON COVERED ON PDDDD:
      1. X-OVER (O) - PROCEDURE CODE M0302 - O'LOC TO 83
      2. ALL ELSE - DENY W/EOB 325.
   B. PROCEDURE CODE 10021 OR 10022:
      1. PROR TO DOS 7/1/02 - FORCE.
      2. 7/1/02 DOS & AFTER - DENY.
   C. PROCEDURE CODE HAS A SEGMENT WITH (H OR Q) IN TYPE ON PDDD FOR DOS ON CLAIM - O'LOC TO 83.
   D. ALL ELSE - DENY.

4. MODIFIER 50
   A. CODE 1601L (PODIATRY ORTHOTIC) - ONLY ONE LINE ON CLAIM-REMOVE THE MOD.
   B. CODE 1601L (PODIATRY ORTHOTIC) - MULTIPLE LINES ON CLAIM WITH MOD 50 - REMOVE THE MOD ON ONE LINE AND DENY ALL OTHER LINES W/EOB 324.
   C. OPTHAMOLOSCOPY (92230-92240) & OPHTHALMIC DIAG IMAGE (92135) - FORCE.
   D. IF THERE IS A (Y) IN THE "BI-SURG" FIELD ON THE PDDD FILE- FORCE.
   E. ALL ELSE:
      1. IF PROCEDURE ONLY BILLED ON 1 LINE - DENY W/EOB 866.
      2. IF PROCEDURE BILLED ON 2 SEPARATE LINES:
         EE: O'LOC TO 09.
         RES: REVIEW DUPE TEXTS TO DETERMINE PAYMENT OF MULTIPLES.

5. MODIFIER 51 - FORCE.

6. MODIFIER 52 - FORCE.

7. MODIFIER 53 - FORCE.

8. MODIFIER 54 - IF 222 IS POSTING, WORK IT FIRST, IF NOT DENY W/EOB 576.
9. MODIFIER 55 - IF 222 IS POSTING, WORK IT FIRST, IF NOT DENY W/EOB 576.
10. MODIFIER 56 - IF 222 IS POSTING, WORK IT FIRST, IF NOT DENY W/EOB 576.
11. MODIFIER 57 & 58 - FORCE.

12. MODIFIER 59 - BILLED W/"J" CODES - FORCE. X-OVER TAPES - FORCE.

13. MODIFIER 76 - FORCE. IF RADIOLOGY PROCEDURE SEE 222 IF POSTING.

14. MODIFIER 77,78 OR 79 - FORCE.

15. MODIFIER 80 - DENY.

16. MODIFIER 90 -
    1. IF PROVIDER TYPE 71 (FAMILY PLANNING) - FORCE.
    2. X-OVER CLAIMS - FORCE.
    3. ANY OTHER CODES - DENY.

17. MODIFIER 99 - CHECK COMMENTS OR CLAIM FOR OTHER MODIFIERS.

18. MODIFIER 1C
    A. ENCOUNTER CODES, 9000M-9001M - REMOVE MODIFIER.
    B. ALL ELSE - IF 565 IS ALSO FAILING - FORCE THE 169. OTHERWISE - DENY.

19. MODIFIER 1H - IF BILLED ON ENCOUNTER CODES, 9000M-9001M- REMOVE MOD. IF BILLED WITH IMMUNIZATIONS (90200-90699) - FORCE. ALL ELSE - DENY.

20. MODIFIER 1M - THIS IS A SPECIAL AGREEMENT MODIFIER THAT IS USED TO BRING EXAMINER INTERVENTION AND OVERRIDE THE SYSTEM.
    EE: CHECK FOR PRIOR AUTH, BY REMOVING 1M MOD & F12.
      A. IF THE SYSTEM POSTS 353 OR THERE IS AUTH ON CLAIM - REINSERT MOD & O'LOC TO 23.
      B. IF 353 DOES NOT POST - PUT THE 1M MODIFIER BACK IN AND FOLLOW THE SPECIAL AGREEMENT AND FORCE 169.
    NOTE: IF ANY QUESTIONS ASK YOUR SUPERVISOR.

21. MODIFIER 1P - TOS 3 - FORCE.

22. MODIFIER 2R - DENY.

23. MODIFIER 5A/5B OR U1/U2 (PHYSICIAN CLAIMS ONLY)

    A. PROVIDER TYPE 22 -
       1. PROCEDURE CODE 0728D OR 92502 - FORCE
       2. PROSTHETIC DEVICES, COLLAGEN IMPLANTS, COCHLEAR IMPLANTS, INTRAOCULAR LENSES OR CORNEAL PROCESSING. REMOVE MODIFIER

WITH EOB 359 IN THE 2ND SLOT.

B. OTHER PROVIDER TYPE:
1. PROCEDURES: 93580,96405-96406,99170 - FORCE.
2. PROCEDURES: 78306, 78320, 78802, 78803, 78806, 78807 - FORCE. *S
3. PROCEDURES: GOO02,G0104,G0105,G0121,G0127,G0159,G0160,G0168, G0185,G0186,G0187 - FORCE.
4. PROCEDURE CODES: 0001T-0040T - FORCE.
5. ALL ELSE - DENY.

24. MODIFIER 5N - VALID FOR CODES 8928H AND 8930H. ALL OTHERS DENY.

25. MODIFIER 6N - FORCE IF ICN BEFORE 95012; IF ICN 95012 OR AFTER- DENY

26. MODIFIER GT
A. PROCEDURE CODES (99241-99275, 99201-99215, 90804-90807 AND 90862 - FORCE
B. ALL ELSE - DENY.

27. MODIFIER HA (TOS 3, PHYSICIANS ONLY)
1. 99201-99215 - FORCE IF DOS IS 7/1/03 & AFTER(REPLACES 1C MOD)
2. T2022 - FORCE IF PT 90 & DOS IS 10/1/03 & AFTER.
3. ALL ELSE - DENY.

28. MODIFIER HI (TOS 3 ONLY)
1. T1023 - FORCE IF DOS IS 7/1/03 & AFTER.
2. ALL ELSE - DENY.

29. MODIFIER HQ (TOS 3, PT 58)
1. 92700,97799,T1024,0130S,0140S,0150S - IF DOS IS 10/1/03 DOS & AFTER - FORCE.
2. ALL ELSE - DENY.

30. MODIFIER HX (TOS 3)
1. 0384M (FOR DATE OF SERVICE 7/1/03 AND AFTER) OR T1017 (BILLED FOR DATE OF SERVICE 10/01/03 & AFTER) FOR PT 75 - FORCE.
2. ALL ELSE - DENY.

31. MODIFIER IH
A. HARD COPY/SCANNER - CHECK YOUR KEYING.
B. ALL ELSE - DENY.

32. MODIFIER LT -
A. PHYSICIAN (J) - MOVE TO 2ND MOD POSITION. (IF ANOTHER MOD ON DETAIL LINE, KEY IT IN 1ST MOD POSITION.)
B. PHYSICIAN X-OVER (O) TOS 3 OR Z.
1. SURGERY CODES (10000-69999) - OVERLOC TO 36.
2. OTHER CODES - PT 20, IF TOS IS 9, CHANGE TO 3 & FORCE 169.
3. ALL ELSE - FORCE.

33. MODIFIER MS - O'LOC TO 83.

34. MODIFIER Q1 - Q9 - TOS 3 - FORCE.

35. MODIFIER RT -
    A. PHYSICIAN SERVICES (J) - MOVE TO 2ND MOD POSITION. (IF ANOTHER MOD ON DETAIL LINE, KEY IT IN 1ST MOD POSITION)
    B. X-OVER (O) (PHYS ONLY)
       1. SURGERY CODES (10000-69999) - O'LOC TO 35
       2. OTHER CODES - PT 20, IF TOS IS 9, CHANGE TO 3 & FORCE 169.
       3. ALL ELSE - FORCE.

36. MODIFIER RT AND LT BILLED FOR SAME LINE, PHYSICIANS & PHYSICIAN X-OVERS - KEY IN MOD 99.

37. MODIFER SL - IF BILLED ON ENCOUNTER CODES, 9000M-9001M - REMOVE MOD. IF BILLED W/IMUNIZATIONS (90200-90699) - FORCE. ALL ELSE - DENY.

38. MODIFIER ST - EFFECTIVE W/DOS 7/1/03 & AFTER FOR ALL PHYSICIAN SERVICES, EXCLUDING (CODES 80000-89999 & POS 3) - FORCE. (REPLACES MOD 9T).

39. MODIFIER TC:
    A. IF PROCEDURE IS (6) NON COVERED ON PDDD:
       1. X-OVER (O) - PROCEDURE CODE M0302 - O'LOC TO 83
       2. ALL ELSE - DENY W/EOB 325.
    B. PROCEDURE CODE HAS A SEGMENT WITH (G OR U) ON PDDD FILE FOR DOS ON CLAIM - O'LOC TO 83.
    C. PROCEDURE CODE 10021 - 10022:
       1. PRIOR TO 7/1/02 DOS - FORCE.
       2. 7/1/02 DOS & AFTER - DENY.
    D. ALL ELSE - DENY.

40. MODIFIER TH:
    A. EFFECTIVE W/DOS 7/1/03 & AFTER FOR TOS 3 (PHYSICIAN & ARNP, & MIDFWIFE & HOMEBIRTH SERVICES - FORCE.
    B. EFFECTIVE W/DOS 7/1/04 & AFTER FOR TOS 3, IF BILLED W/PROC CODE T1001 - DENY W/EOB 302.

41. MODIFIER SE - (PT 75 DASA)- EFFECTIVE W/DOS 10/01/03 & AFTER, PROCEDURE CODES T1017, 0341M OR 0385M - FORCE.

42. ALL ELSE- DENY. UNLESS YOU FEEL A MODIFIER IS POSTING INCORRECTLY, THEN O'LOC TO 83.

MED VENDOR (P)

**NOTE: HIT ENTER FIRST AND 169 MAY DROP OFF. IF THE CLAIM IS BILLED BY PROVIDER WITH A "TOS 3" IT MAY POST A 169 THINKING THE CLAIM IS A "J" & THAT THE MODIFIER IS INVALID WITH PROCEDURE. AFTER IT GOES THRU A 'FRONT LINE' EDIT IT MAY CORRECT TOS TO 9. BECAUSE ALL EDITS ARE HELD, ONCE THE 169 POSTS-EVEN WHEN IN ERROR IT REMAINS UNTIL SOMEONE HITS ENTER. IF 169 DOES NOT DROP OFF CONTINUE THRU TEXT.

NOTE: IF 2 MODIFIERS ON SAME LINE - KEY IN ORDER GIVEN.
 EXCEPTION:

1: 5B OR U2 WITH RR-KEY 5B OR U2 IN FIRST MODIFIER FIELD ON LINE WITH X IN LMC AND O'LOC TO 83.

2. PT 51 (GROUND AMBULANCE)
   A. SINGLE DIGIT MODS - DENY
   B. MODIFIER QL-FORCE
   C. THE LETTERS IN THE FOLLOWING LIST ARE THE ONLY ONES VALID FOR MAKING UP THE 2 DIGIT AMBULANCE CODES. ANY COMBINATION OF THE FOLLOWING FORCE: D,E,G,H,I,J,N,P,R,S,T,X- IF ANY OTHER CODE DENY.
   D. ANY MODIFIER ENDING IN 'S'(SCENE OF INCIDENT) - DENY
   E. ALL ELSE - OVERLOC TO 83 FOR REVIEW & UPDATE.

3. MEDICAL NUTRITION
   A. DATES OF SERVICE 11/01/00 THROUGH 10/15/03 - FORCE.
   B. DOS 10/16/03 FORWARD, MODIFIER BO - FORCE.
   C. ALL ELSE DENY.

4. BANDAGES, DRESSINGS, TAPES, GAUZE
   A. A1-A9 - FORCE.
   B. X1-X9 - FORCE DATES OF SERVICE 10/15/03 AND PRIOR. DATES OF SERVICE 10/16/03 AND AFTER - DENY.

5. 22 -VALID WITH A4351 AND A4352 ONLY - ALL ELSE DENY.

6. 59/DY - INCONTINENCE/DIAPER SUPPLIES - FORCE. ALL ELSE OL TO 83.

7. 1P - FORCE DOS 10/15/03 AND PRIOR. DATES OF SERVICE 10/16/03 AND AFTER - DENY.

8. KS - FORCE.

9. MS - VALID WITH E0450, E0460, E0601, K0532, K0533 ONLY. ALL ELSE DENY.

10. 5B/U2 W/ E0450 OR E0460 - FORCE. ALL ELSE DENY.

11. ALL ELSE - O'LOC TO 83 FOR REVIEW.

TEXT KEY TEXT DESC

174 PERFORMING PROVIDIER NUMBER ERROR/REQUIRED - SYSTEM EOB 045 J,K,L.

1. IF PROVIDER TYPE 40 & SP 60;
   A. EE: IF PROVIDER # IS 7056534, 7080617 - PA-2,
      RES: ROUTE TO MACSC, TIM ROTH, MS 45535 FOR REVIEW (NO PPN # ON FILE).
   B. IF NAME OR DUMMY #8999500 - DENY.
   C. ALL ELSE - DENY.

2. IF PROVIDER TYPE 40 & SPEC. 66 OR 68 - KEY 8999500.

3. PROVIDER TYPE 43 (LAB) USING MODIFIER 90 & ANY OF THE FOLLOWING APPLY - DENY W/EOB 256.
   A. NO #
   B. DUMMY #'S (8999500/9999905)
   C. # IS SAME AS BILLING #
   D. INVALID #

4. PROVIDER TYPE 90 & PROCEDURE CODES 0350M-0368M:
   A. MISSING PROVIDER NUMBER - DENY.
   B. PROVIDER NUMBER PRESENT BUT THE PERFORMING PROVIDER ON PCOP SCREEN DOES NOT MATCH FOR DOS - DENY WITH EOB 399. (TO DETERMINE, PF 4 ON THE PIC & PF 6)
   C. PROVIDER NUMBER ON CLAIM, BUT NO PERFORMING PROVIDER # ON PG 6 OF ELIGIBILITY FILE - EE - O'LOC TO LOC 83. DEA - CHECK PG 6 AND IF APPROPRIATE, LOAD PERFORMING # AND PROCESS CLAIM, OTHERWISE DENY WITH APPROPRIATE EOB.

TEXT KEY	TEXT DESC
176	1. FORCE THE FOLLOWING: A. OUT OF STATE PROVIDERS. B. SHORT STAY: IF THE LAST DATE OF SERVICE ("TO-DT:) IS NOT MORE THAN THAN 2 DAYS AFTER THE FIRST DATE OF SERVICE ("FROM-DT:") (IE. 07/01/03-07/03/03 - *FORCE. 07/01/03-07/04/03 - DENY) *AND AT LEAST ONE OF THE FOLLOWING ACCOMODATIONS CODES IS ON THE CLAIM: 490-SHORT STAY, 71X-RECOVERY ROOM, 76X-TREATMENT/ OBSERVATION, 720-722,724-LABOR ROOM/BIRTHING CENTER. C. PRIMARY DX CODE IS 659.13 (FAILED PITOCIN INDUCTION) AND "TO" DATE IS ONE DAY AFTER "FROM" DATE. D. EMERGENCY ROOM (REV CODE 450) IF STAY IS 24 HRS OR LESS (CHECK ADMIT/DISCHARGE HRS). IF MORE THAN 24 HRS - DENY. E. STATEMENT INDICATING "ASU/QRS WANTS THIS STAY REBILLED AS AN OUTPATIENT". F. IF PROVIDER IS A KIDNEY CENTER (PT 62) - FORCE. G. IF DX CODES AND/OR ICD9.CM (SURGICAL) PROC CODES INDICATE DIALYSIS OR RENAL/KIDNEY FAILURE - FORCE. --IF IN DOUBT ASK YOUR TRAINER/SUPERVISOR. H. SERIES OF TESTING FOR TRANSPLANTS. I. DAILY TREATMENT FOR AIDS. J. SWING BEDS - IF SERVICES ARE FOR SWING BEDS OR ANCILLARY CHARGES AT ICF OF SNF LEVEL - PROCESS AS AN "S" CLAIM TYPE. HARDCOPY CLAIMS - DENY 333 AND REPROCESS. ELECTRONIC CLAIMS - DENY WITH EOB 241. K. SLEEP STUDIES (95805-95811) - IF "TO" DATE IS 1 DAY AFTER "FROM" DATE. L. THERAPIES: 1. HYPERBARIC OXYGEN THERAPY (REVENUE CODE 413) 2. CHEMOTHERAPY - (I.E. REV CODES 33X, CPT CODES 96400 - 96549, CANCER DIAGNOSES CODE). IF IN DOUBT OVERLOC TO 72. 3. RADIATION THERAPY (IF IN DOUBT OVERLOC TO 72) 4. PHYSICAL THERAPY (REVNUE CODE 42X) 5. SPEECH THERAPY (REVENUE CODES 44X, 470X) 6. OCCUPATIONAL THERAPY (REVENUE CODE 43X) 7. NUTRITIONAL THERAPY 2. ALL ELSE - DENY.

TEXT KEY TEXT DESC
177 INVALID/INCORRECT UNITS

VERIFY CLAIM TYPE BY CHECKING CLAIM TITLE ON TOP OF CLAIM SCREEN:
(J) PHYSICIANS START ON PAGE 1
(K) DENTAL STARTS ON PAGE 28
(L) EPSDT STARTS ON PAGE 20
(P) MED VENDOR STARTS ON PAGE 22
(O) MEDICARE XOVER TAPES START ON PAGE 29

---NOTE:NURSE DELEGATION SERVICE (8900N-8903N) - SEE MED VENDORS

---CHECK YOUR KEYING BEFORE APPLYING THIS TEXT.

---REMEMBER - IF NOT SPECIFICALLY ADDRESSED, SEE END OF APPROPRIATE CLAIM TYPE/SECTION FOR DETERMINATION.

PHYSICIANS (J)
---IF AUTHORIZATION # ON THE CLAIM & NOT ADDRESSED BELOW - O'LOC TO 23 FOR LOC 23 RES FOR REVIEW OF AUTH #.

1. CALLS (99201-99215, 99231-99233, 99433, 99261-99263, 99171-99174)
   A. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
   B. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY 305.
   C. IF NON-CONSECUTIVE DAYS ARE BILLED - DENY 305.
   D. IF PAIN MANAGEMENT PERFORMED BY AN ANESTHESIOLOGIST, ALLOW 1 FOLLOWUP HOSPITAL CALL & 1 EPIDURAL. ADDITIONAL REQUIRES AUTHORIZATION - DENY W/EOB 020.

2. ADMITS (99221-99223)
   A. BEGINNING AND ENDING DOS SAME- CUT TO 1 UNIT W/EOB 431.
   B. BEGINNING AND ENDING DATES DIFFERENT - DENY.

3. DISCHARGE (99238) PAY ONLY 1 PER HOSP VISIT, IF MULTIPLES - CUT TO ONE AND USE EOB 431.

4. NURSING HOME VISITS (99301-99333)
   A. BEGINNING & ENDING DATE SAME - DENY 538.
   B. BEGINNING & ENDING DATES DIFFERENT - DENY 417.

5. PSYCHOTHERAPY (90801-90844) -- IN POS 1,21,51:
   A. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
   B. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY 305.
   C. IF NON-CONSECUTIVE DAYS ARE BILLED - DENY 187.

6. PSYCHOTHERAPY (90801-90844) -- IN POS OTHER THAN 1,21,51:
   A. BEGINNING & ENDING DATE SAME - DENY 538. NOTE: IF BILLING IS FOR 90801 AND PROVIDER INDICATES JUSTIFICATION FOR 2ND HR ON SAME DAY - FORCE.
   B. BEGINNING & ENDING DATES DIFFERENT - DENY 417.

7. PULMONARY (94010-94652 & 94664-94770)

A. BEGINNING & ENDING DATE SAME - DENY 538. EXCEPTION - IF CLAIM STATES PATIENT ON VENTILATOR - FORCE.
B. BEGINNING & ENDING DATES DIFFERENT -
1. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
2. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY 305.

8. CRITICAL CARE/PROLONGED SERVICES:
INITIAL HOUR (99291) CC (99354 & 99356) PROLONGED SERVICES
A. IF ENDING AND BEGINNING DOS ARE SAME - CUT TO 1 UNIT W/EOB 431.
B. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
C. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY W/EOB 305.
EACH ADDITIONAL (99292) CC (99355 & 99357) PROLONGED SERVICES
A. IF BEGINNING AND ENDING DOS ARE SAME - FORCE.
NOTE: IF FORCING 99292, 99355 OR 99357 CUT UNITS TO MAX OF 4, W/INFO EOB 101 & FORCE 177.
B. IF BEGINNING AND ENDING DOS ARE DIFFERENT - DENY W/EOB 417.

9. NEONATAL INTENSIVE CARE:
(99293,99294,99295,99296,99298,99299)
A.BEGINNING AND ENDING DOS SAME - CUT TO 1 W/EOB 431.
B.BEGINNING AND ENDING DOS DIFFERENT:
A. IF UNITS EQUAL NUMBER OF DAYS BILLED - FORCE.
B. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY W/EOB 305.

10. FQHC ENCOUNTER CODES:
A. 9000M:
1. IF UNITS ON LINE EQUAL # OF DAYS BILLED - FORCE.
2. IF UNITS DO NOT EQUAL # OF DAYS BILLED - DENY W/EOB 305/187.
3. IF NON-CONSECUTIVE DAYS ARE BILLED - DENY W/EOB 187.
B. 9001M AND 5900M:
1. IF BILLED & PD W/GLOBAL PROCEDURE/MATERNITY OR PRENATAL CARE (5947M, 5951M, 5952M, 59400, 59410, 59425, 59426, 59430, 59510 59515, 59610, 59612, 59614, 59618, 59620 & 59622)-FORCE.
2. ALL ELSE - CUT TO 1 UNIT W/INFO EOB 431.
C. 9007M AND 9005M - CUT TO 1 UNIT W/INFO EOB 431.
D. 9006M - ENCOUNTER CODE BILLED ON ONE LINE ONLY WITH MULTIPLE UNITS & UNITS EQUAL NUMBER OF DIFFERENT MATERNITY SUPPORT SERVICE CODES FOR SAME DOS - FORCE. IF NOT, CUT THE ENCOUNTER CODE UNITS TO THE NUMBER OF MSS CODES BILLED W/INFO EOB 101 & FORCE.
MSS CODES (0400M - 0406M, 0410M, 0420M, 0421M AND 0423M)
NOTE: 9006M - AS OF 10/01/03 & AFTER - THESE SVCS WILL BE BILLED UNDER PROC T1015. FOLLOW E. BELOW-1 ALLOWED PER DAY.
E. T1015 - STARTING DATES OF SERVICE 10/01/03 AND AFTER
1. T1015 W/MODIFIER TH - ALLOW MULTIPLE ENCOUNTER UNITS WHEN BILLED IN COMBINATION WITH A GLOBAL MATERNITY PROC CODE.
2. T1015 BILLED BY A DENTIST (PT 27) - ALLOW MULTIPLE UNITS WHEN BILLED IN COMBO W/A GLOBAL DENTAL PROCEDURE.
3. IF UNITS ON LINE EQUAL # OF DAYS BILLED - FORCE.
4. IF UNITS DO NOT EQUAL # OF DAYS BILLED - DENY W/EOB 305/187.
5. IF NON-CONSECTUTIVE DAYS ARE BILLED - DENY W/EOB 187.
ANY QUESTIONS ON FQHC ENCOUNTERS- SEE SUPV/TRAINER/MMIS

11. ANESTHESIA CODES (00100-01999,02100,02101,5911M-5915M) -
SEE 227 & WORK IT.

EXCEPTION: MOD 99 INDICATING MULTI MODS - 9T/ST & ANESTHESIA MOD ON CLAIM - O'LOC TO 36.

EXCEPTION (01953) NOT BILLED W/MOD, NO BASE ON FILE. PAY UP TO 10 UNITS, W/EOB 101.

EXCEPTION (01996) NOT BILLED W/MOD, NO BASE ON FILE. CUT UNITS TO 1 W/EOB 431.

12. SURGICAL PROCEDURES (10000-69999, 92973-92998, 93501-93536, 96405, 99170, G0104, G0127, G0160, G0168)
NOTE: PHYSICIANS/MATERNITY - SEE NEXT SECTION.
NOTE (36415/36416/36540) SEE LAB PROCEDURES.

A. ANESTHESIA (PT 48/49)
IF TIME UNITS/UNITS ARE INDICATED:
1. NO ANES BASE ON FILE & THERE IS A "2" OR "3" IN THE MULTI SURGI INDICATOR FIELD ON PDDD - DENY W/EOB'S 538/314.
3. NO ANES BASE ON FILE & THERE IS A "O" INDICATOR IN THE MULTI SURGI INDICATOR FIELD ON PDDD - DENY W/EOB 314.
4. IF UNSURE, NOT ADDRESSED ABOVE OR REQUEST APPEAL FROM PROV - - O'LOC TO 59 W/COMMENT IN F7.

B. (20610) ARTHROCENTISIS OF KNEE BILLED WITH J3490, J7315, J7320 - O'LOC TO 14.

C. ALL ELSE - O'LOC TO 36 - WORK OTHER EDITS & INSTRUCTIONS FIRST.
NOTE: ANY INDICATION OF ANESTHESIA, REFER TO SURG/SECTION A.
NOTE: IF TPR POSTING & INSTRUCTIONS ARE PA-2, O'LOC TO 36.
(LOC 36 - FORCE AFTER PRICING 9T/ST) MOD.

13. MATERNITY:
(5935M, 5940M-5949M, 59420, 59430, 5950M, 5951M-5955M)
A. BEGINNING & ENDING DOS ARE SAME - CUT TO 1 UNIT W/EOB 431.
B. BEGINNING & ENDING DOS ARE DIFFERENT - DENY W/EOB 538.
(59425, 59426)
A. BEGINNING & ENDING DOS ARE SAME - CUT TO 1 UNIT W/EOB 431.
B. BEGINNING & ENDING DOS ARE DIFFERENT - DENY.

14. RADIOLOGY (70010-79999)
A. (77400-77416, 77465) DAILY MEGAVOLTAGE
1. IF BILLED ON CONSECUTIVE DAYS - FORCE.
2. IF NON-CONSECUTIVE DAYS ARE BILLED - DENY W/EOB 305.
3. IF SERVICES ON SAME DAY - DENY W/EOB 538.
B. (77419-77430) WEEKLY MEGAVOLTAGE-THERAPY MANAGMENT
THESE PROCEDURES ARE TO BE BILLED ONCE FOR THE ENTIRE WEEK.
IF MULTIPLE UNITS, CUT TO 1 W/INFO EOB 101.
EXCEPTION: IF CLAIM OR COMMENTS INDICATE JUSTIFICATION FOR A HIGHER FEE (IE) YOUNG CHILD, FAST GROWING TUMOR, TERMINAL, OR PATIENTS CONDITION WARRANTS SMALL DOSES TWICE A DAY INSTEAD OF A LARGE DOSE ONCE A DAY, ETC - PA-2 FOR REVIEW BY RES SUP.
C. (76090) IF BILLING MULTIPLE UNITS - DENY W/EOB 302.
D. (76091) CUT TO 1 W/EOB 101.

E. ULTRASOUND ECHOGRAPHY
1. (76805-76815,76818,76819,76825,76827,76856 - IF MULITPLE FETUS, (CHECK DX), CUT BACK OR ALLOW UP TO 2 W/EOB 101, OTHERWISE DENY W/EOB 538.
2. (76816,76826,76828,76857) - IF MULTIPLE FETUS,(CHECK DX), CUT BACK OR ALLOW UP TO 2 W/EOB 101, OTHERWISE DENY W/EOB 538.
3. FORCE 177 IF ALLOWING. IF UNSURE - PA-2 FOR RES REVIEW.

F. BI-100% PROCEDURES PER LINE 2 ON PDDD OR DESCRIPTION OF CODE IS UNI-LATERAL - FORCE UP TO 2. IF MORE THAN 2 - CUT BACK TO 2 WITH INFO EOB 101.

G. ALL ELSE - IF PROVIDER INDICATES BILATERAL - DENY W/EOB'S 538/ 562, OTHERWISE - DENY W/EOB 'S 538/111, EXCEPT CAT SCANS, MRI'S AND ANGIOGRAPHIES - SEE END OF TEXT.

15. LAB (80000-89399, 8000M-8001M, 36415)

A. (8000M-8001M, 82785, 82951, 85029-85030, 86421-86422, 88162,88172 CUT TO 1 UNIT W/EOB 431.

B. IF DRAWING FEE (36415) IS BILLED IN CONJUNCTION WITH (82951 OR 82952) OR IF THE CLAIM INDICATES RUNNING MULTIPLE GLUCOSE TESTS OR IF THE DX IS DIABETES (IE) 250 - FORCE.

C. AUTOMATED LAB PANELS (80002-80012,80016, 80018-80019, 80049-80092) CUT TO 1 UNIT W/INFO EOB 431.

D. MULTICHANNEL TESTS (82040, 82247, 82248, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82942, 82947, 82977, 83615, 83718, 84075, 84100, 84132, 84155, 84170, 84295, 84436, 84443, 84450, 84460, 84478, 84479, 84520, 84550, 85022, 85025, 85651, 86255, 86430, 86592, 86644, 86694, 86704, 86706, 86708, 86777, 86803, 86850, 86900, 86901, 87340) CUT TO 1 UNIT W/INFO EOB 431.

E. COLORECTAL CANCER SCREEN (G0107) - ALLOW UP TO 3 UNITS WHICH = 1 SET. CUT BACK IF NECESSARY W/EOB 101. EXCEPTION 299 WILL POST IF MULTI LINES OR HX INVOLVED. ADJUDICATE PER 299 ACCORDINGLY.

F. 87328 (ANTIGEN) IF DOS IS PRIOR TO 12/31/03 - ALLOW 2, IF MORE THAN 2 ARE BILLED, SEE G. BELOW, 1/1/04 & AFTER - SEE G. BELOW. (CODE DESCRIPTION CHANGED FROM 2 DIFF ANTIGENS TO 1 ANTIGEN)

G. ALL ELSE:
1. BEGINNING & ENDING DATES SAME - DENY W/EOB 538.
2. BEGINNING & ENDING DATES DIFFERENT - DENY W/EOB 417.

16. PM&R (0030M-0034M), THERAPIES (0300B-0301B, 0320B-0330B) SUBSTANCE ABUSE (H0010, H0011) (0133M-0134M, 0143M-0144M, 0153M-0154M, 0159M, 0163M-0164M, 0171M-0172M, 0174M-0179M, 0180M-0189M, 0190M-0196M, 2133M-2134M, 2139M, 2143M-2144M, 2153M-2154M, 2163M-2164M, 2173M-2174M, 2183M-2184M, 2190M-2194M, 2197M)

A. UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.

B. UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY W/EOB 305.

C. NON-CONSECUTIVE DAYS ARE BILLED - DENY W/EOB 187.

D. 0159M - FOR DATE OF SERVICE 6/30/03 AND BEFORE - FORCE.

17. SUBSTANCE ABUSE (0130M-0131M, 0140M-0142M, 0150M-0152M, 0160M-0162M, 2130M-2132M, 2140M-2142M, 2150M-2152M, 2160M-2162M, 2170M-2172M, 2175M, 2177M, 2180M-2182M, 2187M-2189M) FOR ASSESSMENT, INTAKE PROCESSING OR PHYSICAL EXAM - DENY

18. MATERNITY SUPPORT SVCS/MAT CASE MGMT
EXCEPTION 177 TURNED OFF AS OF 10/27/03 TO FACILITATE PROCESSING.
A. MSS - (0400M-0405M, 0420M, 0421M) X-WALKED PROCESSING CODES.
UP UNTIL 9/30/03 - ALLOW 1 UNIT PER PROCEDURE CODE PER DAY.
CUT TO 1 UNIT WITH INFO EOB 431.
10/01/03 & AFTER - ALLOW MULTIPLE UNITS FOR ALL PROCEDURES.
B. MATERNITY CASE MNGMENT (0076M-0082M) CUT TO 1 PER MONTH W/EOB 431. THE MCM PROGRAM IS INTIGRATED INTO MSS AS OF 10/01/03.

19. PAIN MANAGEMENT (0088M-0099M)
A. (0097M-0098M) & UNITS EQUAL NUMBER OF DAYS BILLED - FORCE.
B. ALL ELSE - CUT TO 1 UNIT W/INFO EOB 431.

20. DETOX ADMIT (0025M)
A. BEGINNING & ENDING DOS SAME - CUT TO 1 W/EOB 431.
B. BEGINNING & ENDING DOS DIFFERENT:
1. SPLIT OUT & PAY THE OLDEST DATE 1 UNIT W/EOB 431.
2. DENY EXCESS DATES & UNITS W/EOB 339

21. OCCUPATIONAL THERAPY, SPEECH THERAPY, AUDIOLOGY, MEDICAL NUTRITION THERAPY AND VARIOUS OTHER TESTING PROCEDURES BILLED BY PROVIDER TYPES 18 20 24 36 37 39 40 & 93.
A. 0910M AND 0911M - OVERLOC TO 67
B. 92506:
1. BEGINNING & ENDING DOS SAME:
A. AUTH # - O'LOC TO 37.
B. ALL ELSE - CUT TO 1 W/INFO EOB 431.
2. BEGINNING & ENDING DOS DIFFERENT - O'LOC TO 37.
C. 92507 & 92508:
1. BEGINNING & ENDING DOS SAME - CUT TO 1 W/INFO EOB 431.
2. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 417.
D. 92510 - CUT TO 1 W/INFO EOB 431.
E. 92525 & 92526:
1. BEGINNING & ENDING DOS SAME - CUT TO 1 UNIT W/INFO EOB 101.
2. BEGINNING & ENDING DOS DIFFERENT:
A. UNITS DIVIDE EVENLY - FORCE.
B. UNITS DO NOT DIVIDE EVENLY - DENY W/EOB 538.
F. 92541 - CUT TO 1 W/INFO EOB 431.
G. 92542 - CUT TO 1 W/INFO EOB 431.
H. 92543 - ALLOW 1 UNIT PER IRRIGATION, UP TO 4 UNITS PER EAR. PAY UP TO 8 MAX W/INFO EOB 101 & FORCE 177. DENY ALL OTHERS W/EOB 339.
I. 92544 - CUT TO 1 W/INFO EOB 431.
J. 92545 - CUT TO 1 W/INFO EOB 431.
K. 92546 - ALLOW 1 UNIT PER VELOCITY/PER DIRECTION, UP TO 3 UNITS FOR EACH DIRECTION. IF OVER MAX CUT TO MAX W/INFO EOB 101 & FORCE 177. ANY QUESTIONS O'LOC TO 83.
L. 92547 - CUT TO 1 UNIT W/INFO EOB 431.
M. 92551-92599 - CUT TO 1 UNIT W/INFO EOB 431.
N. 92607 & 92610 - CUT TO 1 UNIT W/INFO EOB 431.
O. 95832-95834 - CUT TO 1 UNIT W/INFO EOB 431.
P. 95860-95875:
1. 95860-95863,95867 - DENY W/EOB 302.
2. 95864,95868-95870 AND 95875 - CUT TO 1 W/INFO EOB 431.

Q. 97001-97003 - CUT TO 1 W/INFO EOB 431.
R. 97150 - CUT TO 1 UNIT W/INFO EOB 431.
S. 97504:
1. PT 36 - FORCE.
2. ALL OTHER PROVIDER TYPES- IF BILL MORE THAN 2 UNITS, CUT TO 2 UNITS, GIVE INFO. EOB 101, AND FORCE THE 0177 EXC. *BJS
T. 97703 - DOS BEFORE 6/1/00 FORCE. DOS 6/1/00 & AFTER FORCE PROVIDER TYPE 36, ALL OTHER PROVIDER TYPES IF MORE THAN 2 UNITS, CUT TO MAX OF 2 PER DAY W/INFO EOB 101 & FORCE THE 177. ALL ELSE FORCE THE 177. EXCEPTION: IF WHEELCHAIR NEEDS ASSESSMENTIS INDICATED ON THE CLAIM ALLOW UP TO 4 UNITS PER DAY.
U. 97803 - IF BILLING 4 OR LESS UNITS PER DOS - FORCE. IF MORE THAN 4, CUT TO 4 W/INFO EOB 101.
V. 97804:
1. DOS PRIOR TO 7/1/02: IF BILLING 2 OR LESS UNITS PER DOS FORCE. IF MORE THAN 2, CUT TO 2 W/INFO EOB 101.
2. DOS 7/1/02 & AFTER: IF BILLING 4 OR LESS UNITS PER DOS FORCE. IF OVER 4, CUT TO 4 W/INFO EOB 101.
W. ALL OTHER PROCEDURE CODES & PT 20, 36, 37, 40 & 58 O'LOC TO 83.

22. IV INFUSION THERAPY: (90780 & 90781)
A. 90780:
1. BEGINNING & ENDING DOS SAME- CUT TO 1 UNIT W/INFO EOB 431.
2. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 417.
B. 90781:
1. BEGINNING & ENDING DOS SAME - FORCE.
NOTE: IF FORCING, CUT TO MAX OF 8 W/INFO EOB 101.
2. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 417.

23. CHEMOTHERAPY INFUSION (96410, 96412, 96414)
A. (96410, 96414) CUT TO 1 UNIT W/INFO EOB 431.
B. (96412)
1. BEGINNING & ENDING DOS SAME - FORCE.
NOTE: IF FORCING, CUT TO MAX OF 7 W/INFO EOB 101.
2. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 417.

24. PROVISION OF CHEMOTHERAPY (96545) OR UNLISTED THER INJ (90799)
A. DENY W/EOB 431.
B. MULTIPLE CLAIMS FOR SAME PROVIDER W/UNIT PROBLEMS - REFER 1 SAMPLE CLAIM BY ROUTING TO PRU/SANDY MITCHELL/MS 5562.

25. RENAL DISEASE (90918-90921) - DENY.

26. RENAL DISEASE (90922-90925), DIALYSIS (90935-90937, 90945-90947):
A. UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
B. UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY W/EOB 305.
C. NON-CONSECUTIVE DAYS ARE BILLED - DENY W/EOB 187.

27. ANTIGENS (95115, 95117, 95120) & IMMUNOTHERAPY (95199)
A. 95115 - DENY W/EOB 302.
B. 95117 - CUT TO 1 UNIT W/EOB 431.
C. 95120 - CUT TO 1 UNIT W/EOB 431.
D. 95199 - CUT TO 1 UNIT W/EOB 431.

28. PODIATRY:
    A. 1600L,1602L,1603L: MULTIPLE UNITS - DENY W/EOB 538/235.
    B. 1601L,1604L: MULTIPLE UNITS - DENY.

29. HIV/AIDS CASE MANAGEMENT (0470M & 0471M) CUT TO 1 UNIT W/EOB 431.

30. CLOZARIL (0857J) OR (90862 W/DX 295-295.9)
    A. BEGINNING & ENDING DOS SAME - CUT TO 1 UNIT W/EOB 431/339.
    B. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 417.

31. RABIES IMMUNE GLOBULIN (90742)
    A. MOD 2R
       1. DOS IS PRIOR TO 7/1/98 - DENY THE 169 EXCEPTION W/EOB 431.
       2. DOS IS 7/1/98 & AFTER - FORCE.
    B. NO MOD 2R - O'LOC TO 83.

32. INJECTABLE DRUGS (J CODES)
    A. 1111J - CUT TO 1 UNIT W/INFO EOB 538.
    B. J1055 - CUT TO 1 UNIT W/INFO EOB 538.
    C. IF MAX SUSPEND STATUS ON PDDD - CUT TO 1 UNIT W/ INFO EOB
       431. EXCEPTION: (J3490) - ENTER CLAIM (177 WILL GO AWAY).
    D. IF DESCRIPTION/COMMENT IS SYNAGIS/PALVIZUMAB/SYNVISC/HYALGAN-
       DO NOT CUT UNITS, O'LOC TO 14.

33. VACCINE/TOXOID ADMINS (90471-90472) & SAME DOS
    A. (90471) DENY W/EOB 452.
    B. (90472) CUT TO 1 UNIT W/EOB 431.
    NOTE:
        A. PRIOR TO 7/1/00 DOS - CODES NOT ALLOWED IN COMBO - DENY THE
           LESSER W/EOB 910.
        B. 7/1/00 DOS & AFTER - ALLOW 1 EACH FOR SAME SESSION,
34. ALL OTHER VACCINES
    A. BEGINNING & ENDING DOS SAME - CUT TO 1 W/EOB 431.
    B. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 538.

35. MIFEPRISTONE (RU-486)
    A. S0190 - ALLOW UP TO 3 UNITS, IF MORE, CUT TO 3 W/EOB 101.
    B. S0191 - ALLOW UP TO 2 UNITS, IF MORE, CUT TO 2 W/EOB 101.

36. SYNAGIS (90378) OR (90399) - DO NOT CUT, IF EXCEPTION 611 IS
    POSTING ON THE LINE, O'LOC TO 23.
    EFF 7/1/03 DOS - FORCE MULTI UNITS UP TO 4, ALL ELSE - O'LOC TO 75.

37. OSTEOPATHIC THERAPY (98925-98929) CUT TO 1 UNIT W/EOB 431.

38. VARICILLIN (90396) ALLOW UP TO 5 UNITS, IF MORE CUT TO 5 W/EOB 101.

39. 92135 (SCAN COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING UNILAT) -
    PAY 2 ONLY, IF OVER CUT TO 2 W/INFO EOB 101 - WITH MOD 50 - FORCE.

40. MIDWIVES (PT 94)
    A. 9804M OR 59409 W/SU MODIFIER - OVERLOC TO 83.
    B. S8415 - CLAIMS PROCESSING: WORK EXCEPTION 365.
       NOTE FOR SPECIALLY APPROVED BATCH FROM BEV ATTERIDGE ONLY:

CUT TO 1 UNIT W/EOB 431.

41. MEDICAL CONFERENCE (99361-99362):
    A. 99361 (MEDICAL CONFERENCE 30 MINUTES APX) - DENY W/EOBS 452/302.
    B. 99362 (MEDICAL CONFERENCE 60 MINUTES APX) - CUT TO 1 W/INFO EOB 431.

42. 0120S (PSYCH EVAL) EFF W/DOS 10/1/03 - O'LOC TO 83, OTHERWISE FORCE.

43. A4646 (CONTRAST MATERIAL) - CUT TO 1 UNIT W/INFO EOB 431.

44. 99075 (COURT TESTIMONY) - ALLOW UP TO 5 UNITS PER HEARING (DAY) IF MORE THAN 5 BILLED, CUT BACK TO 5 W/EOB 431.

45. ALL ELSE:
    A. BEGINNING & ENDING DOS SAME - DENY W/EOB 538.
    B. BEGINNING & ENDING DOS DIFFERENT:
       1. UNITS DIVIDE EQUALLY INTO CONSECUTIVE DAYS - FORCE.
       2. ALL ELSE - DENY W/EOB 417.
    C. UNABLE TO DETERMINE - SEE YOUR SUPERVISOR.

EPSDT/HEALTHY KIDS (L):

1. 99381-99385, 99391-99395 (SCREENING CODES)
   A. BEGINNING & ENDING DATE SAME - DENY 538.
   B. BEGINNING & ENDING DATES DIFFERENT - DENY 417
2. 9000M - FQHC ENCOUNTER
   A. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
   B. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY WITH EOB 305.
   C. IF NON-CONSECUTIVE DAYS BILLED - DENY WITH EOB 305.
3. EPSDT/RABIES IMMUNE GLOBULIN (90742)
   A. IF MOD 2R - FORCE IF DOS IS 7/1/98 AND AFTER
   B. ALL ELSE - DENY.
4. VACCINES/TOXOID ADMINS 90471/90472
   A. 90471 - DENY W/EOBZ 452.
   B. 90472 - CUT TO 1 UNIT W/INFO EOB 431.
   NOTE: PRIOR TO 7/1/00 DOS - THESE CODES MAY NOT BE BILLED IN COMBO, 7/1/00 DOS & AFTER - THEY MAY BE BILLED ONCE EACH FOR SAME SESSION.
5. ALL OTHER VACCINES
   A. BEGINNING & ENDING DOS SAME - CUT TO 1 W/INFO EOB 431.
   B. BEGINNING & ENDING DOS DIFFERENT - DENY W/EOB 431.
6. ALL ELSE - DENY W/EOB 538.

MEDICAL VENDOR (P)

---IF PRIOR AUTH # ON CLAIM: O'L TO 23 RES: WORK ACCORDING TO AUTH.

---RENTAL RATES ARE CALCULATED ON A MONTHLY BASIS UNLESS OTHERWISE INDICATED IN THE BILLING INSTRUCTIONS. SOME RENTALS ARE CALCULATED ON A DAILY BASIS IN WHICH CASE MULTIPLE UNITS ARE APPROPRIATE BUT DAYS MUST MATCH UNITS BILLED. IF PROVIDER BILLING FOR MULTIPLE UNITS ON A MONTHLY RENTAL CLAIM CUT UNITS TO 1 W/INFO EOB 431.

IF PROVIDER BILLING CLAIM FOR DAILY RENTAL CUT UNITS TO MATCH DAYS BILLED W/INFO EOB 101.

1. NURSE DELEGATION (PT 33 & 44) (8900N - 8903N)
   A. BEGINNING & ENDING DOS IS SAME - FORCE.
   B. BEGINNING & ENDING DOS IS DIFFERENT:
      1. DATES DIVIDE EVENLY - FORCE.
      2. DATES DO NOT DIVIDE EVENLY - DENY W/EOB 417.

2. E0776-RR (IV POLE) - CODE CHANGING FROM "WEEKLY" TO "MONTHLY" -
   A. 11/01/00 DOS & AFTER - DENY.
   B. PRIOR TO DOS 11/01/00
      1. MORE THAN 4 UNITS - DENY.
      2. 2, 3 OR 4 UNITS - FORCE.

3. A7509-CODE CHANGED 7/1/03 FROM NO LIMIT TO LIMIT OF ONE PER DAY
   SERVICE DATES PRIOR TO 7/1/03-FORCE
   SERVICE DATES AFTER 7/1/03 AND UNITS DO MATCH NUMBER OF DAYS BILLED-FORCE
   SERVICE DATES AFTER 7/1/03 AND UNITS DON'T MATCH THE NUMBER OF DAYS BILLED DENY W/EOB 305.

4. 4037B, 4039B, 4051B, 4056B, 4057B, 4058B, B4034, B4035, B4036 (ENTERAL SUPPLY KITS)-
   A. IF UNITS MATCH NUMBER OF DAYS BILLED-FORCE
   B. IF UNITS DO NOT MATCH NUMBER OF DAYS BILLED-DENY W/EOB 305
      UNLESS COMMENTS INDICATE "NOT USED DAILY"-FORCE

5. 4085B(ENTERAL TUBING)-
   07/01/01 DOS & AFTER-PROVIDER ALLOWED 1 PER CLIENT EVERY 3 MO
   PRIOR TO DOS 7/1/01-PROVIDER ALLOWED 2 PER CLIENT PER MO
   A. PRIOR TO DOS 7/1/01 CUT UNITS TO 2 W/INFO EOB 101
   B. AFTER 7/1/01 DOS CUT UNITS TO 1 W/INFO EOB 101

6. 4991A-BILIRUBEN LIGHT THERAPY SUPPLIES -ALLOWED MAXIMUM OF 5 DAYS
   0169E-BILIRUBIN LIGHT OR BILI-LITE PAD-ALLOWED MAXIMUM OF 5 DAYS
   E0202- PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER-ALLOWED MAXIMUM OF 5 DAYS.
   A. IF UNITS MATCH NUMBER OF DAYS BILLED-FORCE
   B. IF UNITS UNDER 5 AND DON'T MATCH # OF DAYS BILLED-DENY W/EOB 305
   C. IF OVER 5 UNITS BILLED CUT UNITS TO 5 W/INFO EOB 101

7. B4220, B4222, B4224 (PARENTERAL SUPPLY KITS)
   A. IF UNITS DO NOT MATCH NUMBER OF DAYS BILLED - DENY W/ 305.
      UNLESS COMMENTS INDICATE "NOT USED DAILY" - FORCE

8. PT 51 GROUND AMBULANCE - 0010A (OXYGEN ADMINISTRATION):
   A. IF STATEMENT ON CLAIM OR ATTACHED DOCUMENTS INDICATE A LONG TRIP (I.E. SPOKANE TO SEATTLE) - FORCE.
   B. IF MILEAGE (0007A, 0008A, 0016A) ON SAME CLAIM IS BILLED WITH 50 OR MORE UNITS (MILES) - FORCE.
   C. IF NONE OF THE ABOVE - CUT TO 1 UNIT W/INFO EOB 431.

9. PT 34 PHYSICAL THERAPY -

A. Q0103 OR Q0104 - CUT TO 1 PER DAY W/INFO EOB 431.
B. 95831-95834 MUSCLE TESTING OVERLOC TO 83.
C. 97001-97002 - CUT TO 1 PER DAY W/INFO EOB 431.
D. 97150 - CUT TO 1 PER DAY W/INFO EOB 431.
E. 97504 - DOS BEFORE 6/1/00 FORCE. DOS 6/1/00 & AFTER: IF MORE THAN 2 UNITS, CUT TO MAX OF 2 PER DAY W/INFO EOB 101 & FORCE 177. OTHERWISE FORCE THE 177.
F. 97703 - DOS BEFORE 6/1/00 FORCE. DOS 6/1/00 & AFTER IF MORE THAN 2 UNITS, CUT TO MAX OF 2 PER DAY W/INFO EOB 101 & FORCE 177, OTHERWISE FORCE THE 177. EXCEPTION: IF WHEELCHAIR NEEDS ASSESSMENT IS INDICATED ON CLAIM ALLOW UP TO 4 UNITS PER DAY.

10. IF PROCEDURE CODE & UNITS BILLED SUGGEST A RENTAL BUT TOS IS 9 WITH NO MODIFIER - DENY WITH EOB 036.

11. ADULT DAY HEALTH - P.T. 87 (0801H - 0830H)
A. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
B. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY 305.
C. IF NON CONSECUTIVE DAYS BILLED - DENY 305.

12. MED VENDOR CLOZARIL (0857J)
A. BEGINNING & ENDING DATE SAME - DENY W/EOB 431/339.
B. BEGINNING & ENDING DATE DIFFERENT - DENY W/EOB 417.

13. 0181A (BREAST PUMP KIT) - FORCE.
(NOTE MMIS: PDDD FILE MULTIPLE UNITS 'N' FROM 11/13-12/2/00, CORRECTED 12/2/00.)

14. 4952A - DOS 7/1/00 & AFTER CUT TO 2 UNITS W/INFO EOB 431.

15. PT 39-MEDICAL NUTRITION THERAPY
97802- IF BILLING 8 OR LESS UNITS PER YEAR - FORCE
97803- IF BILLING 4 OR LESS UNITS PER DATE OF SERVICE - FORCE
97804- IF BILLING 2 OR LESS UNITS PER DATE OS SERVICE - FORCE

16. VENT-TRACH WRAPAROUND PAYMENTS 6906T, 6907T, 6908T, 6909T, 6913T 6906V, 6907V, 6908V, 6909V, 6913V ALSO ALS CODES 6912E, 6950E, 6951E IF UNITS = DAYS BILLED FORCE, OTHERWISE DENY W/EOB 305

17. A5119-IF UNITS 50 OR LESS FORCE-IF OVER-DENY
A4253-IF UNITS 50 OR LESS FORCE-IF OVER-DENY
A4221-IF UNITS 4 OR LESS FORCE-IF OVER-DENY

18. S9430- PHARMACY COMPOUNDING AND DISPENSING SERVICES-LMT 3 PER MO
IF UNITS BILLED ARE OVER 3 AND ONE OF THE FOLLOWING COMMENTS ARE ON THE CLAIM-FORCE
1. DOSE ADJUSTMENT REQUIRED
2. MULTIPLE PRESCRIPTIONS/TYPES REQUIRED
3. EMERGENCY FILL
ANYTHING ELSE-DENY

19. A4622-4 UNITS OR LESS-FORCE
MORE THAN 4 UNITS CUT BACK TO 4 WITH EOB 101

20. ALL ELSE-KEY IN 1 UNIT W/INFO EOB 431

DENTAL

1. ROOT PLANING/EXTRACTIONS/RESTORATIONS - MULTIPLE PROCEDURES BILLED ON THE SAME LINE - DENY W/EOB 434.

2. BITEWINGS (D0270, D0272, D0274 - DENY W/EOB 431.

3. 0200D (FQHC ENCOUNTER CODE) FOR DATES OF SERVICE BEFORE 10/01/03 OR T1015 FOR DATES OF SERVICE ON OR AFTER 10/01/03:
IF BILLED W/CODES FOR DENTURES, CROWNS, ROOT CANAL OR SURGERY-FORCE.

4. D3950 (DOWEL POSTS)
A. DOS PRIOR TO 11-1-02 - ALLOW UP TO 3 PER TOOTH.
B. DOS 11-1-02 OR AFTER - KEY 1 UNIT W/INFO EOB 431

5. ALL ELSE - KEY IN 1 UNIT W/INFO EOB 431.

X-OVER TAPE CLAIMS (PHYS/MED VEND)

1. PHYSICIAN CLAIMS (TOS 3)
A. PROCEDURE 66984 W/MOD 55,RT,LT - CUT TO 1 UNIT W/INFO EOB 431.
B. J CODES - FORCE.
C. E & M (99201-99350)
1. UNITS DIVIDE EVENLY INTO DAYS - FORCE.
2. BEGINNING/ENDING DOS SAME - CUT TO 1 W/INFO EOB 431.
3. BEGINNING/ENDING DOS DIFFERENT - DENY W/EOB 305.
D. ESRD (90922 - 90925), DIALYSIS (90935,90937,90945,90947):
1. UNITS DIVIDE EVENLY INTO DAYS - FORCE.
2. UNITS DO NOT DIVIDE EVENLY - DENY W/EOB 305.
E. ESRD (90918 - 90921) - CUT TO 1 W/INFO EOB 101.
F. 00100 - 01999 W/MOD QS - FORCE.
G. PROVIDER TYPE 48/49 - DENY W/EOB 314, UNLESS 636/227 IS POSTING, THEN WORK IT FIRST.
H. SURGERIES (10000 - 69999) EE - O'LOC TO 36, LOC 36
1. EE - 0'LOC TO 36
2. RES/ADJ - CUT BACK TO 1 W/INFO EOB 431 UNLESS DESCRIPTION OR OTHER POLICY, MODIFIERS, ETC APPLIES TO ALLOW MULTI'S.
NOTE: ANY QUESTIONS - SEE TRAINER/MMIS.
I. PROCEDURE INDICATES (BI-100%) IN DESCRIPTION OF PDDD.
1. PROCEDURE BILLED ONLY ON 1 LINE OF CLAIM - PAY MAX OF 2 UNITS.
2. PROCEDURE BILLED ON MULTIPLE LINES - PAY UP TO 2 LINES W/1 UNIT EACH.
J. PSYCHOTHERAPY (90801-90844):
1. IF UNITS ON CLAIM EQUAL NUMBER OF DAYS BILLED - FORCE.
2. IF UNITS DO NOT EQUAL NUMBER OF DAYS BILLED - DENY W/EOB 305.
K. ALL ELSE- DENY W/EOB 305, UNLESS YOU THINK IT SHOULD BE REVIEWED, THEN O'LOC TO 83.

2. XOVER TAPE CLAIMS (TOS 9 OR R)

A. A7003-DOS AFTER 1/1/02 CUT TO 1 UNIT W/INFO EOB 101
DOS PRIOR TO 1/1/02 - FORCE

B. 4037B, 4039B, 4051B, 4056B, 4057B, 4058B, B4034, B4035, B4036
(ENTERAL SUPPLY KITS)-
1. IF UNITS MATCH NUMBER OF DAYS BILLED - FORCE
2. IF UNITS DO NOT MATCH NUMBER OF DAYS BILLED-DENY W/EOB 305
UNLESS COMMENTS INDIATE "NOT USED DAILY" - FORCE.

C. E0431 RR
E0432 RR
E0434 RR
E0439 RR
E0443
- CUT TO 1 UNIT W/INFO EOB 101
(MONTHLY CODE - MEDICARE REQUIRES PROVIDER TO BILL WITH
AMOUNT OF OXYGEN - MAA DOES NOT)

D. 'L' CODE WITH 2 UNITS - FORCE.

E. A0426 - CUT UNITS TO 1 W/INFO EOB 101. (CROSSWALKED TO 0001A)
A0427 - CUT UNITS TO 1 W/INFO EOB 101. (CROSSWALKED TO 0001A)
A0428 - CUT UNITS TO 1 W/INFO EOB 101. (CROSSWALKED TO 0002A)
A0429 - CUT UNITS TO 1 W/INFO EOB 101. (CROSSWALKED TO 0002A)

F. A4232 - FORCE.
NOTE: MMIS-FORCE UNTIL MAA RATE IS CHANGED TO PAY $2.50
PER UNIT TO MATCH MEDICARE UNITS.
(1 BOX = 30) - 08/16/01.

G. ALL ELSE - OVERLOC TO 83.

TEXT KEY TEXT DESC

183 WHEN UNITS EXCEED 99,999
1. MEDICAL NUTRITION AND PARENTERAL - LEAVE UNITS OUT & DENY.

2. BLOOD BANKS (PT 41) LOC 21: CODE 0800M - USE THE 331 TEXT TO PRICE, CODE J7195 - PRICE ACCORDING TO PDDD FILE.

(O) CLAIMS - MEDICARE X-OVER HARDCOPY & NO UNITES - KEY UNITS FROM RA.

(P) CLAIMS
DENY THE FOLLOWING PROVIDER TYPES: 26,34,37,39,40,51,53,55,78,79.
ALL OTHER PROV TYPES: IF FIRST & LAST DOS THE SAME - KEY 1 UNIT.
IF BEGINNING & ENDING DOS ARE DIFFERENT - DENY.

(W) CLAIMS - KEY FROM BACKUP, IF MISSING FROM BACKUP - KEY A "1".

ALL CLAIM TYPES NOTE:
INFO TEXT 999 WILL STATE THAT IF UNITS W/DECIMALS, IE 2.3 - LEAVE UNITS OUT AND DENY.

ALL ELSE - DENY.

TEXT KEY	TEXT DESC
184	LINE ITEM WITH NO CHARGE SUBMITTED - "N/C", "00", LEFT BLANK.

PHYSICIAN CLAIMS (J) AND MEDICAL VENDOR CLAIMS (P) - IF THERE ARE NO CHARGES INDICATED ON THE CLAIM - DENY.
EXCEPTIONS -

1. IT APPEARS TO BE A REQUEST FOR AUTHORIZATION - DENY 155 AND ROUTE CLAIM TO CAU.
2. IF THE BILLING IS INCOMPLETE, I.E., MORE THAN ONE ITEM MISSING, DENY WITH EOB 158.
3. SCANNED CLAIMS, CHECK PROCEDURE CODE FOR ACCURACY.
4. FQHC ENCOUNTER CODES - IF THE PROVIDER TYPE IS 20 OR 71 AND THE SPECIALTY IS NOT 90, DENY W/EOB 711 IN THE 2ND SLOT.
   ALL ELSE - OVERLOC TO 83. *SR
5. ALL ELSE DENY.

DENTAL CLAIMS (K)
1. IF THE CLAIM APPEARS TO BE REQUEST FOR APPROVAL
   A. IF PROCEDURE CODE REQUIRES APPROVAL - DENY AT HEADER LEVEL WITH EOB 155. INDICATE D-155 ON BATCH COVER SHEET AND CLAIM AND PLACE CLAIM IN ROUTING SLOT IN EXAM ENTRY AREA.
   B. IF PROCEDURE CODE DOES NOT REQUIRE APPROVAL - DENY WITH EOB 166.
2. ALL ELSE - DENY.

TEXT KEY TEXT DESC
190 MISSING OR INVALID ITA INDICATOR

THIS EXCEPTION POSTS FOR TWO REASONS:
---YOU HAVE A CLAIM WITH A PSYCHIATRIC PRIMARY DX AND THERE IS NO ITA INDICATOR - "I" INVOLUNTARY/"V" VOLUNTARY --OR--
---THE CLAIM HAS AN "I" (INVOLUNTARY) IN THE ITA FIELD AND THE PRIMARY DX IS NOT PSYCH (290-302.99, 306-307.80, OR 307.82-316.99).

1. IF AUTH # BEGINS WITH "64" - OVERLOC TO 72. *SH

2. IF THE PRIMARY DX IS PSYCHIATRIC:
   A. OUT OF STATE PROVIDERS (ALSO POSTING EXC 317) - ALL ADMITS ARE PAID AS VOLUNTARY. KEY A "V" IN THE ITA FIELD - ENTER.
   B. ALL ELSE - IF NO INDICATION ON CLAIM/COMMENTS/BACKUP - DENY.

3. IF THE PRIMARY DX IS NOT PSYCH AND THE ITA INDICATOR IS "I":
   A. FORCE IF PRIMARY OR SECONDARY DX IS ALCOHOL DIAGNOSIS: 302 - 305.99, V11.3 OR V79.1.
   B. IF POISONING DX 960-989.9 DENY WITH EOB 081.
   C. ALL ELSE - DENY WITH EOB 278.

TEXT KEY TEXT DESC

192 MEDICARE CLAIM NOT SUBMITTED WITHIN 6 MONTHS FROM MEDICARE PROCESS DATE.

NOTE: SYSTEM COUNTS 181 DAYS FROM THE MEDICARE PROCESS DATE TO THE CURRENT JULIAN DATE. CFR STATES ALLOW 6 MONTHS. IN ORDER FOR CLAIMS PROCESSING TO DETERMINE TIMELINESS, COUNT 6 MONTHS FROM THE MEDICARE PROCESS DATE TO THE CURRENT JULIAN DATE. IE: MEDICARE PROCESS DATE IS 1/5/99 AND CURRENT JULIAN DATE IS 7/5/99 OR LESS - FORCE. IF THE CURRENT JULIAN DATE IS 7/6/99 OR MORE - - DENY.

NOTE: CLAIMS FOR SERVICES RENDERED BY A COMMUNITY HEALTH CENTER PROCESSED ON OR BEFORE FEBRUARY 2,1998 (ICN -98033) SHOULD BE FORCED IF THERE IS AN ATTACHED LETTER FROM THE ASSISTANT ATTORNEY GENERALS OFFICE SIGNED BY DONNA TURNER COBB.

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1. IF RETRO/DELAYED CERTIFICATION COUNT 6 MONTHS FROM THE RETRO/DELAYED DATE TO THE CURRENT ICN & IF TIMELY - FORCE. IF NOT WITHIN 6 MONTHS - DENY.

2. REBILLINGS:
   A. CLAIM INDICATES REBILL BUT RA IS NOT ATTACHED OR PREVIOUS ICN NOT REFERENCED ON CLAIM - DENY.
   B. RA IS ATTACHED OR ICN IS REFERENCED
      1. COUNT 6 MONTHS FROM MEDICARE'S PROCESS DATE TO ORIGINAL OR REF ICN (I.E. MEDICARE PROCESS DATE IS 9/5/98 & ORIGINAL OR REF ICN IS 3/5/99 OR LESS) - FORCE.
      2. IF ORIGINAL OR REFERENCED ICN DOES NOT PROVE TIMELINESS - DENY.

3. IF CLAIM IS POSTING EXCEPTION 452 (DENIED BY MEDICARE) AND WILL BE DENIED (ENTIRE CLAIM) TO REBILL AS A J OR P CLAIM AND YOUR ICN IS LESS THAN 1 YEAR FROM DOS - FORCE, IF ICN IS MORE THAN 1 YEAR FROM DOS - DENY W/EOB 018/095.

4. IF DETAIL LINE(S) ARE POSTING EXCEPTION 453 (DENIED BY MEDICARE) & LINE WILL BE DENIED TO REBILL AS A J OR P CLAIM AND:
   A. YOUR ICN IS LESS THAN 1 YEAR FROM DOS - DENY EXCEPTION 453
   B. YOUR ICN IS MORE THAN 1 YEAR FROM DOS - DENY EXCEPTION 453 W/EOB'S 018/095.
   C. FORCE EXCEPTION 192 AND MANUALLY DENY UNTIMELY, MEDICARE ALLOWED LINES W/EOB 546.

TEXT KEY	TEXT DESC
194	

---ON TEST - OVERLOC TO 67---

TEXT KEY TEXT DESC
197 CLAIM HAS COMMENTS

1. IF BACKUP DOCUMENTS/COMMENTS WERE NOT RECEIVED - USE INFO EOB 224 AFTER DENYING OTHER EXCEPTIONS.

2. IF BACKUP DOCUMENTS/COMMENTS ARE INAPPROPRIATE OR LACKING INFO - USE INFO EOB 281 AFTER DENYING OTHER EXCEPTIONS.

3. PSYCH CODES 90804 - 90899 OR ANY OTHER PROCEDURE CODE EXCEPT 0070M IS BILLED & THE COMMENTS INDICATE A PERFORMING PROVIDER NAME PRECEDED BY OR FOLLOWED BY (PHD) OR ANY OF THE FOLLOWING NAMES (GAYLE FAY, ELIZABETH MCCAULEY, MATHEW SPELTZ, CAROL COLE, DR. SULZBACHER, ROSEMARY CALDERON, KAREN MCAVOY, DALE CALLNER OR DAVID R. PATTERSON) - DENY W/EOB 343.

4. IF AUDIT 007 IS POSTING AND THE OUTPATIENT HOSPITAL CLAIM INDICATES "NOT DONE AS A PANEL" OR SOMETHING SIMILAR OR CLAIM INDICATES LAB DONE STAT - FORCE 197 & 007.

5. IF COMMENT "FIRST STEPS - INSURANCE WON'T PAY" AND PROVIDER TYPE IS 35 OR PROCEDURE CODE IS 5935M - FORCE 197 & 263.

6. IF AN "I" IN COMMENTS FIELD OR INDICATION OF INSURANCE BACKUP - KEY A "Y" IN THE TPL FIELD.

7. THE "COMMENTS" MAY PROVIDE PERTINENT INFORMATION NEEDED TO WORK OTHER EXCEPTIONS THAT HAVE POSTED THAT HAVE THE STATUS OF FORCED, SUSPENDED, OR DENIED.

8. PROVIDER TYPE 71 (FAMILY PLANNING) AND CLIA # IN REMARKS FIELD - FORCE. (WE NEED TO KNOW THAT THE LAB WAS CLIA CERTIFIED TO PERFORM THE SERVICE.) DO NOT USE INFO EOB 197.

9. INTERPRETER SERVICES (PT 40) - DIRECT ENTRY AND EMC WITH PROVIDER NAME IN COMMENT FIELD, ENTER DUMMY # (8999500) IN REFERRING PHYS FIELD. (DO NOT KEY DUMMY # FOR CLIENT OR INTERPRETER NAME).

10. COMMENTS ARE KEPT IN MMIS FOR 100 DAYS. IF YOU NEED TO SEE THE COMMENTS TO WORK A CLAIM AND THE ICN IS OVER 100 DAYS OLD YOU WILL NEED TO ORDER MICROFILM.

11. STATEMENT IN COMMENT AND OTHER EXCEPTION "POSSIBLY AUTO DENY" IS POSTING ON THE CLAIM - REVIEW OTHER EXCEPTION FOR POSSIBLE FORCE.

12. IF NONE OF THE ABOVE APPLY AND THE CLAIM IS BEING FINALIZED FORCE THIS EXCEPTION.

TEXT KEY	TEXT DESC
214	WHEN THE PRIMARY SURGICAL PROCEDURE CODE IS ONLY 3 DIGITS AND THERE'S A DECIMAL, DO THE FOLLOWING: 1. IF THE MISSING DIGIT IS BEFORE THE DECIMAL, KEY A LEADING ZERO. FOR EXAMPLE: IF 7.41 - KEY 0741 2. IF THE MISSING DIGIT IS AFTER THE DECIMAL, KEY A TRAILING ZERO. FOR EXAMPLE: IF 74.1 - KEY 7410 3. IF EXCEPTION STILL POSTS - REMOVE THE ZERO & DENY.

TEXT KEY	TEXT DESC
215	WHEN THE SECONDARY SURGICAL PROCEDURE CODE IS ONLY 3 DIGITS AND THERE'S A DECIMAL, DO THE FOLLOWING: 1. IF THE MISSING DIGIT IS BEFORE THE DECIMAL, KEY A LEADING ZERO. FOR EXAMPLE: IF 7.41 - KEY 0741 2. IF THE MISSING DIGIT IS AFTER THE DECIMAL, KEY A TRAILING ZERO. FOR EXAMPLE: IF 74.1 - KEY 7410 3. IF EXCEPTION STILL POSTS - REMOVE THE ZERO & ENTER.

TEXT KEY	TEXT DESC
216	WHEN THE 3RD SURGICAL PROCEDURE CODE IS ONLY 3 DIGITS AND THERE'S A DECIMAL, DO THE FOLLOWING: 1. IF THE MISSING DIGIT IS BEFORE THE DECIMAL, KEY A LEADING ZERO. FOR EXAMPLE: IF 7.41 - KEY 0741 2. IF THE MISSING DIGIT IS AFTER THE DECIMAL, KEY A TRAILING ZERO. FOR EXAMPLE: IF 74.1 - KEY 7410 3. IF EXCEPTION STILL POSTS - REMOVE THE ZERO & DENY.

TEXT KEY TEXT DESC

218 LESS THAN 7 DAYS BETWEEN DATE OF DISCHARGE AND NEW ADMIT DATE.

AS AN INFORMATIONAL NOTE:
THIS EXCEPTION WILL POST AS A DEFAULT ERROR WHEN THE ADMIT DATE OR THE "TO" OR "FROM" DATE HAS BEEN KEYED INCORRECTLY (IE: 01/06/01 INSTEAD OF 01/06/02). IF THIS OCCURS - CORRECT THE DATE. IF THE CLAIM IN HISTORY IS CAUSING THE PROBLEM - FORCE EXC 218 AND ROUTE CLAIM WITH DEAD WORKSHEET TO SUE HILTON IN MMIS SERVICES.

1. CHECK TO SEE IF ONE OF THE CLAIMS IS AN INTERIM OUTLIER. IF THE ADMIT DATE IS THE SAME ON BOTH CLAIMS - FORCE 218 AND WORK EXCEPTION 230.

2. FORCE IF CLAIM(S) IS:
   A. READMIT IS TO A DIFFERENT HOSPITAL. (VERIFY THAT PROVIDERS ARE DIFFERENT, NOT JUST DIFFERENT PROVIDER NUMBERS).
   B. MOTHER POSTING AGAINST BABY.
   C.

--FIRST ADMIT:	--SECOND ADMIT:
DRG 379	DRG 370 TO 374 OR 379
DRG 400 - 404	DRG 409 OR 410
DRG 406 - 414	DRG 409 OR 410
DRG 780 - 783	DRG 409 OR 410
DRG 413	DRG 411
DRG 121, 122, 124 OR 125	DRG 105, 107, 108 OR 545-549
DRG 130, 131	DRG 108, 545-549, 110 OR 111
DRG 146, 147, 148 OR 149	DRG 152 OR 153

   ---GO STRICTLY BY THE CONDITIONS ON THE ABOVE CHART. DO NOT FORCE IF THE ADMITS ARE REVERSED.

   D. IF PATIENT STATUS 07 IS ON THE 1ST ADMIT CLAIM.
   E. HISTORY CLAIM PAID AT $0.00.
   F. DRG 382 (FALSE LABOR).
   G. CLAIMS WITH DIFFERENT MDC'S - SEE PAGES 5-9. IF NO MDC IS GIVEN FOR A DRG, CONSIDER THE MDC'S TO BE THE SAME.

3. NORMAL NEWBORN (DRG 620 AND/OR 629) READMITS FOR JAUNDICE, PHOTO-THERAPY (PRINCIPLE DIAGNOSIS 774.6).
   A. IF READMIT IS TO A DIFFERENT HOSPITAL - FORCE.
   (VERIFY THAT PROVIDERS ARE DIFFERENT, NOT JUST DIFFERENT #'S.)
   B. IF POSTING AGAINST ANOTHER ADMIT FOR DRG 620 OR 629 - DENY OR RECOUP THE RE-ADMIT (DIAGNOSIS 774.6) WITH EOB 443.

4. FAILED PITOCIN INDUCTION (PRIMARY DIAG 659.13).
   A. IF PRIMARY DIAG IS FAILED INDUCTION AND THE "TO" DATE IS NO MORE THAN ONE DAY AFTER THE "FROM" DATE - DENY W/EOB 121.
   B. IF MULTIPLE DIAG OR DATES OF SERVICE - APPLY INSTRUCTIONS IN SECTION 5 BELOW.

5. PREGNANCY OR DELIVERY RELATED CODES (INCLUDES 4TH & 5TH DIGITS).
   A. PAY HIGHEST ALLOWED DRG AND DENY OR RECOUP LOWEST ALLOWED DRG IF:

1. 1ST ADMIT = DELIVERY (VAGINAL OR C-SECTION) OR ANTEPARTUM.
2. 2ND ADMIT = HEMORRHAGE, ABRUPTION PLACENTAE OR PRIMARY DX IS 670 - 670.1.

B. PAY BOTH ADMITS IF:
1. 1ST ADMIT = DELIVERY (VAGINAL OR C-SECTION).
2. 2ND ADMIT = DX CODES 675.1 - 675.2.

C. PAY BOTH ADMITS IF:
1. 1ST ADMIT = PRIMARY DX CODE OF 641-644.2 OR 646.6-646.7
2. 2ND ADMIT = DELIVERY (VAGINAL OR C-SECTION).

6. ALL ELSE - LOCATION 10
PULL BACKUP FOR ALL RELATED CLAIMS:

A. IF READMIT WAS PREVIOUSLY REVIEWED DENY W/EOBS 074 & 526.
--NOTE - IF PROVIDER IS APPEALING ORIGINAL DISPOSITION ADJUDICATE PER TEXT.

B. IF NO BACKUP OR ONLY UB-92'S FOR ALL ADMITS OF RELATED CLAIMS - DENY WITH EOB 238.

C. IF INSUFFICIENT RECORDS HAVE BEEN SUBMITTED, DENY WITH EOB 225, ATTACH FORM LETTER AND RETURN TO THE PROVIDER.

--REQUIRED RECORDS--

	FIRST & LAST TWO DAYS OF:
- ER ADMITTING SHEET/REPORT	- ORDERS
- DISCHARGE SUMMARY	- X-RAY REPORT
- HISTORY AND PHYSICAL	- LAB REPORTS
- OPERATIVE REPORT	- PROGRESS NOTES
- CONSULTATIONS	- NURSES NOTES

D. WHEN REQUIRED RECORDS HAVE BEEN OBTAINED, ATTACH AND COMPLETE FACESHEET (NCC FORM) AND SEND TO QRS, MAILSTOP 45506.

E. WHEN CLAIN HAS BEEN RETURNED, ADJUDICATE PER INSTRUCTIONS ON THE FACE SHEET.
1. USE EOB 503 WHEN QRS RECOUPS PRIOR PAYMENTS UNLESS OTHERWISE STATED ON THE FACESHEET.
2. USE EOB 373 AS AN INFORMATIONAL EOB WHEN FORCING/DENYING CLAIMS PER QRS.

7. DRG'S 468, 476 (UNTIL 01/01/01), AND 477.

A. IF BACKUP ATTACHED - COMPLETE COVER SHEET (NCC FORM) AND SEND CLAIM AND BACKUP TO QRS, MAILSTOP 45506.

B. IF INSUFFICIENT BACKUP, DENY WITH EOB 969. ATTACH FORM LETTER AND RETURN TO THE PROVIDER.

C. WHEN CLAIM RETURNS FROM QRS, ADJUDICATE PER THEIR INSTRUCTIONS.

D. CLAIMS DETERMINED TO BE PROCESSED AS AN "S" CLAIM AND PAID AT RCC RATE, CONVERT TO A "S" CLAIM BY ENTERING AN "A" IN THE "EX-S:" FIELD AND A "Y" IN THE "EX:" FIELD.

8. ALL CLAIMS - PLACE ADJUDICATED FACESHEET IN DRG 218/468/476/477 FILE.

MAJOR DIAGNOSTIC CATEGORIES (MDC)

MDC	DRG'S/DESCRIPTIONS:
01	1-2, 4-25, 34-35, 530-533, 737-739, 761-769. DISEASES AND DISORDERS OF THE NERVOUS SYSTEM.
02	36-48, 534-535.

DISEASES AND DISORDERS OF THE EYE.

03 49-74, 168-169, 185-187, 536-537, 586-587, 759, 786.
DISEASES AND DISORDERS OF THE EAR, NOSE AND THROAT.

04 75-80, 82-90, 92-97, 99-102, 475, 538-542, 631, 740, 770-775, 798-802.
DISEASES AND DISORDERS OF THE RESPIRATORY SYSTEM.

05 103-108, 110-145, 478-479, 543-550, 796-797, 808-809.
DISEASES AND DISORDERS OF THE CIRCULATORY SYSTEM.

06 146-167, 170-183, 188-189, 551-554, 585, 776-779.
DISEASES AND DISORDERS OF THE DIGESTIVE SYSTEM.

07 191-208, 493-494, 555-557, 787-788.
DISEASES & DISORDERS OF THE HEPATOBILIARTY SYSTEM & PANCREAS.

08 209-213, 216-256, 471, 491, 558-561, 755-758, 789-790, 806-807.
DISEASES & DISORDERS OF THE MUSCULOKELETAL SYSTEM & CONNECTIVE TISSUE.

09 257-284, 562-564.
DISEASES & DISORDERS OF THE SKIN, SUBCUTANEOUS TISSUE & BREAST.

10 285-301, 565-566, 740, 753.
ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES & DISORDERS.

11 302-333, 567-569.
DISEASES AND DISORDERS OF THE KIDNEY AND URINARY TRACT.

12 334-352, 570-571.
DISEASES & DISORDERS OF THE MALE REPRODUCTIVE SYSTEM.

13 353-369, 572-573.
DISEASES & DISORDERS OF THE FEMALE REPRODUCTIVE SYSTEM.

14 370-384, 650-652.
PREGNANCY, CHILDBIRTH AND THE PUERPERIUM.

15 602-624, 626-630, 635, 637-641.
NEWBORNS & OTHER NEONATES W/CONDITIONS ORIGINATING IN PERINATAL.

16 392-395, 397-399, 574-575, 760, 784-785.
DISEASES & DISORDERS OF BLOOD & BLOOD FORMING ORGANS & IMMUNOLOGICAL DISORDERS.

17 400-404, 406-414, 576-579, 780-783.
MYELOPROLIFERATIVE DISEASES & DISORDER, & POORLY DIFFERENTIATED NEOPLASMS.

18 415-423, 580-581, 584.
INFECTIOUS AND PARASITIC DISEASES.

19 424-432.
MENTAL DISEASES AND DISORDERS.

20 743-751.
SUBSTANCE USE & INDUCES ORGANIC MENTAL DISORDERS.

21 439-455, 582-583, 752, 791.
INJURIES, POISONINGS AND TOXIC EFFECTS OF DRUGS.

22 456-460, 472. BURNS.

23 461-467, 633-634, 636, 754.
FACTORS INFLUENCING HEALTH STATUS & OTHER CONTACTS W/HEALTH SVS.

24 700-716.
HUMAN IMMUNODEFICIENCY INFECTIONS.

25 730-734, 792-794.
MULTIPLE SIGNIFICANT TRAUMA.

TEXT KEY TEXT DESC
222 SPLIT BILLING PROVIDER USING POS 1,2,5,21,22,23,51,52

PHYSICIANS (J):

--RADIOLOGY PROCEDURES (70000-79999) WITH ANESTHESIA MODS (AA,QZ,QX,QK, AB,AC,AD,QJ,QO,QQ) - FORCE.

1. IF NOT SPECIFICALLY ADDRESSED IN THE 4-LINE OR TEXT AND THERE IS NO MODIFIER: DENY, EXCEPT:

   A. IF PROVIDER #7038094 (HEART INSTITUTE OF SPOKANE) BILLS W/NO MODIFIER - FORCE.

   B. IF PROCEDURE CODE 88331 & PROVIDER #7020142 & NO MODIFIER - FORCE.

   C. IF PROVIDER #7126600 (VASCULAR TESTING LAB/TACOMA) BILLS W/NO MODIFIER - FORCE.

   D. DELIVERIES:
      1. NO MOD AND 1 UNIT - DENY THE 222 AND USE SECOND EOB 452.
      2. NO MOD AND MULTIPLE UNITS - DENY THE 222.

   E. THE FOLLOWING PROVIDERS BILLING SPECIFIC SERVICES IN POS OTHER THAN 3,11,71,81 W/NO MOD 26/TC SHOULD BE FORCE. (AGREEMENT EFF 080101) FOR ANY DOS.
      1. DR KOOIKER (7107337,1470103) SERVICES (95900,95903,95904, 95934,95937,95860,95861)
      2. DR JOHNSON (1096478) SERVICES (95900,95904,95920,95925,95937)
      3. IF CODES OTHER THAN ABOVE - DENY W/EOB 350.
      NOTE: THIS IS PER DR. ERIC HOUGHTON

   F. PROCEDURE CODE 10021/10022 - DOS 7/1/02 & AFTER - FORCE.

NOTE: THE FOLLOWING TEXT ADDRESSES MODIFIERS AND IF IT ADDRESSES TO FLAT DENY USE INFO EOB 285 IN SECOND EOB.
2. MODIFER 21 - DENY.
3. IF MODIFIER 22 AND 52 -SEE BELOW:
   DOS 5/1/95 AND AFTER - CT SCANS - DO NOT PAY FOR ADDITIONAL SLICES (MOD 22 OR 52) NOR THE USE OF MOD 22 ALONE - DENY.

A. ANATOMIC PATHOLOGY (88000-88399):
   1. IF 1 LINE IS BILLED:
      1/1/93 & AFTER W/MOD 26 AND ANOTHER LINE FOR SAME DOS AND SAME SERVICE IS BILLED W/MOD 22 OR 52 - ADD MOD 26 TO THIS LINE USING EOB 571.
   2. IF 2 OR MORE LINES BILLED:
      1/1/93 & AFTER - SAME SERVICE & NO MOD 26 AND AT LEAST ONE OF THE LINES IS BILLED WITH A MOD 22 OR 52 - DENY ALL LINES.
   3. IF ONLY 1 LINE OF SERVICE IS BILLED - DENY.

B. ALL ELSE - CHANGE TO MOD 26 AND ENTER EOB 571 IN SECOND FIELD, FORCE EXCEPTION 222.

4. MODIFIER 24 - DENY.
5. MODIFIER 25 - DENY.
6. MODIFIER 26 - ECHOCARDIOGRAPHY (93307-93350) - FORCE.
7. MODIFIER 26 & PROCEDURE CODE 88331 (FROZEN SECTION) & PROVIDER #7020142 - FORCE.
8. MODIFIER TC - CHECK TO SEE IF PROVIDER HAS A SPECIAL AGREEMENT. IF NO SPECIAL AGREEMENT - DENY WITH EOB 350. IF SPECIAL AGREEMENT FOR PROCEDURE CODE OR CODES BEING BILLED - FORCE. IF SPECIAL AGREEMENT DOESN'T MATCH SERVICES BEING BILLED - DENY WITH EOB 170.
9. MODIFIER 32 - IF MOD 26 PRESENT - KEY IT IN. IF NOT- DENY.
10. MODIFIER 50:
    A. IF PROCEDURE CODE IS BILATERAL - DENY & USE INFO EOB 285.

    B. RADIOLOGY
       1. IF ONE LINE HAS MOD 26 AND ONE LINE IS MOD 50 ONLY FOR THE SAME PROCEDURE - DENY & USE INFO EOB 285.
       2. IF ONE LINE HAS MOD 26 AND ONE LINE IS 50/26 - KEY MOD 26, O'CODE 818 AND ENTER.
       3. IF ONE LINE W/MOD 50 ONLY AND NO MOD 26 - DENY & USE INFO EOB 285.
       4. IF ONE LINE W/MOD 50/26 - ENTER MOD 99 AND PA-2. RES - SEE 368.
    C. PATHOLOGY (88300-88399) - FORCE.

11. MODIFIER 51 - DENY.
12. MODIFIER 52 - SEE "B" ON PAGE 3.
13. MODIFIER 53 - CHANGE MOD TO 26 & OVERCODE 809.
14. MODIFIERS 54/55/56 - IF MOD 26 PRESENT - KEY IT IN, OTHERWISE DENY.
15. MODIFIER 57 - IF THIS IS THE ONLY MOD ON THE LINE - DENY. IF ANY OTHER MOD ON THE LINE - SEE 993 INFO.
16. MODIFIER 58 - IF THIS IS THE ONLY MOD ON THE LINE - DENY. IF ANY OTHER MOD ON THE LINE - SEE 993 INFO.
17. MODIFIER 59 - IF THIS IS THE ONLY MOD ON THE LINE - DENY. IF ANY OTHER MOD ON THE LINE - SEE 993 INFO.
18. MODIFIER 76 - IF ONLY MOD ON LINE - DENY. ANY OTHER MODS SEE 993.
19. MODIFIER 77 - IF ONLY MOD ON LINE - DENY. ANY OTHER MODS SEE 993.
20. MODIFIER 78 OR 79 - IF MOD 26 PRESENT - KEY IT IN. IF NOT - DENY.
21. MODIFIER 90 - DENY W/EOB 285.
22. MODIFIER 91 - IF MOD 26 PRESENT - KEY IT IN AND O'CODE 221-OTHERWISE DENY.
23. MODIFIER 97 AND NO SPECIAL AGREEMENT - DENY.
    MODIFIER 97 WITH SPECIAL AGREEMENT - FOLLOW INSTRUCTIONS.
24. MODIFIER 98 - DENY.
25. MODIFIER 99 - IF MOD 99 IS ONLY MOD ON LINE FOR THE SERVICE - DENY WITH 285, OTHERWISE - OL TO 09.
26. MODIFIER F1-F9 - DENY.
27. MODIFIER GA - DENY.
28. MODIFIER 1R - FORCE.
29. MODIFIERS LT OR RT - DENY W/INFO EOB 285.
30. MODIFER QA - DENY.
31. MODIFIER QB - DENY.

32 MODIFIER QR - CHANGE TO MODIFIER 26 & OVERCODE 221.
33. MODIFIER QU - DENY.
34. MODIFIER Q6 - IF MOD 26 ALSO PRESENT -KEY IT IN, IF NOT DENY.
35. MODIFIER TA-T9 - DENY.
36. MODIFIER YR - DENY.
37. MODIFIER GB/59 - ARE THE ONLY MODIFIERS ON THE LINE - DENY. IF ANY OTHER MODIFIER ON THE LINE - KEY THAT MODIFIER AND USE 810 IN THE OVERCODE.
38. MODIFIER 9T/ST
EE: IF BILLED ALONE OR NO MOD 26 PRESENT - DENY.
MULTIPLE MODS - SEE 993 INFO.
39. IF YOU SEE ANY OTHER MODIFIER THAT IS NOT SPECIFIED IN THE TEXT - OVERLOC TO 83.
40. MODIFIERS LD, LC, RC - DENY.

PHYSICIAN CROSSOVER (O) TOS 3:
01. 10021/10022:
A. PRIOR TO 07/01/02 - ADD MODIFIER 26
B. 07/01/02 AND AFTER - FORCE.
02. ALL ELSE - KEY MOD 26.
EXCEPT IF MOD QK/QY ON CLAIM - FORCE.

TEXT KEY	TEXT DESC
223	

PLACE OF SERVICE IS 3,11,71,81:

MOD 26 & PROCEDURE IS LAB PATHOLOGY - FORCE, IF MOD 90 ALSO - SEE BELOW.

MOD 90 & 26 OR TC:
1. KEY 26/27 ON CLAIM, ENTER TO GET PRICE
2. ENTER AN "A" IN STATUS TO CREATE MANUAL PRICE & O'CODE 808.
3. KEY MOD 90 ON CLAIM (NOTE) IF 174 POSTS, WORK IT APPROPRIATELY
4. ADD MOD 26/27 TO COMMENTS, NOTING LINE #

ALL ELSE - DENY.

TEXT KEY TEXT DESC

226 PROCEDURE CODE REQUIRES MODIFIER

MED VENDOR (P) -

EXCEPTION IS SET TO AUTODENY UNLESS THERE IS A PA# ON CLAIM.

PRIOR AUTH# ON CLAIM:
1. EXAM ENTRY-
   A. MEDICAL NUTRITION - OVERLOC TO 23
   B. ALL ELSE - DENY.
2. EMC & RESOLUTIONS - MEDICAL NUTRITION:
   NOTE: FORCE 261 EXC IF FORCING 226, PA2 261 EXC IF DENYING 226.
   REVIEW AUTH FILE:
   A. IF EVERYTHING MATCHES AUTH FILE - FORCE
   B. IF DATE DOES NOT MATCH AUTH FILE - DENY W/EOB 245
   C. IF PROC CODE DOES NOT MATCH AUTH FILE - DENY W/EOB 251
   D. IF UNITS EXCEED AMOUNT AUTHORIZED (REVIEW NOTES ALSO)
      - DENY W/EOB 246
   E. NOT ADDRESSED ABOVE - OVERLOC TO 83.

MEDICARE X-OVER (O) HARDCOPY (TAPE SET TO PAY)

1. ENTER MOD FROM MEDICARE BACKUP IF APPROPRIATE (SEE TRAINER/SUP/MMIS IF ANY QUESTIONS).
2. IF NO MOD ON CLAIM OR BACKUP - DENY.

PHYSICIANS (J)
PT 95 (RNFA) REQUIRE A MOD 80 ON SERVICES W/A "Y"
IN ASSISTANT FIELD ON PDDD.
1. EXCEPTION 332 ALSO POSTING ON SAME LINE - WORK THE 332.
2. EXCEPTION 330 ALSO POSTING ON SAME LINE - WORK THE 330.
3. MOD 99 AND SURGERY PROCEDURES (10000-69999, EXCEPT 36415, 93501-93545,93561-93562):
   EE - O'LOC TO 36
   RES (LOC 36) - IF MOD 80 ON CLAIM PRICE APPROPRIATELY WORKING 368 EXC AND 053 EXC IF FAILING.
4. E&M CODE W/DX V22-V23.9 IN EITHER FIELD & NO MOD TH:
   A. DOS PRIOR TO 7/1/03 - FORCE.
   B. DOS 7/1/03 & AFTER - DENY PER RATES MANAGER.
5. ALL ELSE - DENY THE 226 EXC.

TEXT KEY TEXT DESC

227 PT 48 OR 49 - MODIFIER MISSING

1. FORCE ALL PROCEDURES BILLED W/1 UNIT INCLUDING THOSE LISTED BELOW: (20550,20600,20605,20610,31500,31525,31575,36000-36660,31622, 31656,62270-62298,62310,62311,62318,62319,62350,62351,62355, 62355,62360-62362,62365,63650,63655,63660,63685,63688,63690, 63691,64400-64550,64600-64610,64626,64627,64999,67500 - 67515, 93313,93503,99190)

2. IF THE FOLLOWING PROCEDURE CODES ARE BILLED WITH MULTIPLE UNITS, CUT TO 1 UNIT W/EOB 431.(62272-62282, 62287, 62289, 64600-64640).

3. IF PT 48/49 IS INDICATING THE PROCEDURE DID NOT REQUIRE A GENERAL ANESTHETIC AND JUST DID THE PROCEDURE AS A REGULAR PHYSICIAN - FORCE. IE (01996)

4. IF PT 48/49 BILLING & NO MOD ON LINE, BUT ANOTHER LINE ON CLAIM WITH P1,P2,P3, ETC IN PLACE OF THE PROCEDURE CODE AND THAT LINE HAS A VALID ANESTHESIA MOD - DENY THE 227 W/EOB 452 IN 2ND EOB.

5. IF PT 48/49 BILLING & NO MOD ON LINE, BUT ANOTHER LINE ON CLAIM WITH A VALID MOD AND THAT PROCEDURE IS BEING DENIED ON 380 EXCEPTION - DENY THE 227 EXCEPTION & INFO EOB 452.

6. PROCEDURE IS CPT ANESTHESIA (00100 - 01999) & DOS IS 070100 & AFTER - DENY. EXCEPTION (01996) - IF BILLED W/1 UNIT - MANUAL PRICE AT $21.70 W/INFO EOB 589. EXCEPTION 177 ONLY POSTING, DENY W/EOB 562.
   MDCR X-OVER CLAIMS - 01996 - FORCE. ALL ELSE - O'LOC TO 83.

7. ALL ELSE:
   A. IF THE PROCEDURE IS BILLED W/MULTI UNITS AND HAS ANES BASE FOR DOS - DENY.
   B. OTHERWISE - OVERLOC TO 83.

TEXT KEY TEXT DESC
230 POSSIBLE INTERIM OUTLIER

NOTE: THIS EXCEPTION IS ALSO USED TO PAY LATE CHARGES & SPLIT CLAIMS.

ALL DATES OF SERVICE (ELIGIBLE AND NONELIGIBLE) MUST BE INCLUDED ON ALL DRG CLAIMS. IF NONELIGIBLE DAYS ARE NOT INCLUDED - DENY W/EOB 268.

THERE MUST BE A PAID OUTLIER CLAIM IN THE SYSTEM BEFORE YOU CAN PAY INTERIM OUTLIER CHARGES. THE CLAIM MUST BE FOR THE FIRST PART OF THE HOSPITAL STAY (I.E. THE ADMIT DATE AND FIRST DATE OF SERVICE ARE THE SAME AND THE PATIENT STATUS WAS 30). IF YOU DON'T HAVE A CLAIM THAT MEETS THIS CRITERIA - DENY. NOTE: IF IN DOUBT - SEE TRAINER/SUPERVISOR.

NOTE: IF CLAIM INDICATES MEDICARE BENEFITS EXHAUSTED, MEDICARE DECERTIFIED THE STAY, OR CLIENT BECAME MEDICARE ELIGIBLE DURING THE STAY - OVERLOC TO 72.

THE SYSTEM WILL SUBTRACT PATIENT PAY AND/OR TPL FROM THE MANUAL PRICING WHEN THE REIMBURSEMENT AMOUNT IS CALCULATED. DO NOT SUBTRACT THESE TWO AMOUNTS

1. IF CLAIM IS ALSO POSTING 218:
   A. IF THE ADMIT DATES ARE THE SAME FOR ALL RELATED HX CLAIMS - FORCE.
   B. IF ANY CLAIM(S) HAVE A DIFFERENT ADMIT DATE, YOU MUST ALSO WORK EXCEPTION 218.

-- HOW TO PRICE INTERIM OUTLIER CLAIMS, LATE CHARGES, OR SPLIT CLAIMS:

2. DETERMINE WHICH PROGRAM THE RECIPIENT IS ON FOR THE DATE OF ADMIT:
   A. IF PROGRAM IS NOT U, M, W, OR X - MULTIPLY THE TOTAL BILLED AMOUNT MINUS ANY NON-COVERED CHARGES BY THE RATE ON CHARGE MODE 04 (USE THE RATE THAT WAS IN EFFECT ON THE ADMIT DATE). MANUALLY PRICE THE CLAIM AT THIS AMOUNT. KEY 265 IN THE 2ND EOB.
   B. IF PROGRAM M, U, Q, W, OR X:
      STEP A - MULTIPLY THE RATE ON CHARGE MODE 12 (USE CHARGE MODE 01 FOR PSYCH DRG'S 424-432) BY THE RATE ON CHARGE MODE 10 (USE THE RATE THAT WAS IN EFFECT ON THE DATE OF ADMIT).
      STEP B - MULTIPLY THE TOTAL BILLED AMOUNT, MINUS ANY NON-COVERED CHARGES BY THE ANSWER IN STEP 1.
      STEP C - MANUALLY PRICE THE CLAIM AT THIS AMOUNT. KEY 265 IN THE 2ND EOB.

TEXT KEY	TEXT DESC
235	1. CLAIM FOR BABY BILLED WITH PARENT(S) PIC: A. "J0" (OCC CODE FIELD) AND BABY'S BIRTH DATE (OCC DATE FIELD) MUST MUST BE ENTERED FROM THE CLAIM. IF EXC 235 STILL POSTS: EE - IF AUTH NUMBER ON CLAIM - OVERLOC TO 23. IF NOT - DENY. RES - SEE #4 BELOW. B. IF "J0" OCCURENCE CODE IS NOT ON THE CLAIM - DENY W/EOB 747. 2. SWING BED/ANCILLARY CHARGES - FORCE. 3. FAIRFAX HOSPITAL (3300001) AND THE COMMENTS INDICATE "DISCHARGED PER COURT ORDER" - FORCE. 4. IF AUTH NUMBER : EE: OVERLOC TO 23. RES: CHECK COMMENTS ON AUTH FILE - IF COMMENTS STATE "FORCE 235" - THEN FORCE. OTHERWISE - DENY. 5. CLAIMS FOR CLIENTS WHO DO NOT HAVE PART A MEDICARE AND MEDICARE HAS PROCESSED AS AN INPATIENT & PAID ON THE PART B CHARGES - FORCE. 6. ALL ELSE -DENY.

TEXT KEY TEXT DESC

244 LINE ITEM SERVICE DATE NOT ELIGIBLE

EXAM ENTRY

IF CLAIM STATES "CHILDREN'S PROGRAM" - DENY WITH EOB 300, ROUTE CLAIM TO MENTAL HEALTH, M/S 5320. (IF MEDICAL I.D. CARD STATES "CHILDREN'S HEALTH" BUT CLAIM DOES NOT - DO NOT ROUTE TO MENTAL HEALTH, PROCESS IN ACCORDANCE WITH THE 4 LINE.)

DENTAL (K) - DENTURES-D5110, D5120, 0515D, D5211, D5212, D5510, D5520, 0552D, D5610, D5630, 0565D, D5650, D5660, IF THE CLIENT IS ELIGIBLE FOR THE DATE OF SERVICE THAT THE MOLD (IMPRESSION) WAS TAKEN, USE THAT DATE OF SERVICE AND PROCESS.

LOC 36 (ELIG)

CHECK OIS FOR LINE ITEM SERVICE DATE

1. IF FOUND - BUILD SEGMENT COVERING DATE OF SERVICE.
2. IF NOT FOUND - STAGE WORKSHEET TO BATCH TO CHECK FOR MEDICAL I.D. CARD.
   A. IF MEDICAL I.D. CARD IS ATTACHED - BUILD SEGMENT PER MEDICAL I.D. CARD.
   B. IF NO MEDICAL I.D. CARD - RETURN WORKSHEET & BATCH TO CLAIMS PROCESSING SUPERVISOR.

TEXT KEY TEXT DESC
245

CLIENT IS LOCKED INTO DESIGNATED HOSPICE AGENCY AND PRIMARY CARE PHYSICIAN FOR THE ELECTION (HOSPICE) PERIOD.

FORCE -- CASA PROVIDERS (TYPE 23, SPECIALTY 50)
FORCE -- INTERPRETER SERVICES (PT 40, SPEC 60 OR 63)
FORCE -- SCHOOL MEDICAL SERVICES (PT 58)
FORCE -- EYEGLASS CONTRACTOR (2020436)

NOTE: TPL HEALTH INSURANCE PREMIUMS - FORCE.

NOTE: ALL CLAIM TYPES (EXCEPT HOSPICE PT 63, SEE PG 6 #5)
IF CLAIM/BACKUP/COMMENTS STATES "NOT RELATED TO TERMINAL ILLNESS" "NOT COVERED BY HOSPICE SVS" OR HAS A "K" - ENTER A "K" IN THE ITA FIELD AND ENTER.

NOTE: HIV/AIDS CASA CODES (0470M - 0472M) ARE PAYABLE WITH HOSPICE - FORCE

NOTE: IF MEDICAL ID CARD DOES NOT HAVE AN "X" IN HOSPICE BOX - FORCE

NOTE: THERE MAY BE MORE THAN ONE HOSPICE RESTRICTION PERIOD. IF TEXT IS UNCLEAR (I.E., MULTIPLE ENTRIES OF SAME PROVIDER TYPES) OR IF DEATH DATE AND END DATE OF RESTRICTION (PAGE 5 ELIGIBILITY FILE) DO NOT MATCH - OVERLOC TO 83, EXCEPT HOSPICE PROVIDER TYPE 63 - OVERLOC TO 67, ALL ELSE SEE BELOW.

1. J (PHYSICIAN)
   A. OPTOMETRIST SERVICES (PT 28) - FORCE

   B. OPHTHALMOLOGY SERVICES (PROV SPEC 18) - FORCE

   C. IF DATES OF SERVICE ARE NOT WITHIN THE HOSPICE RESTRICTION DATES - PAGE 5 OF ELIG FILE - FORCE.

   D. IF PHYSICIANS SERVICES FOR HOSPITAL ADMIT/DISCHARGE DATES ARE THE SAME AS BEGINNING OR ENDING DATE OF HOSPICE RESTRICTION DATES- FORCE.

   E. ADJUSTMENTS-IF REPORT ATTACHED, OVERLOC TO 67 AND ROUTE CLAIM AND B/U TO DINEEN KILMER, MMIS SERVICES, MS 45564.

F. DATES OF SERVICE WITHIN THE HOSPICE RESTRICTION DATES - CHECK FOR MATCH OF PROVIDER,PERFORMING PROVIDER #,REFERRING # OR NAME.

   1. NO MATCH - DENY WITH EOB 312/313
   2. MATCH - FORCE ALL PROCEDURES EXCEPT: (LAB & X-RAY)
      A. 36415 - FORCE.
      B. IF PROCEDURE HAS (PC) SEGMENT ON PDDDD FILE:
         1. MOD 26 IS PRESENT ON CLAIM - FORCE.
         2. MOD 26 IS NOT PRESENT - DENY W/EOB 728

C. IF PROCEDURE DOES NOT HAVE (PC) SEGMENT ON PDDDD FILE: DENY.

2. R,S,M,V,W - EXCEPTION: HOSPICE PROVIDER (PT 63) - SEE 5 ON PG 6

A. IF DATE OF ADMIT IS THE SAME AS ENDING DATE OF HOSPICE RESTRICTION OR DATE OF HOSPITAL DISCHARGE IS SAME AS BEGIN DATE OF HOSPICE RESTRICTION--FORCE.

B. IF CLAIM STATES "NOT RELATED TO TERMINAL ILLNESS" OR "NOT CVRD BY HOSPICE SERVICES" - FORCE.

C. HOME HEALTH - IF ENTIRE CLAIM DOS ARE WITHIN HOSPICE SPAN ON ELIG FILE - DENY W/EOB 313/312. IF PARTIAL CLAIM DOS ARE WITHIN HOSPICE SPAN - FORCE EXC 245 AND LINE DENY THOSE WITHIN HOSPICE SPAN W/EOB 313/312.

D. OTHERWISE, DENY WITH EOB 312/313.

3. T (NURSING HOME)

A. IF THE ENDING DATE OF THE CLAIM IS THE SAME AS THE BEGINNING DATE OF THE HOSPICE ELIGIBILIY AND THE CLAIM HAS A DISCHARGE CODE OTHER THAN 6 - FORCE.

B. IF THE BEGINNING DATE OF THE CLAIM IS THE SAME AS THE ENDING DATE OF THE HOSPICE ELIGIBILIY - FORCE.

C. IF IN HOSPICE FOR THE FIRST DAY OF THE SEGMENT BILLED - DENY W/ EOB'S 312/313. IF ENDING DATE IN 9 SCREEN IS ROLLED OVER, CHANGE ENDING DATE TO THE LAST DAY OF THE MONTH 7 PUT NOTE IN PROVIDER LOG.

D. IF THE HOSPICE DAYS BEGIN DURING THE SEGMENT (ANY DAY OTHER THAN THE 1ST DAY OF THE SEGMENT) CHANGE DISCHARGE CODE TO 5, CHANGE THE ENDING DATE TO MATCH HOSPICE BEGIN DATE, AND CHANGE TOTAL NUMBER OF DAYS. USE EOB'S 921/398, FORCE THE 245 AND MAKE NOTE FOR PROVIDER LOG IF AFTER THE TADS HAVE BEEN PRINTED. MAKE CHANGES IN BOTH 2 SCREEN AND THE 9 SCREEN.

E. IF IN HOSPICE DURING THE ENTIRE SEGMENT - DENY W/EOB'S 312/313. CHANGE ENDING DATE TO THE LAST DAY OF THE MONTH IN THE 9 SCREEN.

NOTE: BE SURE TO WRITE A NOTE FOR THE PROVIDER LOG WHEN STOPPING THE ROLLOVER. INDICATE IF AN AWARD LETTER IS REQUIRED TO READMIT THE PATIENT IF HOSPICE IS MORE THAN 30 DAYS.

4. P (MED VENDOR)- IF 245 POSTING AND AUTH# ON CLAIM - O/L TO 23:

A. IF STATEMENT ON CLAIM, "NOT RELATED TO TERMINAL ILLNESS" OR "NOT COVERED BY HOSPICE SVS" - FORCE.

B. FORCE AMBULANCE, OPTICAL AND HEARING AIDS

C. EQUIPMENT RENTAL - IF ENDING DATE OF SERVICE IS THE SAME AS THE BEGINNING DATE OF HOSPICE (SEE PAGE 5 OF THE RECIPIENT FILE) -

FORCE.

D. ALL ELSE - DENY W/EOB 312/313.

5. M HOSPICE (PT 63)
   A. DATE(S) OF SERVICE ARE NOT WITHIN THE HOSPICE ELIGIBILITY DATES ON PAGE 5 OF THE ELIGIBILITY FILE - DENY WITH EOB 737.
   B. PART OF THE DATES OF SERVICE ARE NOT WITHIN THE HOSPICE ELIGIBILITY DATES ON PG 5 OF ELIGIBILITY FILE - DENY W/EOB 737.
   C. ALL ELSE OVERLOC TO 67.

6. O (MEDICARE X-OVER) - SEE #1 (J-PHYSICIAN) OR #4 (P-MED VENDOR).

TEXT KEY TEXT DESC
247 RECIPIENT HAS QMB COVERAGE

NOTE: MEDICARE BACKUP ATTACHED INDICATES MEDICARE MADE PAYMENT AND THE ORIGINAL OR REF ICN IS MORE THAN 6 MONTHS BEYOND THE MEDICARE PAID DATE - DENY W/EOB 546. BACK UP WITH "CONTRACT ADJUST" SEE (E) BELOW. ALL ELSE DENY W/EOB 335.

NOTE: (ITA) ALL CLAIM TYPES - OVERLOC TO 65.

1. LOC 55 (MANAGED MEDICARE) - WORK PER 988 TEXT.

2. DENTAL (K) - EXAM ENTRY
   A. BABY ON MOM'S PIC-FORCE
   B. CLAIMS WITHOUT MEDICARE PAYMENT - DENY.
   C. MEDICAL I.D. CARD WITH "QMB" ONLY - DENY.
   D. MEDICAL I.D. CARD WITH QMB AND ANOTHER PROGRAM - OVERLOC TO 65.
   E. MEDICAL I.D. CARD W/ANOTHER PROGRAM & NO QMB - OVERLOC TO 65.
   F. ALL ELSE - DENY.

3. NURSING HOMES (T)
   A. IF PATIENT CLASS 20 - SEARCH ACES FOR VALID ELIGIBILITY, IF PRESENT UPDATE MMIS ELIGIBILITY AND PAY. IF VALID ELIGIBILITY NOT FOUND IN ACES, STAGE FOR AWARD LETTER. IF VALID AWARD PRESENT FOR DATES OF SERVICE, CHANGE MMIS ELIGIBILITY FOR DATES OF SERVICE TO ALLOW PAYMENT. OTHERWISE DENY W/EOB 279 AND 492.
   B. IF PATIENT CLASS 24 - FORCE.

4. OUTPATIENT & INPATIENT (M,R,S)
   A. IF MEDICARE BACKUP SHOWS PAYMENT - DENY WITH EOB 333 & REPROCESS AS HOSPITAL X-OVER.
   B. ALL ELSE - DENY.

5. PHYSICIAN (J), MEDICAL VENDOR (P) & EPSDT (L) CLAIMS
   NOTE: IF THE 261 EXCEPTION IS POSTING PA-2 THE 261, UNLESS YOU ARE FORCING THE 247 PER FOLLOWING TEXT, THEN ALSO FORCE THE 261.
   EXCEPTION: IF MEDICARE BACKUP ATTACHED WITH "CONTRACT ADJUST" PAYMENT THEN PA2 THE 247 EXCEPTION AND WORK 261 EXCEPTION.

   A. OUT OF STATE PROVIDER AND MEDICARE EOMB/RA ATTACHED SHOWING MEDICARE ALLOWED: DENY W/EOB 333 AND RE-ICN AS A CROSSOVER-O.

   B. OUT OF STATE PROVIDER, MEDICARE ALLOWED IN CLAIM BOX 24K AND NO EOMB/RA - DENY W/EOB 335.

   C. INSTATE/BORDER AREAS WITH MEDICARE EOMB/RA ATTACHED SHOWING MEDICARE ALLOWED - DENY W/EOB 335.

   D. MEDICARE DENIAL ATTACHED INDICATING DENIAL CODE 28/31 (MAY BE PRECEDED BY PR/CO/OA/CR) OR DESCRIPTION OF NOT ELIGIBLE FOR PART B BENEFITS, SERVICES BEFORE ENTITLEMENT, SERVICES AFTER

ENTITLEMENT ENDED AND THE SERVICES ARE ALLOWABLE BY MEDICAID -
- FORCE & OVERCODE 111.

E. ALL ELSE - DENY.

TEXT KEY TEXT DESC
248 KITSAP PHYSICIANS SERVICE (SOUND HEALTH CARE)

NOTE: IF PREMIUM CODES 0303M, 0325M, 0339M, 0339M, OR 0340M - GO TO PAGE 7 OF THIS TEXT.

ALL CLAIM TYPES EXCEPT MEDICARE XOVERS(O)

1. NON-COVERED SERVICES - FORCE.
   A. ADULT DAY HEALTH
   B. ANNUAL FAMILY PLANNING SERVICE EFF 7/1/88 DOS (PT 71)
   C. BLOOD PRODUCTS AND COMPONENTS
   D. CASE MANAGEMENT (PT 23)
   E. CHIROPRACTORS (PT 30)
   F. CHRONIC PAIN MANAGEMENT (CODES 0088M-0099M)
   G. COMMUNITY MENTAL HEALTH (PT 73)
   H. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE STATE "CHEMICAL USING PREGNANT WOMAN" - FORCE.
   I. DENTAL SERVICES OR DENTAL ANESTHESIA (0100M) - EXCEPT DENY THE FOLLOWING AS IT IS COVERED BY KITSAP:

      1. APICAL ABSCESS TREATED BY OPEN & DRAIN (PALLIATIVE TREATMENT), EXTRACTION, OR ROOT CANAL
      2. TOTAL DENTAL EXTRACTIONS PRIOR TO RADIATION THERAPY, CANCER OF THE MOUTH.
      3. ANY ORAL FRACTURE
      4. "ORAL HYGIENE" FOR SYSTEMIC OR RELATED TO PRESYSTEMIC CANCER (HODGKIN'S DISEASE, MARROW TRANSPLANTS, ETC.).
      5. BONY CYST TREATMENT
      6. TUMOR THERAPY
      7. SEQUESTRECTOMY

   J. DETOX (3 OR 5 DAYS)
   K. DISPENSING, FITTING & EYEGLASS REPAIRS (CODES 9272M-9276M, 92340-92342, 92352-92354, 92370-92371)
   L. ENTERAL AND PARENTERAL SERVICES
   M. EYEGLASSES
   N. ARTIFICIAL EYES
   O. FIRST STEPS MATERNITY (CODES 5970M-5976M)
   P. HEARING AIDS
   Q. HOSPICE (PT 63)
   R. INDIAN HEALTH (PT 15 - CODE 5999M)
   S. ITA CARE
   T. KIDNEY DIALYSIS/HEMODIALYSIS
   U. MATERNITY SUPPORT SERVICES (PT 35)
   V. OCCUPATIONAL THERAPY (REV CODE 430, 08000-08050, 0700M-0705M)
   W. PM&R, ALL SERVICES (J) 0030M-0035M & (S) HOSPITALS
   X. SPEECH THERAPY SERVICES (92506-92508)
   Y. SUBSTANCE ABUSE (PT 75)
   Z. TRANSPORTATION OTHER THAN AMBULANCE (PT 42,45,50,54,55,96)
  ZA. NUTRITIONAL COUNSELING (CODES 0900M-0902M)
  ZB. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC) &:
      1. IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES -

635-636.9 OR V61.7)
2. IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
ZC. WEIGHT LOSS (REVENUE CODES 942 & 949)
ZD. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
ZE. DEPO-PROVERA FOR BIRTH CONTROL (CODE 9913M) - FORCE.
ZF. NORPLANT SYSTEM KIT (CODE 9910M)
ZG. REMOVAL OF NORPLANT CODES 1798M, 1799M, 11976, 1197M &:
1) DATE OF SERVICE IS 3/1/92 OR AFTER - FORCE.
2) DATE OF SERVICE IS BEFORE 3/1/92 - DENY.

2. IF DIAGNOSIS IS 290.0 - 319.0 (PSYCHIATRIC) -
A. INPATIENT OR HOSPITAL CLAIM - FORCE 248,349,353,488,620
B. PHYSICIAN CLAIM WITH POS 1,21,52 - FORCE 348,349,353,488
C. PHYSICIAN CLAIM WITH POS 3,11,71 OFFICE CALL & DESCRIPTION IS MEDICATION MANAGEMENT OR TREATMENT - FORCE.
D. PROVIDER #7023328 (KITSAP PSYCHIATRIC RESIDENTIAL TRTM CTR) W/POS 3 - FORCE.

3. IF THE CLAIM HAS AN HMO EOB ATTACHED & IT STATES:
A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY E/EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
F. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - USE OVERCODE 680 AND OVERLOC TO 79.

4. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
B. NON-COVERED SERVICE - SEE ABOVE & IF LISTED - FORCE. IF NOT LISTED DENY.
C. CHARGES APPLIED TO DEDUCTIBLE OR CO-PAY - DENY WITH EOB 151.
D. ANY OTHER STATEMENT - DENY.

5. NO EOB ATTACHED/NO COMMENT ON CLAIM:
A. NON-COVERED SERVICES - FORCE.
B. NO COUPON ATTACHED - DENY.
C. COUPON ATTACHED STATING HMO - DENY.

MEDICARE CROSSOVERS
1. IF CLAIM IS FROM KIDNEY CENTER PROVIDER - FORCE.
2. ANY OTHER PROVIDER - DENY.

HMO PREMIUM BILLS
1. WHEN THE HMO/HIO HAS BILLED THE WRONG AMOUNT FOR A REQUESTED AMOUNT FOR A PREMIUM PAYMENT - DENY WITH EOB(963. DO NOT USE EOB)
2. WHEN THE CSO HAS NOT INDICATED A HMO/HIO ENROLLMENT BY CODING THE MEDICAL ELIGIBILITY SCREEN - DENY WITH EOB(964. DO NOT USE EOB)
3. IF DOS PRIOR TO 12/1/90 & THE RA SHOWS A DUPLICATION OF PREMIUM

BILLINGS - DENY WITH EOB 460.
4. IF OUR RECORDS INDICATE WE HAVE PAID FEE FOR SERVICE CLAIMS FOR THE DATES OF SERVICE - DENY WITH EOB 460.
5. IF TPL SCREEN SHOWS KITSAP PRIVATE INSURANCE COVERAGE FOR DATES OF SERVICE ON CLAIM - DENY WITH EOB 955.

CLAIMS PROCESSING ADJUSTMENTS:
1. WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT SOUND CARE (KPS) PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

2. IF DATE OF SERVICE 7/1/93 OR AFTER APPLY THE FOLLOWING TEXT:

A. FORCE THE FOLLOWING SERVICES (NON-COVERED BY KPS):

1. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICES - FORCE.

2. PHYSICIAN (J CLAIM TYPE)
A. ORGAN TRANSPLANTS
B. DIAGNOSIS IS 290.0 THRU 319.0 &:
1. PLACE OF SERVICE IS 3 & DESCRIPTION IS MEDICATION MANAGEMENT OR TREATMENT.
2. PLACE OF SERVICE IS 1 - FORCE 248, 353 AND/OR 488.
C. DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
D. PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
E. SERVICES FOR CUP DIAGNOSIS CODE 648.33.
F. IF CLIENT IS UNDER 21 YEARS OLD & SERVICE IS RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982 OR 58983.
G. ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM)
H. PT 24 & SERVICES ON SAME DAY AS TB CODES (9011M-9014M AND RELATED TO VISIT - FORCE.
I. PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.

3. HOSPITALS (M,R,S CLAIM TYPES)

A. ORGAN TRANSPLANTS
B. DIAGNOSIS IS 290.0 THRU 319.0 - FORCE 248,353,488 AND/OR 620.
C. DENTAL DIAGNOSIS 520 THRU 525.9
D. CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
E. PM&R SERVICES
F. WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
G. ITA CARE
H. REVENUE CODE 511 (PAIN CLINICS) & DATE OF SERVICE IS 1/1/94 THROUGH 12/31/94.
I. REVENUE CODE 942 (DIABETIC COUNSELING)

J. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC)
1. IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
2. IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.

K. IF CLIENT IS UNDER 21 YEARS OLD AND STERILIZATION DIAGNOSIS CODE V25.2.

B. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

1. OVER $ LIMITATION - FORCE.
2. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
3. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
4. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
5. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION- DENY WITH EOB 783.
6. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT MENTIONED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
7. IF DENIAL EOB STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DATE OF SERVICE - DENY WITH EOB 217.
8. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS, OR SIMILAR STATEMENT - DENY WITH EOB 217.

C. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR - FORCE.

D. IF NO EOB/STATEMENT ON CLAIM:
1. NO MEDICAL ID CARD ATTACHED - DENY.
2. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

E. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

F. ALL ELSE - DENY.

TEXT KEY TEXT DESC
250 NOT ELIGIBLE WITH THIS PIC

EXAM ENTRY:

1. OUT OF STATE PROVIDERS:

   A. DO ALPHA, SSN, OR CASE NUMBER SEARCH FROM PF5 SCREEN. IF PIC IS FOUND - KEY IN.
   B. PIC NOT FOUND - DENY. UNLESS THERE IS A MEV, ID CARD, AWARD LETTER COMPUTER PRINT OUT FROM THE LOCAL CSO OR FROM THE LOCAL CSO OR FROM MMIS, LISTING ELIGIIBILITY INFO FOR DOS - O'LOC TO 65.

2. IN STATE AND BORDER AREA PROVIDERS:

   A. MEDICAL ID CARD:
      1. CLIENT NOT ON ID CARD OR CARD IS NOT FOR DOS - DENY W/EOB 091.
      2. STATE ISSUED CARD - CHECK KEYING, IF CORRECT - O'LOC TO 65.
      3. LOCAL CSO ISSUED CARD IS INDICATED BY "AUTHORIZATION OPEN EFFECTIVE" BOX AT TOP RIGHT CORNER OF CARD - CHECK KEYING, IF CORRECT DO ALPHA, SSN OR CASE NUMBER SEARCH FROM PF5 SCREEN. IF PIC IS FOUND - KEY IN W/INFO EOB 029.
      4. PIC NOT FOUND - O'LOC TO 65.
   B. MEDICAL ELIGIBILITY VERIFICATION: (MEV) .
      1. CLIENT NOT ON MEV OR IF THE DOS IS NOT WITHIN THE SAME MONTH AS THE "AS OF" DATE - DENY W/EOB 091.
      2. IF THE DOS IS WITHIN THE SAME MONTH AS THE "AS OF" DATE - O'LOC TO 65.
   C. AWARD LETTER:
      1. CLIENT NOT ON AWARD LETTER OR AWARD LETTER IS NOT FOR DOS - DENY W/EOB 091.
      2. IF VALID AWARD LETTER, DO ALPHA, SSN OR CASE NUMBER SEARCH FROM PF-5 SCREEN. PIC FOUND - KEY IN W/INFO EOB 029.
      3. PIC NOT FOUND - O'LOC TO 65.
   D. COMPUTER PRINT OUT FROM THE LOCAL CSO OR MMIS LISTING ELIGIBILITY INFO, OR TAKE CHARGE APPLICATION, OR COPY OF ACES.ONLINE - O'LOC TO 65.
   E. IF CLAIM STATES CHILDREN'S PROGRAM - O'LOC TO 83 FOR REVIEW. TEXT PREVIOUSLY STATED TO DENY W/EOB 300, ROUTE CLAIM TO MENTAL HEALTH OB 42-F. (IF MEDICAL ID CARD STATES CHILDRENS HEALTH, BUT CLAIM DOES NOT, DO NOT ROUTE TO MENTAL HEALTH, ADJUDICATE PER INFO ABOVE).

   F. ALL ELSE - DENY. EXCEPTION: ITA - SEE FOLLOWING TEXT.

3. ITA - EXAM ENTRY (ALL CLAIM TYPES)
   A. DO ALPHA SEARCH (FROM NAME,SSN OR OTHER INFO ON CLAIM/BACKUP IF PIC FOUND, CORRECT PIC, AND USE EOB 029 IN SECOND INFO SLOT.
   B. IF PIC NOT FOUND AND FORM 13-628 IS NOT ATTACHED, DENY W/EOB 378.

C. IF FORM 13-628 IS ATTACHED, CHECK IF PROPERLY COMPLETED.
1. SECTION 4 MUST HAVE AN INITIAL DENTENTION OR REVOCATION DATE AND BE SIGNED AND DATED. COUNTY DESIGNEE MUST BE INDICATED ON FORM. (CAN BE A COUNTY STAMP).
AND
2. DOS ON CLAIM MUST BE WITHIN DETENTION PERIOD. DETENTION PERIOD IS DEFINED AS TIME SPAN A PERSON WAS DETAINED, AS INDICATED BY DETENTION DATE/REVOCATION DATE AND DISCHARGE DATE ON ITA FORM.
AND
3. DOS ON CLAIM MAY BE ONE DAY PRIOR TO DETENTION DATE/REVOCATION DATE. ALSO, ALLOW A SPAN OF 30 CALENDAR DAYS FROM INITIAL DETENTION DATE/REVOCATION DATE IF NO DISCHARGE DATE IS INDICATED.

D. IF FORM PROPERLY COMPLETED AND DOS OKAY - O'LOC TO 65.
E. IF FORM MISSING DATE OR SIGNATURE - DENY W/EOB 378.
F. IF DOS ON CLAIM OR LINE DO NOT FALL WITHIN DETENTION PERIOD ON ITA FORM - DENY CLAIM OR LINE W/EOB 058.

LOC 65
ITA - SEARCH PARTIAL PIC & SOCIAL SECURITY # WHEN AVAILABLE.
1. IF FOUND - CORRECT PIC ON WORKSHEET & KEY WORKSHEET.
2. IF NOT FOUND - BUILD RECORD ON "Q" PROGRAM, "U" MATCH, "O" MED ELIG CODE FOR TO & FROM DATES STAMPED ON CLAIM. (IF NO STAMP, BUILD SEGMENT FOR TO & FROM DOS). ALSO, PUT AN "I" INDICATOR IN THE ITA FIELD IF IT HAS BEEN OMITTED. CHECK LISTING AT END OF THIS TEXT FOR CASE NUMBER AND ADDRESS.

LOC 65
ALL CLAIM TYPES (EXCEPT ITA)
A. IF ID CARD OR PROOF OF ELIGIBILITY IS ATTACHED COVERING DOS -
1) CHECK CASE # THAT IS LISTED ON ID CARD, IF FOUND CORRECT PIC ON WORKSHEET.
2) SEARCH BY PARTIAL PIC - IF FOUND CORRECT PIC ON WORKSHEET.
3) RUN CASE # ON OIS
4) RUN PARTIAL PIC ON OIS

REGION CONTACT PERSONS & PROGRAM MANAGERS

IDENTIFY CSO NUMBER (COUNTY OF RECIPIENT) FROM COUPON. FIND WHICH REGION IT IS UNDER AND ROUTE THE CLAIM TO THE APPROPRIATE REGION CONTACT PERSON LISTED (INDICATING THE CSO NUMBER & NAME ON THE ROUTING SLIP).

REGION 1 - JANET WESTBROOK, B 32-6

CSO	CSO NAME	CSO	CSO NAME
01	OTHELLO/ADAMS	26	NEWPORT/PEND OREILLE
04	WENATCHEE/CHELAN	32	SPOKANE CENTRAL/SPOKANE
09	WENATCHEE/DOUGLAS	33	COLVILLE/STEVENS
10	REPUBLIC/FERRY	38	COLFAX/WHITMAN
13	MOSES LAKE/GRANT	58	SPOKANE E. VALLEY/SPOKANE
22	DAVENPORT/LINCOLN	59	SPOKANE NORTH/SPOKANE
24	OKANOGAN/OKANOGAN	60	SPOKANE SOUTHWEST/SPOKANE

REGION 2 - KEN BLACK, B 39-6

CSO	CSO NAME	CSO	CSO NAME
02	CLARKSTON/ASOTIN	36	WALLA WALLA/WALLA WALLA
03	PASCO/BENTON	39	YAKIMA/YAKIMA
07	WALLA WALLA/COLUMBIA	50	TOPPENISH/YAKIMA
11	PASCO/FRANKLIN	54	SUNNYSIDE/YAKIMA
12	CLARKSTON/GARFIELD	57	SUNNTSIDE/BENTON
19	ELLENSBURG/KITTITAS		

REGION 3 - LINDA MITTLEIDER, N 31-7

CSO	CSO NAME	CSO	CSO NAME
15	OAK HARBOR	37	BELLINGHAM/WHATCOM
28	FRIDAY HARBOR/SAN JUAN	52	MTLAKE TERRACE/SNOHOMISH
29	MOUNT VERNON/SKAGIT	63	ANACORTES - CLOSED
31	EVERETT/SNOHOMISH		

REGION 4 - BILL BEALE, N 44-3

CSO	CSO NAME	CSO	CSO NAME
40	EASTSIDE/KING	45	FEDERAL WAY/KING/SOUTH
41	RAINIER/KING	46	CAPITOL HILL/KING
42	KING NORTH/KING	47	BELLTOWN/KING
43	KENT/KING	55	WEST SEATTLE/KING
44	BURIEN/KING	56	CENTRAL SERV./KING

REGION 5 - PAT HAGUE, N 27-5

CSO	CSO NAME
18	BREMERTON/KITSAP
27	PIERCE CENTRAL/PIERCE
48	PIERCE SOUTH/PIERCE
49	PIERCE WEST/PIERCE
51	PIERCE EAST/PIERCE

REGION 6 - BILL GREEN OR PAT HENNING, KR-23

CSO	CSO NAME
05	PORT ANGELES/CLALLAM
06	VANCOUVER/CLARK
08	KELSO LONGVIEW/COWLITZ
14	ABERDEEN/GRAYS HARBOR
16	PORT TOWNSEND/JEFFERSON
20	WHITE SALMON/KLICKITAT
21	CHEHALIS/LEWIS
23	SHELTON/MASON
25	SOUTH BEND/PACIFIC
30	STEVENSON/SKAMANIA
34	OLYMPIA/THURSTON
35	CATHLAMET/WAHKIAKUM
53	ORCHARDS/CLARK
61	ELMA/GRAYS HARBOR
62	GOLDENDALE/KLICKITAT
64	FORKS/CLALLAM

TEXT KEY TEXT DESC
251 HMO - GROUP HEALTH

NOTE: IF PREMIUM CODES 0300M, 0304M, 0305M, 0330M, 0332M, 0334M GO TO PAGE 7 OF THIS TEXT (ALL CLAIM TYPES EXCEPT MEDICARE CROSSOVERS (O).)

1. NON COVERED GROUP HEALTH SERVICES - FORCE
   A. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ECT) &:
      1. IF VOLUNTARY TERMINATION OF PREGNANCY & DOS IS 2/1/89 OR AFTER-FORCE. IE DX CODES (635-636.9 OR V61.7)
      2. IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - REFER TO #20 AS IT IS CONSIDERED A DELIVERY.
   B. ADULT DAY HEALTH (PROVIDER TYPE 87)
   C. ANNUAL FAMILY PLANNING EFFECTIVE 7/1/88 DOS (PT 71).
   D. BLOOD COMPONENTS AND PRODUCTS
   E. CASE MANAGEMENT (PROVIDER TYPE 23)
   F. CHIROPRACTIC SERVICES (PROVIDER TYPE 30)
   G. COMPOUNDED DRUGS UNDER NDC 00990-0000-00
   H. CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) (CODE 94660).
   I. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN - FORCE.
   J. DENTAL SERVICES OR DENTAL ANESTHESIA (0100M)
   K. DISPOSABLE NON-REUSEABLE SUPPLIES.
   L. DRUGS (CLAIM TYPE D) WHEN PRESCRIBED BY A DENTIST (PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5").
   M. DURABLE MEDICAL EQUIPMENT (DME) - FORCE; EXCEPTION: IF FOR ORTHOPEDIC APPLIANCE OR BRACE AND DATE OF SERVICE IS AFTER 3/31/89 - DENY.
   N. EYEGLASSES (SUPREME OPTICAL OR WESTERN OPTICAL)
   O. FIRST STEPS DISCRETIONARY ADD-ON FEE (5970M - 5976M).
   P. FITTING FEE, DISPENSING & REPAIR OF EYEGLASSES (CODES 9272M-9276M, 92340-92342,92352-92354,92370-92371)
   Q. HEARING AIDS (PROVIDER TYPE 84).
   R. HOME HEALTH SERVICES - FORCE. IF DATE OF SERVICE IS AFTER 4/1/89 - DENY.
   S. INDIAN HEALTH SERVICES (PROCEDURE CODE 5999M).
   T. MATERNITY CARE, PRE-NATAL,DELIVERY & POST-PARTUM CARE (HOSPITAL & PHYSICIAN SERVICES) - IF DATE OF SERVICE IS 12/1/87 OR AFTER AND RECIPIENT LIVES IN THURSTON (34) OR MASON (23) COUNTIES OR IF RECIPIENT LIVES IN PIERCE COUNTY (27) & DOS IS 02/01/88 OR AFTER - FORCE (THIS DOES NOT INCLUDE NEWBORN CARE - DENY IT).
   U. MATERNITY SUPPORT (PROVIDER TYPE 35)
   V. ORGAN TRANSPLANTS (HEART, KIDNEY, CORNEAL, BONE MARROW, LIVER) & PATIENT OVER 13 YEARS OF AGE - FORCE.
   W. OXYGEN AT HOME - FORCE (IF DATE OF SERVICE IS AFTER 4/1/89 - DENY)
   X. PM&R (ALL SERVICES) - (J) 0030M - 0035M, (S) HOSPITALS.
   Y. PODIATRY (PROVIDER TYPE 32).
   Z. PROSTHETICS (PROVIDER TYPE 38) - FORCE (IF DATE OF SERVICE IS AFTER 4/1/89 - DENY).
  ZA. SPEECH THERAPY FOR CONGENITAL CONDITIONS. ANYTHING ELSE - DENY.
  ZB. TRANSPORTATION OTHER THAN AMBULANCE (PROVIDER TYPES 42,45,50,54,

55,96),
ZC. WEIGHT LOSS (REVENUE CODES 948 & 949)
ZD. OCCUPATIONAL THERAPY
ZE. NUTRITIONAL COUNSELING (CODES 0900M-0902M)
ZF. ENTERAL THERAPY
ZG. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
ZH. DEPO-PROVERA FOR BIRTH CONTROL (CODE 9913M) - FORCE.
ZI. NORPLANT KIT CODE 9910M
ZJ. REMOVAL OF NORPLANT SYSTEM CODES 1798M, 1799M, 11976, 1197M &:
1. DATE OF SERVICE IS 3/1/92 OR AFTER - FORCE.
2. DATE OF SERVICE IS BEFORE 3/1/92 - DENY.
ZK. SERVICES FOR DIAGNOSIS 314.0-314.01 (ATTENTION DEFICIT DISORDER).

2. DIAGNOSIS CODES 290.0 THRU 314, 314.1 THRU 319.0 OR PT 75 - GROUP HEALTH ALLOWS UP TO $1,000 FOR SUBSTANCE ABUSE, PSYCHIATRIC SERVICES & ITA:

A. IF THERE IS AN AMOUNT IN THE INSURANCE FIELD AND MENTAL HEALTH BENEFITS MAXED (PER INS. FIELD AMOUNT OR BACK-UP INDICATING BENEFITS EXHAUSTED) - FORCE 251, 349, 353, 620.

B. IF THERE IS NO AMOUNT IN THE INSURANCE FIELD AND
1. DENIAL ATTACHED STATING OVER $ LIMITATION-FORCE 251,349,353,620
2. DENIAL ATTACHED FOR ANY OTHER REASON - SEE SECTION "C" BELOW.
3. NO DENIAL ATTACHED - DENY.

3. IF THE CLAIM HAS AN HMO EOB/DENIAL LETTER ATTACHED AND IT STATES:
A. OVER $ LIMITATION - FORCE
B. NOT AUTHORIZED/REFERRED - DENY W/EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY W/EOB 151.
D. IF EOB SHOWS PAYMENT - DENY W/EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.
F. IF "DENIAL" STATES NOT COVERED AND SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - USE OVERCODE 680 AND OVERLOC TO 79.

4. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
B. NON-COVERED SERVICES - (SEE ABOVE) IF LISTED - FORCE. IF NOT LISTED - DENY.
C. CHARGES APPLIED TO DECUCTIBLE OR CO-PAY - DENY WITH EOB 151.
D. ANY OTHER STATEMENT - DENY.

5. NO EOB ATTACHED/NO STATMENT ON CLAIM-
A. NON COVERED SERVICES - FORCE.
B. NO COUPON ATTACHED - DENY.
C. COUPON ATTACHED STATING HMO - DENY.

MEDICARE CROSSOVERS (O)

1. IF CLAIM IS FROM KIDNEY CENTER PROVIDER - FORCE.

2. ANY OTHER PROVIDER - DENY.

HMO PREMIUM BILLS

1. WHEN THE HMO/HIO HAS BILLED THE WRONG AMOUNT FOR A REQUESTED AMOUNT FOR A PREMIUM PAYMENT - DENY W/EOB(963.DO NOT USE EOB)
2. WHEN THE CSO HAS NOT INDICATED A HMO-HIO ENROLLMENT BY CODING THE MEDICAL ELIGIBILITY SCREEN - DENY W/EOB(964.DO NOT USE EOB)
3. IF DOS PRIOR TO 12/1/90 & THE RA SHOWS A DUPLICATION OF PREMIUM BILLINGS - DENY W/EOB 041.
4. IF OUR RECORDS INDICATED WE HAVE PAID FEE FOR SERVICE CLAIMS FOR THE DATES OF SERVICE - DENY W/EOB 460.
5. IF TPL SCREEN SHOWS PRIVATE INSURANCE COVERAGE WITH HMO WE PAID PREMIUMS TO - DENY W/EOB 955.

CLAIMS PROCESSING ADJUSTMENTS (PRIOR TO 7/1/93)

WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT THE HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY W/EOB 229.

FOR DATES OF SERVICE 7/1/93 OR AFTER APPLY THE FOLLOWING -
NOTE: SEE ADJ INFO FOR 7/1/93 AND AFTER AT END OF THIS TEXT

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY GROUP HEALTH):

   A. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER #'S 7500002, 7500176, 7500184, - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, WITH POS 2, 3 OR 5).
   B. PHYSICIAN (J CLAIM TYPE)
      1. ORGAN TRANSPLANTS (HEART,KIDNEY,CORNEAL,BONE MARROW,LIVER) - IF CLIENT OVER 13 YEARS OF AGE.
      2. DIAGNOSIS CODES 290.0 THRU 319.0 & DATES OF SERVICE ARE:
         A. BEFORE 10/1/93 - GROUP HEALTH ALLOWS UP TO $1,000 FOR SUBSTANCE ABUSE, PSYCHIATRIC SERVICES & ITA. FORCE 251, 353, OR 488 IF CLAIM OR ATTACHED BACKUP INDICATES OVER $ LIMIT. IF NO DENIAL OR DENIAL STATES OTHER REASON - DENY.
         B. 10/1/93 & AFTER - IF POS 1, 2 OR 5 - FORCE.
3. DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
4. ITA SERVICES
5. IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
6. SERVICES FOR CUP DIAGNOSIS CODE 648.33.
7. CLIENT UNDER 21 YEARS OLD & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, OR 58983.
8. ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM.
9. PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M)

& RELATED TO VISIT - FORCE.
10. PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.

C. HOSPITALS - (M,R,S CLAIM TYPES)
1. ORGAN TRANSPLANTS (HEART, KIDNEY, CORNEAL, BONE MARROW, LIVER) IF CLIENT OVER 13 YEARS OF AGE.
2. DIAGNOSIS CODES 290.0 THRU 319.0 & DATES OF SERVICE ARE:
A. BEFORE 10/1/93 - GROUP HEALTH ALLOWS UP TO $1,000 FOR SUBSTANCE ABUSE, PSYCHIATRIC SERVICES AND ITA. FORCE 251, 353 OR 620 IF CLAIM OR ATTACHED BACKUP INDICATES OVER $ LIMITATION. IF NO DENIAL OR DENIAL STATES OTHER REASON-DENY.
B. 10/1/93 OR AFTER - FORCE.
3. DENTAL DIAGNOSIS 520 THRU 525.9
4. CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
5. ITA CARE
6. PM&R SERVICES
A. IF DOS BEFORE 3/1/95 - FORCE.
B. IF DOS 3/1/95 OR AFTER & CLIENT ENROLLED IN PROVIDER #'S 7500002, 7500176, 7500184 - DENY.
7. REVENUE CODE 942 (DIABETIC COUNSELING)
8. WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949)
9. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT ETC)
A. IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B. IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
10. IF CLIENT IS UNDER 21 YEARS OLD & STERILIZATION DX CODE V25.2.

D. DRUGS (D CLAIM TYPE)

1. COMPOUNDED UNDER NDC 00990-0000-00 TO 10.
2. PRESCRIBED BY DENTIST(PRESCRIBING # BEGINS WITH "5" OR COMMENTS INDICATE DENTAL PRESCRIPTION.)
3. DISPOSABLE NON-REUSABLE SUPPLIES
4. IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 251 IS STILL POSTING - DENY.
A. PRESCRIBED BY FAMILY PLANNING CLINIC.
B. PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER.
C. PRESCRIBED BY HEALTH DEPARTMENT.
D. ABORTION RELATED PRESCRIPTION.

E. MEDICAL VENDOR (P CLAIM TYPE)

1. DURABLE MEDICAL EQUIPMENT - EXCEPTION: IF FOR ORTHOPEDIC APPLIANCE OR BRACE - DENY.
2. DISPOSABLE NON-REUSABLE SUPPLIES.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.

E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, NO COVERAGE FOR DOS, OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR - FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
252 RECIPIENT NOT ELIGIBLE FOR ALL DATES OF SERVICE.

CHILDREN'S PROGRAM - DENY WITH EOB 300 AND MANUALLY ROUTE CLAIM TO MENTAL HEALTH, MAILSTOP OB 42-F.

NURSING HOMES
1. IF EXCEPTION 253 IS ALSO FAILING - REDUCE THE DAYS TO THE DEATH DATE OR THE DATE THE ELIGIBILITY ENDS, WHICHEVER WILL RESULT IN FEWER DAYS. USE EOB'S 398 AND 075.
2. IF THE ELIGIBILITY EXCEEDED BY ONE DAY ON A DISCHARGE, FORCE.
3. OTHERWISE, REDUCE DAYS TO THE LAST DATE OF ELIGIBILITY USING EOB 398.

ELIGIBILITY UNIT
1. CHECK OIS FOR COVERAGE OF DATES OF SERVICE:
   A. IF FOUND - BUILD SEGMENT COVERING DATES OF SERVICE.
   B. IF NOT FOUND - STAGE WORKSHEET & CHECK FOR MEDICAL ID CARD:
      1. IF NO MEDICAL ID CARD - RETURN BATCH & WORKSHEET, WITH ELIGIBLE DATES WRITTEN ON THE WORKSHEET, TO THE CLAIMS PROCESSING SUPERVISOR.
      2. IF MEDICAL ID CARD COVERING ALL DATES OF SERVICE - ADD MISSING DATES THEN ENTER WORKSHEET.
      3. IF MEDICAL ID CARD COVERING ONLY PART OF THE DATES OF SERVICE - ADD COVERED DATES TO ELIGIBILITY FILE. RETURN BATCH AND WORKSHEET, WITH ELIGIBLE DATES WRITTEN ON THE WORKSHEET, TO THE CLAIMS PROCESSING SUPERVISOR.

2. ITA - INSTITUTIONAL R & S CLAIMS
   A. CHECK FOR ITA FORM #DSHS 13-628:
      1. IF NOT ATTACHED OR PROPERLY COMPLETED - DENY WITH EOB 378.
      2. IF DATES ON ITA FORM DO NOT MATCH DATES BILLED - DENY WTIH EOB 058.
   B. INPATIENT (S) CLAIMS - CHECK ITA FORM #DSHS 13-628 SECTION II:
      1. IF BOX 1 IS CHECKED - BUILD SEGMENT ACCORDING TO ID CARD.
      2. IF BOX 2 IS CHECKED AND ELIGIBILITY PAPERS ARE ATTACHED, BUT NOTHING IN OIS - BUILD A "Q" RECORD COVERING THE DATES INDICATED IN SECTION IV #1, #5, #6. IF #7 IS CHECKED - BUILD A SEGMENT FOR 5 DAYS ONLY UNLESS AN APPROVED EXTENSION TO COVER MORE DAYS IS ATTACHED.
      3. IF BOX 3 OR 4 IS CHECKED - BUILD 3 DAYS ONLY. EXCEPTION: IF CLAIM IS FOR MORE THAN 3 DAYS - DENY WITH EOB 574.
      4. IF EXC 252 STILL POSTS, CHECK SECTION III OF FORM FOR APPROVED MENTAL HEALTH EXTENSION. ADD ADDITIONAL DAYS IF APPROVED. OTHERWISE - DENY.

C. DRG (R) CLAIMS - CHECK ITA FORM # DSHS 13-628 SECTION II:
   1. IF BOX 1 IS CHECKED - BUILD A SEGMENT ACCORDING TO ID CARD.
   2. IF BOX 2 IS CHECKED AND ELIGIBILITY PAPERS ARE ATTACHED - BUILD A SEGMENT TO COVER DATES OF SERVICE INDICATED IN SECTION IV, #1, #5, #6, #7.
   3. IF BOX 3 OR 4 IS CHECKED - BUILD A SEGMENT FOR 3 DAYS ONLY.

4. IF NO BOXES CHECKED OR EXC 252 STILL POSTS AFTER FOLLOWING THE ABOVE INSTRUCTIONS - RETURN BATCH & WORKSHEET, WITH ELIGIBLE DATES WRITTEN ON THE WORKSHEET, TO THE CLAIMS PROCESSING SUPERVISOR.

DRG (R) CLAIMS - RESOLUTION (AFTER ELIGIBILITY UNIT HAS REVIEWED)

1. TO DETERMINE IF WE SHOULD PAY THE ENTIRE DRG PAYMENT OR WHETHER THE DRG PAYMENT SHOULD BE PRORATED - DO THE FOLLOWING (EXCEPTION: PATIENT STATUS 02 TRANSFERS SEE #2 ON PAGE 5):
   A. DETERMINE THE FOLLOWING:
      1. THE PATIENT'S ELIGIBLE DAYS DURING THE STAY; AND
      2. THE DRG AVERAGE LENGTH OF STAY (PF4 UNDER THE DRG); AND
      3. THE DRG AVERAGE LENGTH OF STAY (PF4 UNDER THE DRG) MINUS THE PATIENT'S INELIGIBLE DAYS DURING THE STAY.

   --NOTE: WHEN CALCULATING DAYS - ALWAYS INCLUDE THE DATE OF DISCHARGE.
   --NOTE: WHEN MANUALLY PRICING - DO NOT DEDUCT PATIENT PAY, TPL, ETC. THE SYSTEM WILL DEDUCT THESE AMOUNTS.

   B. IF THE PATIENT'S ELIGIBILE DAYS A(1) ARE EQUAL TO OR GREATER THAN THE DRG AVERAGE LENGTH OF STAY A(2) - FORCE EXCEPTION 252 AND PAY THE FULL DRG.

   C. ALL ELSE:
      1. TAKE THE GREATER OF THE PATIENT'S ELIGIBLE DAYS DURING THE STAY A(1) OR THE DRG AVERAGE LENGTH OF STAY A(2) MINUS THE PATIENT'S INELIGIBLE DAYS A(3) AND DO THE FOLLOWING:
         A. DIVIDE THAT NUMBER BY THE DRG AVERAGE LENGTH OF STAY A(2). CARRY THE ANSWER OUT TO THE 4TH DECIMAL. THEN:
         B. MULTIPLY THAT NUMBER BY THE DRG ALLOWED AMT. ROUND UP OR DOWN TO THE NEAREST CENT.
         C. MANUALLY PRICE CLAIM AT THIS AMOUNT. KEY 502 IN THE 2ND EOB FIELD.

2. PATIENT STATUS 02 (TRANSFER):
   A. DIVIDE THE NUMBER OF ELIGIBLE DAYS BY THE ACTUAL LENGTH OF STAY.
   B. MULTIPLY THAT NUMBER BY THE DRG ALLOWED AMOUNT.
   C. MANUALLY PRICE CLAIM AT THIS AMOUNT. KEY 502 IN THE 2ND EOB FIELD.

TEXT KEY TEXT DESC
253 POSSIBLE RECIPIENT DEATH

ELIGIBILITY UNIT

VERIFY DEATH DATE AND UPDATE RECORD.
1. WORK THE WORKSHEET.
2. IF ALL THE LINES ARE NOT DENIED - DELIVER WORKSHEET TO THE APPROPRIATE UNIT FOR ADJUDICATION.

MMISS SERVICES

(J) CLAIM TYPE:
PROCEDURE CODE 0351M - OVERLOC TO 57

(K) CLAIM TYPE:
1. IF PROCEDURE CODE 0515D - FORCE.
2. ALL ELSE - DENY SERVICES AFTER DEATH DATE.

(L) CLAIM TYPE

(M) CLAIM TYPE

1. HOME HEALTH (PT 44) CLAIM HAS SPAN OF DATES: IF DATES ARE LISTED ON CLAIM, CHECK ELIGIBILITY FILE PAGE (2) FOR COVERED DATES. SPLIT DATES PUTTING NON-COVERED DATES ON SEPARATE LINE - THEN MANUALLY DENY LINES FOR NON-COVERED DATES W/EOB 011.

NOTE: KEY ONLY CONSECUTIVE DAYS ON 1 LINE. IF NON-CONSECUTIVE DAYS, KEY ONLY 2 DAYS ON 1 LINE.

(O) CLAIM TYPE:

1. MED VENDOR CLAIMS - O'LOC TO 65

2. PHYSICIANS CLAIMS - O'LOC TO 65

(P) CLAIM TYPE

1. MEDICAL VENDORS (PT 2 6, 39, 78, 79, AND 82)

A. MONTHLY RENTAL (I.E. UNIT = 1), FLAT RATE FOR ENTIRE MONTH - PRORATE IN ORDER TO PAY ONLY DATES CLIENT IS ELIGIBLE - SEE DATES WRITTEN ON CLAIM BY ELIGIBILITY UNIT OR PAGE 2 OF THE CLIENT'S FILE.

TO PRORATE, DIVIDE "MAA ALLOWED" BY 30 DAYS THEN MULTIPLY THAT "DAILY RATE" BY THE NUMBER OF DAYS ELIGIBLE AND MANUALLY PRICE THE LINE WITH INFORMATIONAL EOB 398.

B. IF PROCEDURE CODE IS A "DAILY" CODE (SEE PDD FILE) THEN SPLIT LINES AND PAY ONLY THOSE DATES ELIGIBLE. BE SURE

TO ADJUST MONEY AND UNITS ON EACH LINE.

C. IF PROCEDURE CODE BILLED DOES NOT REQUIRE SPAN OF DATES THEN KEY ENDING DATE TO MATCH BEGINNING DATE WITH INFORMATIONAL EOB 398.

D. ALL ELSE - DENY WITH EOB 478.

(R) CLAIM TYPE

(S) CLAIM TYPE

(T) CLAIM TYPE

TEXT KEY TEXT DESC
254 HMO - GROUP HEALTH OF SPOKANE

NOTE!! IF PREMIUM CODES 0301M, 0320M-0322M AND DOS IS PRIOR TO 12/1/90, OVERLOC TO LOC 58.

------IF DATE OF SERVICE 7/1/93 & AFTER GO TO PAGE 6 OF THIS TEXT-------

1. NON-COVERED HMO SERVICES - FORCE
   A. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.) &:
      1) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES - (635-636.9 OR V61.7)
      2) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
   B. ADULT DAY HEALTH CARE (PROVIDER TYPE 87).
   C. ALCOHOLISM DETOX TREATMENT (CODES 0025M, 0026M)
   D. ANNUAL FAMILY PLANNING EFFECTIVE 7/1/88 DOS (PROVIDER TYPE 71).
   E. BLOOD PRODUCTS AND COMPONENTS.
   F. CASE MANAGEMENT (PROVIDER TYPE 23).
   G. CHIROPRACTORS.
   H. CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) - IF DATE OF SERVICE IS BEFORE 7/1/88 - FORCE; IF DOS IS 7/1/88 OR AFTER - DENY
   I. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN - FORCE.
   J. DENTAL SERVICES (CLAIM TYPE K), DENTAL ANESTHESIA (0100M). ATTACHED - FORCE.
   K. LAB FOR DENTAL SERVICES (DIAGNOSIS CODES 520 THROUGH 525.9)
   L. DENTAL RELATED SERVICES
   M. DRUGS WHEN PRESCRIBED BY A DENTIST (PRESCRIBING # BEGINS W/"5")
   N. EYEGLASSES (SUPREME OPTICAL OR WESTERN OPTICAL)
   O. FIRST STEPS DISCRETIONARY ADD-ON FEE (5970M - 5976M).
   P. FITTING FEE, DISPENSING & REPAIR OF EYEGLASSES (CODES 9272M-9276M, 92340-92342,92352-92354,92370-92371)
   Q. HEARING AIDS (PROVIDER TYPE 84).
   R. HOSPICE (PROVIDER TYPE 63).
   S. INDIAN HEALTH SERVICES (PROCEDURE CODE 5999M).
   T. MENTAL HEALTH DIAGNOSES (2900 THRU 3190) IF INPATIENT (R,S) (J & POS 1) AND/OR OUTPATIENT (M) (J & POS 2 OR 5).
   U. ITA CARE
   V. KIDNEY DIALYSIS/HEMODIALYSIS - FORCE IF DATE OF SERVICE IS BEFORE 7/1/88; IF DOS IS 7/1/88 OR AFTER - DENY.
   W. MATERNITY SUPPORT (PROVIDER TYPE 35).
   X. NEUROMUSCULAR CTRS (PT 36) - FORCE EXCEPT FOR EVALUATIONS, PROCEDURE CODES 0001M, 9255M AND 92506 - DENY.
   Y. ORTHOPEDIC APPLIANCES & BRACES IF HMO DENIAL ATTACHED. IF DOS 9/1/88 OR AFTER - DENY.
   Z. ORTHOTICS - FORCE UNLESS ATTACHED TO A LEG BRACE & THEN DENY.
  ZA. COMMUNITY MENTAL HEALTH (PROVIDER TYPE 73).
  ZB. OXYGEN AT HOME- FORCE IF DATE OF SERVICE IS BEFORE 7/1/88; IF DOS IS 7/1/88 OR AFTER - DENY.
  ZC. PM&R SERVICES (ALL) - (J) 0030M - 0035M, (S) HOSPITALS.
  ZD. PODIATRY ORTHOTICS (1600L-1602L) - FORCE IF DATE OF SERVICE IS BEFORE 7/1/88; IF DOS 7/1/88 OR AFTER - DENY.

ZE. PROSTHETICS (PT 38 - FORCE IF DATE OF SERVICE IS BEFORE 7/1/88; IF DOS 7/1/88 OR AFTER - DENY.
ZF. PSYCHOLOGICAL EVALUATIONS (PROCEDURE CODE 0070M).
ZG. SUBSTANCE ABUSE (PROVIDER TYPE 75).
ZH. TRANSPORTATION OTHER THAN AMBULANCE (PROVIDER TYPES 42,45,50,54, 55,96).
ZI. OCCUPATIONAL THERAPY
ZJ. NUTRITIONAL COUNSELING (CODES 0900M-0902M)
ZK. WEIGHT LOSS (REVENUE CODES 942 & 949)
ZL. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
ZM. DEPO-PROVERA FOR BIRTH CONTROL (CODE 9913M) - FORCE.
ZN. NORPLANT KIT (CODE 9910M) - FORCE.
ZO. REMOVAL OF NORPLANT SYSTEM CODES 1798M, 1799M, 11976, 1197M &:
1) DATE OF SERVICE IS 3/1/92 OR AFTER - FORCE.
2) DATE OF SERVICE IS BEFORE 3/1/92 - DENY.

2. IF THE CLAIM HAS AN HMO EOB/DENIAL ATTACHED AND IT STATES:
A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY W/EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY W/EOB 151.
D. IF EOB SHOWS PAYMENT - DENY W/EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - USE OVERCODE 680 AND OVERLOC TO 80.

3. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFEC-TIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
B. NON-COVERED SERVICES -(SEE ABOVE) IF LISTED - FORCE. IF NOT LISTED - DENY.
C. CHARGES APPLIED TO DEDUCTIBLE OR CO-PAY - DENY WITH EOB 151.
D. ANY OTHER STATEMENT - DENY.

4. NO EOB ATTACHED/NO STATEMENT ON CLAIM:
A. NON COVERED SERVICES - FORCE.
B. NO COUPON ATTACHED - DENY.
C. COUPON ATTACHED STATING HMO - DENY.

HMO PREMIUM BILLS

1. WHEN THE HMO/HIO HAS BILLED THE WRONG AMOUNT FOR A REQUESTED AMOUNT FOR A PREMIUM PAYMENT - DENY W/EOB(963.DO NOT USE EOB)

2. WHEN THE CSO HAS NOT INDICATED A HMO-HIO ENROLLMENT BY CODING THE MEDICAL ELIGIBILITY SCREEN - DENY W/EOB(964.DO NOT USE EOB)

3. IF DOS PRIOR TO 12/1/90 & THE RA SHOWS A DUPLICATION OF PREMIUM BILLINGS - DENY W/EOB 041.

4. IF OUR RECORDS INDICATED WE HAVE PAID FEE FOR SERVICE CLAIMS FOR THE DATES OF SERVICE - DENY W/EOB 460.

5. IF TPL SCREEN SHOWS PRIVATE INSURANCE COVERAGE WITH HMO WE PAID PREMIUMS TO - DENY W/EOB 955.

CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT THE HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY W/EOB 229.

--IF DATE OF SERVICE 7/1/93 OR AFTER APPLY THE FOLLOWING--

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY GROUP HEALTH NW):

A. ALL CLAIM TYPES - IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE

B. PHYSICIAN (J CLAIM TYPE)
1) SPEECH THERAPY FOR CONGENITAL CONDITIONS.
2) MENTAL HEALTH DIAGNOSIS 290.0 THRU 319.0 & PLACE OF SERVICE IS 1, 2 OR 5.
3) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
4) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PRODEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
9) SERVICES FOR CUP, DX CODE 648.33.

C. HOSPITALS (M,R,S CLAIM TYPES)
1) MENTAL HEALTH (DIAGNOSIS 290.0 THRU 319.0)
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) PM&R SERVICES
5) REVENUE CODE 942 (DIABETIC COUNSELING)
6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949)
7) ITA CARE
8) SPEECH THERAPY FOR CONGENITAL CONDITION
9) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES (635-636.9 OR V61.7)
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
10) IF CLIENT IS UNDER 21 YEARS OLD & STERILIZATION DX CODE V25.2.

D. PHARMACY - D CLAIM TYPE
1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR

COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 254 IS STILL POSTING - DENY.
A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CLINIC
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:
   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT MENTIONED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
   H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
256 DETAIL DOS NOT ELIGIBLE

RESOLUTIONS - PHYSICIANS

IF THERE IS NO MEDICAL ID CARD OR THE ID CARD COVERS ONLY PARTIAL MONTH:

1. SPAN OF DATES WITH MULTIPLE UNITS (I.E.UNITS=DAYS); SPLIT OUT THE DATE(S) OF SERVICE THE CLIENT WAS NOT ELIGIBLE, ENTER, AND DENY THE EXCEPTION 244 & GIVE INFO EOB 398.
   EXCEPTION: SCHOOL SERVICES (PT 58) - DENY W/EOB 478.
   EXCEPTION: ALL ELSE- IF DAYS DON'T DIVIDE EVENLY, DENY THE 256 AND GIVE 2ND INFO EOB OF 305.

2. SPAN OF DATES WITH 1 UNIT: ADJUST THE DATES OF SERVICE ON LINE TO REFLECT THE CLIENT'S ELIGIBILITY, FOUND ON PAGE 2 OF THE CLIENT'S FILE. USE THE INFORMATIONAL EOB 398.

3. SPAN OF DATES WITH 1 UNIT OR MULTIPLE UNITS AND THE SERVICE IS PAID A FLAT FEE FOR A SPECIFIED PERIOD OF TIME (I.E. TRIMESTER CARE, POST-PARTUM CARE OR CASE MANAGEMENT:
   A. CHECK PAGE 2 OF ELIGIBILITY FILE TO DETERMINE WHEN ELIGIBILITY STARTS
   B. ADJUST THE CLAIM "FROM" AND "TO" DATE TO REFLECT THAT DATE. KEY IN ONE (1) UNIT. USE THE INFORMATIONAL EOB 398.

MED VENDORS (P)

1. PT 26, 39, 78, 79 AND 82

   A. MONTHLY RENTAL (I.E. UNIT = 1, FLAT RATE FOR ENTIRE MONTH) - PRORATE IN ORDER TO PAY ONLY DATES CLIENT IS ELIGIBLE (SEE DATES WRITTEN ON CLAIM BY ELIGIBILITY UNIT OR PAGE 2 OF THE CLIENT'S FILE.

      TO PRORATE, DIVIDE "MAA ALLOWED" BY 30 DAYS THEN MULTIPLY THAT "DAILY RATE" BY THE NUMBER OF DAYS ELIGIBLE AND MANUALLY PRICE THE LINE W/ INFO EOB 398.

   B. IF PROCEDURE CODE IS A "DAILY" CODE (SEE PDDD FILE) THEN SPLIT LINES AND PAY ONLY THOSE DATES ELIGIBLE. BE SURE TO ADJUST MONEY AND UNITS ON EACH LINE.

   C. IF PROCEDURE CODE BILLED DOES NOT REQUIRE SPAN OF DATES THEN KEY ENDING DATE TO MATCH BEGINNING DATE W/INFO EOB 398.
      (IF UNSURE SEE TRAINER/SUPERVISOR/MMIS.)

   D. ALL ELSE - DENY W/EOB 478.

MEDICARE X-OVERS (O)

1. MED VENDOR X-OVER(TOS 9)-OVERLOC TO 65.

2. PHYSICIAN X-OVER (TOS 3) - OVERLOC TO 65.

   ELIGIBILITY

   A. IF THE MEDICAL ID CARD COVERS THE DOS BUILD THE CORRECT SEGMENT(S) AND ENTER THESE DATES ON THE WORKSHEET.

   B. IF THERE IS NO MEDICAL ID CARD THEN GIVE THE WORKSHEET TO THE RES. SUPERVISOR TO HAVE THE INELIGIBLE DATES OF SERVICE SPLIT OUT.

TEXT KEY TEXT DESC
257 "A" RECIPIENT ON REVIEW

PHYSICIANS CLAIM TYPE: (J)

NOTE: "WHEN VERIFYING PROVIDER NAME, FIRST NAME OR INITAL AND LAST NAME MUST MATCH"

FORCE THE FOLLOWING EXCEPTIONS:

1. A. CLAIMS W/SERVICES PERFORMED IN POS 1,2,5,21,22,23,51,52-FORCE. EXCEPTION: IF POS (3,11,71,81) ON THE CLAIM W/POS 1,2,5,21,22, 23,51,52 ON ANOTHER LINE & NO REFERRING PROVIDER OR THE REFERRING PROVIDER IS NOT THE PRIMARY PROVIDER - FORCE THE 257 & MANUALLY DENY THE LINES W/POS (3,11,71,81) W/EOB 035.
   B. CLAIMS BILLED BY AMBULATORY SURGICAL CENTERS (PT 22) - FORCE.

2. PROCEDURE SPANS:
   A. 80000-89999 OR 36415 ARE THE ONLY PROCEDURES ON THE CLAIM - FORCE.
   B. 0400M-0410M, 0076M-0082M, 59000-59899, 5930M-5985M, 99241-99275 ARE ANYWHERE ON CLAIM - FORCE.

3. 1C MOD OR STATEMENT "BABY ON PARENT'S PIC"
4. HARD COPY CLAIMS FOR ANY CORRECTION CENTER, I.E. CORRECTION HEALTH CLINIC OF TACOMA, PIERCE COUNTY CORRECTION CENTER, ETC.
5. BLOCK 17 INDICATED - "ER" REFERRAL OR HAS HOSPITAL NAME.
6. COUPON DOES NOT HAVE XXX IN THE RESTRICTED FIELD OR "CLIENT ON REVIEW".
7. STATEMENT ON CLAIM, COMMENTS OR BACK-UP - NO RESTRICTION ON MEDICAL ID CARD (COUPON).
8. ITA CLAIMS - FORCE.

--IF YOU CANNOT FORCE PER ABOVE - SEE BELOW.
1. PF-4 UNDER CLIENT PIC.
2. PF-5 TO RESTRICTED SCREEN TO VERIFY WHO THE PRIMARY CARE PROVIDER IS DURING THE DATE SPAN ON THE CLAIM.
3. IF CLIENT IS NOT RESTRICTED TO A PHYSICIAN OR CLINIC, (SPAN FOR PHARMACY ONLY) - FORCE.
4. CHECK CLAIM/COMMENTS/BACKUP FOR NAME/NUMBER THAT MATCHES SCREEN.
   A. IF REFERRING/PERFORMING/BILLING # ON CLAIM IS REAL CLOSE TO # ON RESTRICTED SCREEN "I.E" <ONE OR TWO DIGITS> - FORCE 257.
   B. IF REFERRING/PERFORMING/BILLING # ON CLAIM AND SCREEN ARE DIFF-ERENT, BUT THE NAMES ON THE CLAIM AND SCREEN MATCH - FORCE 257.
   C. IF REFERRING/PERFORMING/BILLING # ON CLAIM AND SCREEN ARE MEMBERS OF THE SAME GROUP, OFFICE, ETC OR CLAIM STATES "COVERING FOR" AND INDICATES THE DR. ON THE SCREEN - FORCE.

--OTHER THAN THE ABOVE - DENY.

TEXT KEY TEXT DESC
258 HMO - KAISER

NOTE: IF DOS BEFORE 12/1/90 & PREMIUM CODES 0302M, 0315M-0317M, 0335M-0338M - OVERLOC TO 58.

-- IF DATES OF SERVICE 7/1/93 & AFTER GO TO PAGE 6 OF THIS TEXT --

1. NON-COVERED KAISER SERVICES - FORCE
   A. SPEECH THERAPY FOR CONGENITAL CONDITIONS - OTHERWISE DENY.
   B. DENTAL SERVICES (CLAIM TYPE K), DENTAL ANESTHESIA (0100M)
   C. DENTAL RELATED SERVICES
   D. DRUGS (CLAIM TYPE D) WHEN PRESCRIBED BY A DENTIST (PRESCRIBING PROVIDER NUMBER BEGINS WITH A 5)
   E. OTHER THAN AMBULANCE TRANSPORTATION (PROVIDER TYPES 42,45,50,54, 55,96)
   F. HEARING AIDS (PT 84)
   G. PODIATRY ORTHOTICS (1600L - 1602L) - FORCE, EXCEPT IF DATE OF SERVICE IS SEPTEMBER 1, 1988 & AFTER - DENY.
   H. PROSTHETICS IF HMO DENIAL ATTACHED (PT 38) - IF DOS 9/1/88 OR AFTER - DENY.
   H. OXYGEN AT HOME - FORCE, EXCEPT IF DATE OF SERVICE IS SEPTEMBER 1, 1988 & AFTER - DENY.
   J. HOME RESPIRATORY THERAPY SERVICES - FORCE, EXCEPT IF DATE OF SERVICE IS 9/1/88 OF AFTER - DENY.
   K. ADULT DAY HEALTH CARE (PROVIDER TYPE 87)
   L. ORTHOPEDIC APPLIANCES IF HMO DENIAL ATTACHED. IF DOS 9/1/88 OR AFTER - DENY.
   M. PSYCHIATRIC CONDITIONS: MEDICAL HEALTH SERVICES INCLUDING TREAT-MENT FOR MENTAL ILLNESS OR DISORDER - ALL CLAIM TYPES INCLUDING ITA AND PSYCHOLOGICAL EVALUATIONS.
   N. ALL PM&R SERVICES - (J) 0030M-0035M, (S) HOSPITALS
   O. CHIROPRACTORS
   P. BLOOD PRODUCTS AND COMPONENTS
   Q. DURABLE MEDICAL EQUIPMENT - FORCE, EXCEPT IF DATE OF SERVICE IS 9/1/88 OR AFTER - DENY.
   R. DRUG & ALCOHOL ABUSE (P.T. 75)
   S. ANNUAL FAMILY PLANNING EFFECTIVE JULY 1, 1988 DOS (PT. 71)
   T. EYEGLASSES (SUPREME OPTICAL OR WESTERN OPTICAL)
   U. FITTING FEE, DISPENSING & REPAIR OF EYEGLASSES (CODES 9272M-9276M, 92340-92342,92352-92354,92370-92371)
   V. NEURO-MUSCULAR REHABILITATION IF HMO DENIAL ATTACHED. IF DOS 9/1/88 OR AFTER - DENY.
   W. CASE MANAGEMENT (PROVIDER TYPE 23)
   X. MATERNITY SUPPORT (PROVIDER TYPE 35)
   Y. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN - FORCE.
   Z. HOSPICE (PT 63)
  ZA. 5970M-5976M (1ST STEPS DISCRETIONARY ADD-ON FEE)
  ZB. OCCUPATIONAL THERAPY
  ZC. NUTRITIONAL COUNSELING (CODES 0900M-0902M)
  ZD. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC) &:

1) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
2) IF SPONTANEOUS OR MEDICALLY JUSTIFIED - DENY.

ZE. MENTAL HLTH DRUGS(THERAPEUTIC CLASSES 440,441,442,444,430) FORCE.
ZF. WEIGHT LOSS (REVENUE CODES 942 & 949)
ZG. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
ZH. DEPO-PROVERA FOR BIRTH CONTROL - FORCE.
ZI. NORPLANT KIT CODE 9910M - FORCE.
ZJ. REMOVAL OF NORPLANT SYSTEM CODES 1798M, 1799M, 11976, 1197M &:
1) DATE OF SERVICE IS 3/1/92 OR AFTER - FORCE.
2) DATE OF SERVICE IS BEFORE 3/1/92 - DENY.

2. IF THE CLAIM HAS AN HMO EOB/DENIAL ATTACHED AND IT STATES:
A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY W/EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY W/EOB 151.
D. IF EOB SHOWS PAYMENT - DENY W/EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND THE SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - DENY WITH EOB 217.

3. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
B. NON-COVERED SERVICES - (SEE ABOVE) IF LISTED - FORCE. IF NOT LISTED, DENY.
C. CHARGES APPLIES TO THE DEDUCTIBLE OR CO-PAY - DENY WITH EOB 151.
D. ANY OTHER STATEMENT - DENY.

4. NO EOB ATTACHED/NO STATEMENT ON CLAIM:
A. NON COVERED SERVICES - FORCE.
B. NO COUPON ATTACHED - DENY.
C. COUPON ATTACHED STATING HMO - DENY.

HMO PREMIUM BILLS
1. WHEN THE HMO/HIO HAS BILLED THE WRONG AMOUNT FOR A REQUESTED AMOUNT FOR A PREMIUM PAYMENT - DENY W/EOB(963.DO NOT USE EOB)
2. WHEN THE CSO HAS NOT INDICATED A HMO-HIO ENROLLMENT BY CODING THE MEDICAL ELIGIBILITY SCREEN - DENY W/EOB(964.DO NOT USE EOB)
3. IF DOS PRIOR TO 12/1/90 & THE RA SHOWS A DUPLICATION OF PREMIUM BILLINGS - DENY W/EOB 041.
4. IF OUR RECORDS INDICATED WE HAVE PAID FEE FOR SERVICE CLAIMS FOR THE DATES OF SERVICE - DENY W/EOB 460.
5. IF TPL SCREEN SHOWS PRIVATE INSURANCE COVERAGE WITH HMO WE PAID PREMIUMS TO - DENY W/EOB 955.

CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT THE HMO HAS PAID THEIR MAXIMUM ALLOWABLE, AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY W/EOB 229.

-- IF DATE OF SERVICE IS 7/1/93 OR AFTER APPLY THE FOLLOWING TEXT --

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY KAISER):

A. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICED - FORCE EXCEPT - IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER #7500010 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3, OR 5).

B. PHYSICIAN (J CLAIM TYPE)
1. DIAGNOSIS CODES 290.0 THRU 319.0 (PSYC)
2. ITAA
3. DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
4. IT PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
5. SPEECH THERAPY FOR CONGENITAL CONDITIONS.
6. ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR

STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM)
7. CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
8. PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
9. PT 20 & TB CODES(9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
10. SERVICES FOR CUP, DX CODE 648.33.

C. HOSPITALS - (M,R,S CLAIM TYPES)
1. TREATMENT FOR MENTAL ILLNESS INCLUDING ITA.
2. DENTAL DIAGNOSIS 520 THRU 525.9
3. CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4. PM&R SERVICES
A. IF DOS BEFORE 3/1/95 - FORCE.
B. IF DOS 3/1/95 OR AFTER & CLIENT ENROLLED IN PROVIDER # 7500010 - DENY.
5. REVENUE CODE 943 (DIABETIC COUNSELING)
6. WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949)
7. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A. IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B. IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
8. IF CLIENT IS UNDER 21 YRS OLD & STERILIZATION DX CODE V25.2.

A. PHARMACY - D CLAIM TYPE
1. IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
2. IF THERAPEUTIC CLASS 430, 440-442 OR 444.
3. IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 258 IS STILL POSTING - DENY.
A. PRESCRIBED BY FAMILY PLANNING CLINIC
B. PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C. PRESCRIBED BY HEALTH DEPARTMENT

D. ABORTION RELATED PRESCRIPTION.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE NON-COVERED" LIST - DENY WITH EOB 763.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
   H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC

259 NOTE: IF CLAIM OR BACKUP INDICATES MEDICARE BENEFITS EXHAUSTED, MEDICARE DECERTIFIED THE STAY, OR IF THE CLIENT BECAME ELIGIBLE FOR MEDICARE DURING THE HOSPITAL STAY - OVERLOC TO 72.

NOTE: IF CLAIM OR BACKUP INDICATES GOVERNMENT EMPLOYEES HOSPITAL ASSOC. (GEHA) - PUT A "Y" IN THE TPL FIELD, FORCE EXCEPTION 259 AND PA2 EXCEPTION 165.

NOTE: IF A MANAGED HEALTH CARE OR HMO REMITTANCE IS ATTACHED- OVERLOC TO 55.

1. HOSPICE (PROVIDER TYPE 63) - THESE WILL BE OUTPATIENT (M) CLAIMS. MEDICARE PART A PAYS FOR HOSPICE CARE AND RELATED PROFESSIONAL SERVICES IN FULL. EXCEPTION: PART A DOES NOT COVER NURSING HOME ROOM & BOARD (REVENUE CODES 650 AND 653) (DOS 10/1/03 & AFTER ROOM & BOARD CODES ARE 115, 125, 135 & 145)
   A. IF REV CODE 650, 653, 115, 125, 135 AND/OR 145 ARE THE ONLY CODES BILLED ON THE CLAIM-FORCE.
   B. IF OTHER REV CODES ARE BILLED WITH REV CODES ABOVE - MANUALLY PRICE THE OTHER REV CODES AT 0.00. KEY 061 IN THE FIRST EOB FIELD ON THE LINE AND FORCE EXC 259.
   C. IF THE PROVIDER INDICATES THE CLIENT HAS PART B ONLY, OR INCLUDES A COPY OF THE MEDICARE ID CARD SHOWING PART B ONLY - FORCE.
      **EXCEPTION: IF PROFESSIONAL (PHYSICIAN) CHARGES APPEAR ON THE CLAIM - MANUALLY PRICE THE PROFESSIONAL CHARGES AT 0.00. KEY 298 IN THE FIRST EOB FIELD ON THE LINE, THEN FORCE EXC 259.
   D. ALL ELSE - DENY.

2. INPATIENT (R & S) CLAIMS:
   A. IF CLAIM OR BACKUP INDICATE MEDICARE PART A PAYMENT:
      1. HARDCOPY CLAIMS - DENY W/EOB 333 & REPROCESS AS A CROSSOVER "V" CLAIM.
      2. ELECTRONIC CLAIMS - DENY W/EOB 226.
   B. FORCE THE FOLLOWING:
      1. ANCILLARY CHARGES FOR SWING BED CLAIMS.
      2. COMMENT STATING "NO MEDICARE" OR "FORCE MEDICARE" PER AUDREY FINNIGAN" - FORCE W/OVERCODE 111.
      3. MEDICARE EOMB/DENIAL STATING NO PART A & NO PART B (MUST STATE BOTH) - FORCE W/OVERCODE 111.
      4. COPY/PRINT OUT OF MEDICARE'S ELIGIBILITY/COMMON WORKING FILE (CWF) SHOWING CLIENT DOES NOT HAVE MEDICARE PART A & PART B (MUST STATE BOTH) - FORCE W/OVER CODE 111.
   C. DENY THE FOLLOWING:
      1. MEDICARE DENIAL ATTACHED AND THERE IS NO PRINTED DENIAL REASON - DENY W/EOB 783.
      2. THE DATES OF SERVICE ON THE MEDICARE EOMB DO NOT MATCH THE DATES OF SERVICE ON THE CLAIM - DENY W/EOB 105.
      3. MEDICARE ADJUSTMENT REASON/REMARK CODES (MAY BE PRECEDED BY "PR"):
         18 THRU 24 - DENY W/EOB 334

D. ALL ELSE:
NOTE: WHEN WORKING EXC 259 FOR INPATIENT (R & S) CLAIMS, YOU MUST ADDRESS BOTH MEDICARE PART A & PART B. IF YOU ARE NOT SURE THAT YOU HAVE A VALID PART A AND/OR PART B DENIAL OR YOUR SITUATION IS NOT ADDRESSED IN THIS TEXT - OVERLOC TO 72.

1. IF THERE ARE NO COMMENTS, BACKUP, ETC. REGARDING MEDICARE COVERAGE - DENY.
2. OTHERWISE:
   A. CHECK CLAIM/BACKUP FOR A VALID MEDICARE PART A DENIAL. THE FOLLOWING ARE VALID MEDICARE PART A DENIALS:
      -- MEDICARE EOMB/DENIAL INDICATING NO MEDICARE PART A BENEFITS OR SERVICE IS NOT COVERED.
      -- COMMENT ON CLAIM STATING "NO PART A PER AUDREY FINNIGAN".
      -- COPY OF THE CLIENTS MEDICARE ID CARD STATING "NO ENTITLEMENT TO PART A.
      -- COPY/PRINT OUT OF MEDICARE'S ELIGIBILITY/COMMON WORKING FILE (CWF) STATING NO PART A.
   B. IF YOU DO NOT HAVE A VALID PART A DENIAL - DENY.
   C. IF YOU HAVE A VALID PART A DENIAL - CHECK THE CLAIM/BACKUP FOR A VALID MEDICARE PART B DENIAL. THE FOLLOWING ARE VALID PART B DENIALS:
      -- MEDICARE EOMB/DENIAL STATING NO PART B BENEFITS.
      -- COMMENT ON CLAIM STATING "NO PART B PER AUDREY FINNIGAN".
      -- COPY OF CLIENTS MEDICARE ID CARD STATING "NO ENTITLEMENT TO PART B.
      -- COPY/PRINT OUT OF MEDICARE'S ELIGIBILITY/COMMON WORKING FILE (CWF) STATING NO PART B.
3. IF YOU HAVE A VALID PART B DENIAL - FORCE.
4. IF YOU DO NOT HAVE A VALID PART B DENIAL - CHECK THE CLAIM FOR PART B CHARGES. PART B CHARGES INCLUDE:
   LABORATORY SERVICES
   X-RAY/RADIOLOGY SERVICES
   SURGICAL DRESSINGS
   CASTS/SPLINTS/BRACES/PROSTHETIC DEVICES

   A. INPATIENT (S) CLAIMS:
      *NOTE: IF THE CLAIM OR BACKUP INDICATE A MEDICARE PART B PYMT - DO NOT ENTER THE PYMT ON THE F6 SCREEN. PART B SERVICES MUST BE PROCESSED ON A "W" CLAIM. FOLLOW THE INSTRUCTIONS BELOW:
      1. IF THE PART B CHARGES HAVE BEEN DELETED OR ARE LISTED IN THE NON-COVERED FIELD - FORCE.
      2. IF THE PART B CHARGES HAVE NOT BEEN DELETED OR ARE NOT LISTED IN THE NON-COVERED FIELD - DENY W/EOB 292.

   B. DRG (R) CLAIMS:
      *NOTE: PART B CHARGES ARE INCLUDED IN THE DRG ALLOWED AMOUNT EVEN WHEN THEY HAVE BEEN DELETED FROM THE CLAIM OR HAVE BEEN LISTED IN THE NON-COVERED FIELD.
      1. IF MEDICARE PART B PAYMENT IS INDICATED ON THE CLAIM OR BACKUP - ENTER THE PAYMENT IN THE "*MED-AMT:" FIELD (F6 SCREEN) & FORCE EXC 259. *NOTE: DO NOT CHANGE THE NET CLAIM CHARGE. MMIS WILL DEDUCT THE PAYMENT FROM THE ALLOWED AMOUNT.

2. IF THERE IS NO PART B PAYMENT INDICATED ON THE CLAIM OR BACKUP - DENY W/EOB 270.

TEXT KEY TEXT DESC
261 RECIPIENT IS ELIGIBLE FOR MEDICARE PART B

----------OUT OF STATE W/EOMB OR MEDICARE RA ATTACHED----------

--- PHYSICIAN (J) AND MED VENDOR (P) CLAIM TYPES ---
-OUT OF STATE CLAIMS ONLY-

1. IF ALL LINES ON CLAIM HAVE MEDICARE ALLOWED AMOUNT:
   A. DENY CLAIM AT HEADER WITH EOB 333.
   B. WRITE DENIAL REASON (333), COMPLETE ICN# AND YOUR USER ID# IN BOX 22.
   C. PUT THE CLAIM IN THE SLOT MARKED RE-ICN "O" FOR REPROCESSING.

NOTE: PHYSICIAN CLAIMS - IF THE ORIGINAL OR REFERENCED ICN IS MORE THAN 6 MO BEYOND THE MEDICARE PAID DATE - DENY W/EOB 546. IF THE MEDICARE PAID DATE ID MISSING - DENY W/EOB'S 335/767.

2. IF SOME LINES ARE NON ALLOWED BY MEDICARE:
   A. PROCESS NON-ALLOWED LINES UNDER CURRENT ICN. DENY ALLOWED LINES WITH EOB 333.
   B. MAKE COPY OF CLAIM/BACKUP.
   C. CROSS OUT LINES PROCESSED AS J OR P.
   D. CORRECT TOTAL CHARGE.
   E. WRITE DENIAL REASON (333), COMPLETE ICN# AND YOUR USER ID# IN BOX 22. 333 IF CLAIM IS BEING DENIED FOR ANY REASON
   F. PUT THE CLAIM IN THE SLOT MARKED RE-ICN "O" FOR REPROCESSING.

NOTE: DO NOT DENY 333 IF CLAIM IS BEING DENIED FOR ANY REASON (IE TIMELINESS, ELIGIBILITY) OR IF PA-2'D FOR NO PROVIDER # ON FILE, ETC.

NOTE: DO NOT DENY 333 IF CLAIM IS LACKING MEDICARE RA COVERING DATES OF SERVICE BILLED.

FYI: SOME EXCEPTIONS ARE SET TO PAY ON X-OVERS, SO, IF IN DOUBT-CHECK PF1 SCREEN FOR "O" CLAIM STATUS.

------ OUT-OF STATE ----- OUTPATIENT (M) ------

IF MEDICARE RA, EOMB, OR DMERC RA ATTACHED AND THERE WAS A PAYMENT, DO NOT KEY MONEY AMOUNT IN THE INSURANCE FIELD OR PUT A "Y" IN THE TPL FIELD - DENY WITH EOB 333 AND TRANSFER THE INFORMATION TO THE CORRECT CLAIM FORM (UB-92) AND PROCESS THE CLAIM AS A X-OVER.

IF MEDICARE DENIAL IS ATTACHED, CHECK APPROPRIATE SECTION OF THIS TEXT FOR ADJUDICATION.

IF NO MEDICARE RA, DMERC RA, OR EOMB ATTACHED, AND/OR THERE IS NO INDICATION THAT MEDICARE WAS BILLED, CHECK APPROPRIATE SECTION OF THIS TEXT FOR FORCEABLE ITEMS, AND IF NOT THERE - DENY TO BILL MEDICARE.
IF THERE IS A DISCLAIMER OR SOME INDICATION THAT THE PATIENT DOES NOT HAVE MEDICARE - FORCE IF COPY OF COMMON WORKING FILE (CWF) ATTACHED.

OTHERWISE DENY W/EOB 918.

---------- END OF OUT-OF-STATE INSTRUCTION ----------

---------- IN-STATE INSTRUCTION ----------

----- ALL CLAIM TYPES -----

GENERAL INSTRUCTIONS
LOC 55 - "MANAGED" MEDICARE" - SEE 988 TEXT. *T

IF CLAIM/BACKUP INDICATES GOVERNMENT EMPLOYEES HOSPITAL ASSOC. (GEHA) - FORCE, PUT A "Y" IN TPL AND PA2. THIS IS NOT MEDICARE.

IF A COPY OF THE COMMON WORK FILE (CWF) IS ATTACHED AND SHOWS THAT THE CLIENT WAS NOT ELIGIBLE FOR THE DOS BILLED - FORCE W/OVERCODE 111. IF THE CWF SHOWS THE CLIENT WAS ELIGIBLE FOR THE DOS BILLED - DENY W/EOB 918. IF THE CWF DOES NOT COVER THE CLIENT - DENY W/EOB 105.

"BENEFICIARY FIELD" ON MEDICARE EOMB HAS MONEY BUT MEDICARE PAID $0.00 - DENY W/EOB 988.

MEDICARE SUMMARY NOTICE - WHICH STATES "UNASSIGNED CLAIMS"-DENY W/988.
ACTION CODE MA28 (PROVIDER DID NOT ACCEPT ASSIGNMENT) - DENY W/EOB 988.
MAA RA'S PREVIOUSLY DENIED W/EOB 095 MUST HAVE MEDICARE'S EOMB ATTACHED - NOT ATTACHED, DENY W/EOB 095 AGAIN.

MEDICARE PAID ("ALLOWED")
---
1. MEDICARE PAID DATE IS MORE THAN 6 MONTHS PRIOR TO THE ORIGINAL OR REF ICN THAT ESTABLISHED TIMELINESS - DENY W/EOB 546.
2. OUTPATIENT (M) CLAIMS - DENY 333 AND REPROCESS AS A CROSSOVER (W) CLAIM TYPE.
3. MEDICARE EOMB IS INCOMPLETE, MISSING COLUMN TITLES OR REASON CODES- DENY W/EOBS 281/335.
4. MEDICARE PAID DATE IS MISSING - DENY W/EOBS 335/364.
5. ALL ELSE - DENY CLAIM OR PAID LINE(S) W/EOB 335 & PA2 ALL EXCEPTIONS OTHER THAN ELIGIBILITY AND TIMELINESS.

MEDICARE "CONTRACT ADJUST" -- DOES NOT APPLY TO OUTPATIENT (M) CLAIMS.

IF CONTRACT ADJUST FIELD OR ONE OF THE ITEMS BELOW LISTED ON THE ATTACHED EOMB:
1. PROV# (6 DIGIT) AT TOP OF RA/EOMB BEGINS WITH A (5)
2. 1 LINE ON THE RA & MULTIPLE LINES ON THE CLAIM
3. RURAL HEALTH, COMMUNITY HEALTH OR HOSPITAL IS INDICATED IN PROVIDER NAME FIELD ON RA/EOMB BEGINS WITH A (1) IE (141)
4. BACKUP STATES PART A
5. BACKUP STATES PART B & AT LEAST ONE OTHER ITEM ON THIS LIST IS PRESENT.

   A. PHYSICIAN (TOS 3) - DENY W/EOB 565. THIS APPLIES WHETHER OR NOT MEDICARE MADE A PAYMENT.
      EXCEPTION:PT36, 37/SP76 OR 40/SP66

1. MEDICARE ALLOWED - DENY W/EOB 565
2. NO ALLOWED - FORCE.

B. MED VENDOR (TOS 9) --
1. PT 51 (GROUND AMBULANCE)
A. MEDICARE ALLOWED - DENY W/EOB 335
B. NO ALLOWED - PROCEED THRU TEXT.
2. PT 34 (PHYSICAL THERAPY)
1. MEDICARE ALLOWED - DENY W/EOBS 565/966.
2. NO MEDICARE ALLOWED - PROCESS CLAIM REGARDLESS OF THE TYPE OF MEDICARE BACKUP.

NO MEDICARE ELIGIBILITY

MEDICARE EOMB'S WITH REASON CODE 26,27,28 AND 31 OVERRIDE ALL OTHER REASON CODES FOR THE SAME DATE OF SERVICE. IF THERE IS A REASON CODE ON ANOTHER DETAIL LINE FOR THE SAME DATE OF SERVICE,FOLLOW THE INSTRUCTIONS FOR THE REASON CODES 26,27,28 OR 31 ONLY AND DISREGARD OTHER MEDICARE REASON CODES.
STATEMENT ON CLAIM (FROM PROVIDER) "NOT ELIG FOR MEDICARE", "NO MEDICARE COVERAGE", "NO PART B", "REFUGEE OR ALIEN" - CHECK TEXT & IF NOT FORCEABLE - DENY 918.

IF MEDICARE HEALTH INSURANCE CARD IS ATTACHED & DOS ON CLAIM IS BEFORE ENTITLEMENT TO PART B - FORCE & OVERCODE 111.
- IF ENTITLEMENT IS FOR PART A & DATE IS WITHIN 1 YEAR OF THE DOS ON CLAIM - FORCE & OVERCODE 111.
IF ENTITLEMENT DATE IS NOT WITHIN 1 YEAR - DENY W/EOB 918.

IF MEDICARE EOMB HAS EITHER OF THE FOLLOWING MESSAGES - FORCE & OVERCODE 111:
- "WE WERE UNABLE TO OBTAIN YOUR CORRECT HEALTH INSURANCE NUMBER. IF YOU ARE ELIGIBLE FOR MEDICARE B, WRITE YOUR ENTIRE MEDICARE CLAIM NUMBER FROM YOUR RED, WHITE, AND BLUE HEALTH INSURANCE CARD ON THIS FORM AND RETURN IT."

- "WE HAVE NO RECORD OF COVERAGE FOR THE MEDICARE NUMBER SHOWN ON THIS NOTICE. IF YOUR PATIENT IS ELIGIBLE FOR MEDICARE PART B OBTAIN THE CORRECT NUMBER FROM THE PATIENT & RESUBMIT THE CLAIM TO US."

MEDICARE BACKUP STATES, "NOT ELIGIBLE FOR PART B", "SERVICES BEFORE ENTITLEMENT" OR SIMILAR STATEMENT INDICATING CLIENT NOT ELIGIBLE FOR MEDICARE & SERVICE(S) ARE ALLOWABLE BY MAA - FORCE & OVERCODE 111.

DENIAL LETTERS

DENIAL FROM MEDICARE IS A "BLANKET DENIAL LETTER" AND IS NOT WITHIN 6 MONTHS OF THE CURRENT ICN - DENY W/EOB 916.

IF LETTER ATTACHED ("NOTICE OF MEDICARE CLAIM DETERMINATION") AND MEDICARE IS DENYING SERVICES - FORCE, UNLESS DENIAL REASON IS SPECIFICALLY ADDRESSED ELSEWHERE IN TEXT. IF SO, FOLLOW SPECIFIC INSTRUCTIONS.

LETTER FROM MDCR IS DECLARING SERVICES BY AN RNFA (PT 95) ARE NOT COVERED/NOT ALLOWED - FORCE, UNLESS HX TAPE (MEDIA 2) INDICATES PAYMENT.

IF LETTER ATTACHED INDICATING CLIENT IS "END STAGE RENAL DISEASE" FORCE

MISSING OR INCORRECT INFO ON BACKUP - DENY W/EOB 281.
CLIENT DOES NOT MATCH - DENY W/EOB 105.
DATE OF SERVICE DOES NOT MATCH - DENY W/EOB 105.
NO STATEMENT DATE ON MEDICARE DENIAL - DENY W/EOB 205.
NO COLUMN HEADINGS, TITLES OR OTHER APPROPRIATE INFORMATION - DENY W/EOB 281.

OUTPATIENT CLAIMS (M)

NOTE: HOSPICE CLAIMS (PT 63) SEE 259 TEXT.

NOTE: HOME HEALTH CLAIMS (PT 44) - FORCE.

1. IF CLAIM OR COMMENTS STATE "FORCE MEDICARE PER AUDREY FINNIGAN - FORCE WITH OVERCODE 111.
2. IF CASE # ON ID CARD INDICATES "R" CATEGORY OF ASSISTANCE - FORCE.
3. IF OUTPATIENT CLAIM IS 24 HOURS OR LESS AND CLAIM/COMMENTS STATE "NO PART A", FORCE IF THERE ARE NO PART B (LAB, X-RAY, ETC) CHARGES ON THE CLAIM, OTHERWISE DENY W/EOB 292.
4. THE FOLLOWING SERVICES ARE NOT COVERED BY MEDICARE - FORCE IF:
   A. 88141-88155, 88164-88167. EXCEPTION IF DX IS V76.2, V76.47, V76.49, OR V15.89 - DENY.
   B. CLAIM IF FOR DENTAL RELATED SERVICES.
   C. CLAIM IS FOR THE SOLE PURPOSE OF STERILIZATION AND HAS DX CODE V25.2.
   D. CLAIM HAS DX CODES 367.0-367.9, 370.0, 378.1, V72.0.
   E. KIDNEY CENTERS/OUTPATIENT DIALYSIS REVENUE CODES 260, 303, 304, 825, 835, 845, 855, 880, 881, AND/OR 889. --NOTE: IF THERE ARE ANY OTHER REVENUE CODES ON THE CLAIM AND THERE IS NO DENIAL FROM MEDICARE - CREATE AN EXCEPTION AT LINE LEVEL AND DENY OTHER REVENUE CODES W/EOB 916. THEN FORCE EXCEPTION 261.
5. ALL ELSE:
   A. IF NO MEDICARE BACKUP/EOMB ATTACHED:
      1. IF CLAIM/COMMENTS STATE "NOT ELIGIBLE FOR MEDICARE", "NO MEDICARE COVERAGE, "NO PART B", "ALIEN", "NOT A RESIDENT OF THE U.S.", OR SIMILAR STATEMENT - DENY W/EOB 918.
      2. ALL ELSE - DENY.
   B. IF MEDICARE BACKUP/EOB ATTACHED:
      1. IF EOMB DOESN'T COVER THE CLIENT/DATES OF SERVICE - DENY W/EOB 105.
      2. IF MEDICARE DENIAL WITH NO REASON CODE - DENY W/EOB 783.
      3. IF MEDICARE DENIAL WITH REASON CODE - REFER TO THE FOLLOWING CHART. IF THE REASON CODE IS NOT LISTED BELOW - SEE SUPERVISOR/TRAINER.

MEDICARE REMARKS/REASON CODES FOR OUTPATIENT (M) CLAIMS:
--NOTE: REASON CODES MAY BE PRECEDED W/"PR","CO","OA", OR "CR"

13 -- DENY W/EOB 334
14 -- DENY W/EOB 334
16 -- DENY W/EOB 211
17 -- DENY W/EOB 211
18 THRU 25 -- DENY W/EOB 334
26 THRU 28 -- FORCE WITH OVERCODE 111
29 -- DENY W/EOB 334
30 -- DENY W/EOB 918
31 -- FORCE WITH OVERCODE 111
35 -- FORCE
46 -- FORCE
48 -- FORCE
49 -- IF PRIMARY DX IS V70.9, V72.5, V72.6, V72.8, OR V72.9 - DENY W/EOB 336. *EXCEPTION: IF CLAIM OR COMMENTS INDICATE NO MEDICAL DX - FORCE. ALL ELSE - FORCE.
50 -- FORCE
60 -- DENY W/EOB 334
96 -- FORCE
97 -- DENY W/EOB 334 *SH
109 -- DENY W/EOB 334
110 -- DENY W/EOB 334
119 -- FORCE
125 -- DENY W/EOB 211

IF NOT LISTED: OVERLOC TO 72.

--------MED VENDOR (CLAIM TYPE P)--------

NOTE: IF 378,326 & 331 EXCEPTIONS ALSO FAILING WORK FIRST AND IF DENYING THEN PA2 261, UNLESS DENYING WITH EOB 335 (MEDICARE PAID)

---WHEN B/U IS ATTACHED WORK PER B/U SECTION OF TEXT BEGINNING ON PAGE 21

MED VENDOR (CLAIM TYPE P) WITH NO MEDICARE RA/EOMB BACKUP:

**** DME BILLED IN PLACE OF SERVICE 7,8,31 OR 32 - FORCE. MEDICARE *** DOES NOT COVER SERVICES PROVIDED IN A NURSING HOME. *DC

IF PRIOR AUTH # ON CLAIM --
EE - O'LOC TO 23.
RES -
A. MEDICAL NUTRITION
1. IF 226 EXC ALSO POSTING - WORK 261 PER 226 TEXT INSTRUCTIONS.
2. IF NO 226 EXC POSTING WORK 261 AS IF NO PA # PRESENT.

B. ALL ELSE - CHECK NOTES ON AUTH FILE & FORCE 261 IF NOTES SAY MEDICARE WILL NOT COVER. OTHERWISE WORK ACCORDING TO THE FOLLOWING TEXT.

--IF 432 EXCEPTION ALSO FAILING THEN WORK FIRST AND IF FORCING 432 THEN ALSO FORCE 261 EXCEPTION.

1. PROSTHETIC AND ORTHOTICS

A. IF THERE IS A STATEMENT ON CLAIM "SHOE IS NOT ATTACHED TO BRACE" -FORCE.
B. IF THERE IS A STATEMENT ON CLAIM "MEDICARE DOES NOT COVER" OR SIMILAR STATEMENT AND NOT ADDRESSED ABOVE - O'LOC TO 83 FOR MMIS REVIEW AND UPDATE.
C. ALL ELSE - DENY TO BILL MEDICARE.

2. GROUND AMBULANCE
A. IF 'NON-EMERGENT TRANSPORT' - FORCE ALL 261'S THAT ARE POSTING. MEDICARE PAYS ONLY "EMERGENT" TRANSPORTS (TRIPS).
NOTE: A TRANSPORT CONSISTS OF A BASE RATE, MILEAGE AND OTHER SERVICES ADMINISTERED DURING THE TRANSPORT SO 1 CLAIM WOULD NORMALLY BE 1 TRANSPORT.
NOTE: "NON-EMERGENT" COMMENT MAY BE ON DETAIL LINE AS PART OF THE DESCRIPTION OR A STATEMENT FROM ANYWHERE ON THE CLAIM.

EMC: IF REMARKS ON CLAIM "NON-EMERGENT TRANSPORT"-FORCE

B. ALL ELSE - DENY TO BILL MEDICARE.

3. OXYGEN AND RESPIRATORY THERAPY
A. IF STATEMENT ON CLAIM "OXYGEN PRN" OR "OXYGEN AS NEEDED" - FORCE.
B. OXYGEN SUPPLIES BILLED IN PLACE OF SERVICE 7,8,31,32 OR 54 FORCE. MEDICARE DOES NOT PAY FOR OXYGEN IN A NURSING HOME.
C. OXYGEN AND OXYGEN SUPPLIES BILLED IN ANY OTHER PLACE OF SERVICE DENY TO BILL MEDICARE.

4. INFUSION (PROVIDER TYPE 40, SPECIALTY 57 - IV THERAPY)
NOTE: PT 26 (PHARMACY) & PT 39 (DME SUPPLIER) MAY ALSO BILL INFUSION SUPPLIES(SUPPLIES CAN INCLUDE I.V. POLES,INFUSION PUMPS USED TO ADMINISTER DRUG). IF YOU THINK YOUR PROCEDURE CODE FALLS UNDER INFUSION BUT ARE UNSURE-SEE TRAINER OR SUP.
A. IF STATEMENT ON CLAIM "NON-COVERED DRUG BY MEDICARE" - FORCE. (MEDICARE DOES NOT PAY FOR SUPPLIES IF DRUG IS NON-COVERED.)
B. IF STATEMENT ON CLAIM "ELASTOMERIC PUMP" OR "ELASTOMERIC PUMP AND SUPPLIES" - FORCE.
C. IF STATEMENT ON CLAIM "IDPN-INTERDIALYTIC PARENTERAL NUTRITION NOT COVERED BY MEDICARE" - FORCE.
D. POS 7,8,31,32 OR 54 AND PT 40 - FORCE.
E. POS 7,8,31,32 OR 54 AND PT 26 OR 39 OL TO 83.
F. ALL ELSE - DENY TO BILL MEDICARE.

5. MEDICAL NUTRITION FORMULA (ENTERAL) & PARENTERAL
A. IF STATEMENT ON CLAIM "ORAL" OR MODIFIER BO - FORCE.
B. IF STATEMENT ON CLAIM "MEDICARE DOES NOT COVER" - FORCE.
C. IF STATEMENT ON CLAIM "NOT TUBE FEED" - FORCE (MEDICARE COVERS ONLY MEDICAL NUTRITION DELIVERED BY TUBE). FORCE ANY FEEDING BAGS TUBES, OR MEDICAL NUTRITION ACCESSORIES BILLED ON THE SAME CLAIM.
E. ALL ELSE - DENY TO BILL MEDICARE.

6. NON-DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES
A. URINARY BAGS, LEG STRAPS, CATHETERS, ADHESIVE REMOVERS, LUBRICANTS, AND INSERTION TRAYS
1. IF DIAG 599.0, 707, 707.0, 707.10-707.19, 707.7-707.9

788.2, 788.20, 788.21, 788.29, 788.3-788.39(INCONTINENCE) ON DETAIL LINE OR BOX 21 OR STATEMENT "INCONTINENCE" ANYWHERE ON CLAIM - FORCE. UNLESS OTHER DIAGNOSIS OR STATEMENT ON CLAIM INDICATES A PERMANENT IMPAIRMENT OF URINATION SUCH AS PARAPLEGIA, QUADRIPLEGIA OR SPINAL CORD INJURY - DENY

2. STATEMENT "REPLACING MALFUNCTIONING BODY ORGAN" - FORCE.
3. STATEMENT ON CLAIM "SECONDARY DRESSING" - FORCE.
4. STATEMENT ON CLAIM "MEDICARE DOES NOT COVER" OR SIMILAR STATEMENT - FORCE.
5. ALL ELSE - DENY TO BILL MEDICARE.

B. SKIN BARRIERS
1. DIAG 599.0 (URINARY TRACT INFECTION), 788.3-788.39 (URINARY INCONTINENCE), 344.61 (NEUROGENIC BLADDER) ON DETAIL LINE OR BOX 21 OR STATEMENT "INCONTINENCE" ANYWHERE ON CLAIM - FORCE.
2. STATEMENT ON CLAIM "MEDICARE DOES NOT COVER" - FORCE.
3. BILLED WITH A DIAPER CODE (4521A, 4610A-4612A, 4616A-4621A, 4625A, 4630A, 4640A, A4521-A4530, A4533, A4535,T1500) - FORCE

C. 4461A-4482A, A6402-A6406, A6422, A6424, A6426, A6428(GAUZE) A6021-A6024, A6196-A6224, A6228-A6230, A6234-A6264(DRESSINGS) 4585A, 4595A, 4760A-4769A, 4771A, 4799A, 0089A, 0090A, 0094A-0095A, 0098A, A4450, A4452(TAPE).

1. DIAGNOSIS 599.0, 707, 707.0, 707.1, 707.10-707.19, 707.8, 707.9, 788.2, 788.20, 788.21, 788.29 OR 788.3-788.39 (INCONTINENCE) ON DETAIL LINE OR BOX 21 OR STATEMENT "INCONTINENCE" ANYWHERE ON CLAIM-FORCE
UNLESS OTHER DIAG OR STATEMENT ON CLAIM INDICATES A PERMANENT IMPAIRMENT OF URINATION SUCH AS PARAPLEGIA, QUADRIPLEGIA OR SPINAL CORD INJURY THEN DENY.

2. IF ANY OF THE FOLLOWING STATEMENTS ON CLAIM - FORCE:
   A. "SECONDARY DRESSING"
   B. "NON-SURGICAL DRESSING"
   C. "PRESSURE ULCER"
   D. "FIRST DEGREE BURNS" (MUST BE FIRST DEGREE)
   E. "MEDICARE DOES NOT COVER"

3. ALL ELSE - DENY TO BILL MEDICARE.

D. A4320, A4322, A4323, A4355(IRRIGATION SUPPLIES)
1. STATEMENT ON CLAIM "CARE OF SKIN", "CARE OF PERINEUM" - FORCE.
2. STATMENT ON CLAIM "MEDICARE DOES NOT COVER" OR SIMILAR STATEMENT - FORCE.
3. ALL ELSE - DENY TO BILL MEDICARE.

E. A4375-A4383, A4387-A4393, A5051-A5054, A5061-A5063, A5071-A5073(OSTOMY POUCHES). PROVIDER SHOULD BILL MEDICARE FIRST IF FOR ILEOSTOMY OR COLOSTOMY.
1. IF ANY OF THE DIAGNOSIS LISTED ARE V44.2, V55.2 (ILEOSTOMY) OR V44.3, V55.3 (COLOSTOMY) - DENY.
2. IF ONLY DIAG ON CLAIM IS V589 (DUMMY DIAG) - DENY.
3. ALL ELSE - FORCE.

F. NEEDLES OR SYRINGES FOR VITAMIN B-12 W/DIAG OF PERNICIOUS, MEGALOBLAST, FISH TAPEWORM, APLASTIC OR MACROCYTIC ANEMIA - FORCE.

7. DME (DURABLE MEDICAL EQUIPMENT) AND RELATED SUPPLIES:

DME BILLED IN PLACE OF SERVICE 7,8,31 OR 32 FORCE-MEDICARE DOES NOT COVER. *DC

A. E1340 BILLED IN PLACE OF SERVICE 7,8,31 OR 32 FORCE-MEDICARE DOES NOT COVER.
ANY OTHER PLACE OF SERVICE-DENY TO BILL MEDICARE

B. E0305, E0310(BEDSIDE RAILS)
IF STATEMENT ON CLAIM "HOME STYLE RAILS" OR "PATIENT HAS NO HOSPITAL BED" OR SIMILAR STATEMENT - FORCE.
IF UNSURE-SEE TRAINER OR SUPERVISOR.

C. A4660, A4663 (BP CUFF AND BP KIT)
1.IF STATEMENT ON CLAIM "HOME DIALYSIS PATIENT" - DENY
2. ANYTHING ELSE - FORCE.

8. PT 87 FORCE

9. IF STATEMENT ON CLAIM "MEDICARE DOES NOT COVER" AND NOT ADDRESSED ABOVE-FORCE

10. IF NOT ADDRESSED ABOVE AND NO MEDICARE BACKUP - DENY.

MED VENDOR (CLAIM TYPE P) WITH MEDICARE BACKUP ----------

1. PT 29 (OPTICAL)
MEDICARE PAYS ONLY FOR THE INITIAL PAIR OF CONTACT LENS OR GLASSES AFTER CATARACT SURGERY.
IF MEDICARE DENIES FOR THE SECOND PAIR:
A. CLAIM IS NOT FROM OUR OPTICAL CONTRACTOR - DENY W/EOB 925
B. CLAIM IS FROM OUR OPTICAL CONTRACTOR - FORCE.

2. PT 87 - FORCE

3. ALL ELSE -

A. EXAM ENTRY -

1. IF EVERYTHING ON MEDICARE'S DENIAL MATCHES THE CLAIM - ADJUDICATE PER ACTION CODE LIST.

2. IF EVERYTHING MATCHES BUT THE PROCEDURE CODE O/L TO LOC 21 EXCEPTION: PT 51 & 53 (GROUND & AIR AMBULANCE) - PROCESS PER ACTION CODE ONLY. BECAUSE OF DIFFERENT BILLING REQUIREMENTS BETWEEN MAA AND MEDICARE THE ONLY MATCH REQUIRED IS THE CLIENT & DOS.

3. PT 51 (AMBULANCE) MEDICARE DENIAL/OR STATEMENT ON CLAIM
"PATIENT COULD HAVE TRAVELED BY OTHER MEANS" - FORCE

4. IF EVERYTHING ON MEDICARE'S DENIAL MATCHES THE CLAIM EXCEPT
THE BILLED AMOUNT - DENY W/EOB 105.

B. RES -
1. EVERYTHING MATCHES BUT PROCEDURE CODE
A. IF CODE ON MEDICARE DENIAL IS A "X-OVER ONLY"
1. AND CODE ON CLAIM IS SAME SERVICE - FORCE.
2. IF PROCEDURE CODE IS A9270 WITH MEDICARE DENIAL REASON
PR-46 OR PR-96 AND MONEY AMOUNT MATCHES CLAIM,
CONSIDER AS SAME SERVICE AND FORCE.
3. ALL ELSE OVERLOC TO LOC 83.
EXCEPTION PT 40 -
PROVIDER MAY ITEMIZE SUPPLIES FOR A4221 & A4222 - IF
MONEY DENIED BY MEDICARE ADDS UP TO AMOUNT BILLED ON
CLAIM - FORCE. OTHERWISE - DENY W/EOB 105.
MMIS: (A4221 - KIT INCLUDES CATH SITE & FLUSH SOLUTIONS,
CANNULAS, NEEDLES, DRESSING AND INFUSION SUPPLIES-
EXCLUDING INSULIN RESERVOIR)
(A4222 - KIT INCLUDES CASSETTE OR BAG, DILUTING
SOLUTIONS, TUBING AND OTHER ADMIN SUPPLIES, PORT CAP
CHARGES, AND PREP CHARGES.)

B. IF CODE ON MEDICARE DENIAL IS NOT A "X-OVER ONLY" CODE -
DENY W/EOB 105. (PROVIDER SHOULD BILL MAA SAME CODE AS
MEDICARE IF CODE IS NOT A X-OVER ONLY CODE.)

2. PROVIDER HAS SPLIT OR COMBINED LINES -
A. IF PROVIDER HAS COMBINED A MEDICARE DENIED LINE WITH A
MEDICARE "PAID" LINE - DENY W/EOB 105.
PROVIDER MUST BILL ANY "PAID" LINES ON A X-OVER CLAIM.
B. IF MONEY ADDS UP ON THE DENIED SPLIT OR COMBINED LINES -
FORCE.

3. NOT ADDRESSED ABOVE - SEE TRAINER/MMIS.

FYI - MEDICARE'S MODIFIER 'CC' MEANS MEDICARE CHANGED THE CODE THE
PROVIDER ORIGINALLY BILLED.

------MED VENDORS REMARKS/ACTION CODES------

--- USE THE CORRESPONDING ADJUDICATION NEXT TO REASON CODE UNLESS THE
PRECEDING TEXT GIVES YOU SPECIFIC INSTRUCTIONS TO DO OTHERWISE.

(THIS SECTION IS FOR MED VENDOR CLAIM TYPE ONLY.)

MEDICARE REMARKS/ACTION CODES FOR MED VENDOR CLAIMS ONLY:
(REASON CODES MAY BE PRECEDED BY "PR", "CO", "OA" OR "CR")

16--------DENY W/EOBS 334/211
17--------DENY W/EOB 211
18--------DENY W/EOB 334

19--------DENY W/EOB 334
20--------DENY W/EOB 334
21--------DENY W/EOB 334
22--------DENY W/EOB 334
26--------FORCE
27--------FORCE & OVERCODE 111 (AUDREY FINNIGAN).
28--------FORCE & OVERCODE 111 (AUDREY FINNIGAN).
29--------DENY W/EOB 334
31--------FORCE & OVERCODE 111 (AUDREY FINNIGAN).
35--------FORCE
42--------A) IF NO OTHER ACTION CODE PRESENT ON LINE AND MEDICARE HAS
HAS MADE A PARTIAL PMT-DENY W/EOB 335.
B) IF ACTION CODES AND/OR A3, 71 ALSO PRESENT- DENY W/EOB 334.
46--------FORCE
47--------FORCE
48--------FORCE
49--------SEE SPECIAL INSTRUCTIONS
50--------FORCE (MED VENDOR ACTION CODES)
52--------FORCE
56--------FORCE
57--------FORCE
58--------FORCE
60--------FORCE
93--------MEDICARE PAID ON LINE-DENY W/EOB 335
96--------FORCE
97--------DENY W/EOB 334 UNLESS PT 51 (AMBULANCE) - FORCE.
106-------FORCE
107-------FORCE
108-------FORCE
109-------DENY W/EOB 334
110-------DENY W/EOB 334
112-------DENY W/EOB 334
117-------FORCE
119-------FORCE
125-------DENY W/EOB 211
(MED VENDOR ACTION CODES)
BZ--------FORCE
CG--------DENY W/EOB 211
CQ--------DENY W/EOB 334
CU--------FORCE
CV--------FORCE
CZ--------DENY W/EOB 211
DK--------DENY W/EOB 334
DX--------FORCE
DY--------FORCE
EB--------DENY W/EOB 334
EC--------FORCE
EH--------FORCE
ER--------DENY W/EOB 334
EW--------DENY W/EOB 334
IP--------FORCE
IY--------FORCE
JP--------FORCE
JT--------FORCE

KN--------FORCE
LD--------FORCE
PF--------FORCE
WA--------FORCE (MED VENDOR ACTION CODES)
WM--------FORCE

A3--------DENY W/EOB 334
B5--------FORCE
B7--------PT 34 - FORCE.
B8--------FORCE
B9--------FORCE
B11-------DENY W/EOB 334
B15-------SEE SPECIAL INSTRUCTIONS
B17-------FORCE
B18-------DENY W/EOB 334
D3--------DENY W/EOB 334
MA28------DENY W/EOB 988

IF NOT ADDRESSED ABOVE - OVERLOC TO 83 W/COMMENT "ACTION CODE?".

MEDICARE REASON/REMARKS:

1. PT 51 (AMBULANCE) MEDICARE DENIAL STATES "THAT PATIENT COULD HAVE TRAVELED BY OTHER MEANS" - FORCE.

-- SPECIAL INSTRUCTIONS FOR MED VENDOR --

2. B15 (PHYSICAL THERAPY)
   A. PT 34 - DOS PRIOR TO 7/1/97 - FORCE.
   B. PT 34 - DOS AFTER 7/1/97 - DENY W/EOB 937/324.
   C. PT 26 & 39 - FORCE.
   D. ALL ELSE - OVERLOC TO 83 (MMIS TO REVIEW & UPDATE)

3. 49 - PT 51 (AMBULANCE) DENY W/EOB 334 UNLESS STATEMENT ON CLAIM "NECESSARY TO TRANSPORT LYING DOWN (SUPINE POSITION)" OR "WAS MEDICALLY NECESSARY TO TRANSPORT BY AMBULANCE" OR SIMILAR STATEMENT.

4. ALL ELSE - IF NOT ADDRESSED ABOVE - OVERLOC TO 83 W/COMMENT "ACTION CODE?"

----- PHYSICIAN (J) -----

NOTE: REMARKS/REASONS START ON PAGE 40

NOTE: EXCEPTION 261 POSTS AT HEADER LEVEL IF ALL THE SERVICES ON THE CLAIM ARE PAYABLE (PER THE PDDD FILE) BY MEDICARE. EXAMINERS WILL STILL NEED TO CHECK 261 TEXT FOR EACH SERVICE ON THE CLAIM. IF TEXT STATES TO FORCE ONE OR MORE OF THE LINE LEVEL SERVICES, EXAMINERS WILL NEED TO FORCE THE 261 AT HEADER AND MANUALLY DENY DETAIL LINES THAT ARE PAYABLE BY MEDICARE W/APPROPRIATE EOBS.

1. IF ARNP (PERFORMING PROV. # BEGINS WITH A 9 OR PERFORMING PROV.

FIELD STATES ARNP) IS PERFORMING SERVICE & NO MD ON PREMISES, OR STATEMENT SAYING "HAS NOT SEEN MD THIS MONTH", W/WO MEDICARE BACKUP - FORCE. NOTE: EE - PF-4 UNDER "9" # TO SEE IF ARNP (PT 93)

2. IF ARNP (REFERRING PROV. # BEGINS WITH A 9 OR REFERRING PROV. FIELD STATES ARNP) IS LISTED AS THE REFERRING PROVIDER, WITH OR WITHOUT MEDICARE BACKUP - FORCE. NOTE: EE - PF-4 UNDER "9"# TO SEE IF ARNP (PT 93).

3. MEDICARE NORMALLY DOES NOT PAY FOR THE FOLLOWING SERVICES: IF THIS SECTION TELLS YOU TO DENY & MEDICARE BACKUP/EOMB INDICATES OTHERWISE - FOLLOW THE DIRECTION FOR BACKUP.

   A. HEALTH DEPARTMENTS (PT 24) BILLING FOR THE FOLLOWING PREVENTIVE PROCEDURES (90665, 90690, 90691, 90692, 90707, 90712, 90713, 90716-90718, 90725, 90632-90634, 90733, 90740-90748, 90782 & 86580) W/DX (V74.1,V05.9,OR V06.9) - FORCE.

   B. 92506-92508 FORCE WHEN BILLED BY PT 37. ALL OTHER PT'S - DENY.

   C. 88141-88155, 88164-88167:
      1. PROV # 7858509 - FORCE.
      2. DX OTHER THAN V76.2, V76.47, V76.49 OR V15.89 - FORCE.
   NOTE: THE ABOVE DX CANNOT BE REFERENCE ANYWHERE TO THE LINE THE 88141-88155, 88164-88167 WAS BILLED ON.
      3. ALL ELSE - DENY.

   D. 92002-92287, 99201-99275, 99281-99285, 99301-99350 -
      1. IF DX CODES 367-368.9, 378.1, V53.1, V72.0, OR OTHER ROUTINE EYE EXAM - FORCE UNLESS MEDICARE B/U SHOWS PAYMENT, THEN - DENY WITH EOB 335. NOTE: IF # 1,2,3 OR 4 ARE INDICATED ON THE DETAIL LINE AND AT LEAST ONE REFERS TO BOX 21 AS ONE OF THE ABOVE DX OR OTHER ROUTINE EXAM - FORCE.
      2. OTHER DX CODES FOR THE ABOVE PROCEDURES - DENY, EXCEPT SEE H. (DENTAL SERVICES) FIRST.

   E. 36415:
      1. IF BILLED W/CLOZARIL CASE MANAGMENT CODE (0857J) OR (90862) W/A DX RELATED TO MENTAL HLTH SUCH AS (295 - 295.9) - FORCE.
      2. OR P9000 BILLED W/90740,90743,90744,90746,90747,90748 OR ANY INDICATION OF HEPATITIS B DX - FORCE. IF MDCR IS DENYING P9000 FOR OTHER THAN HEP B - DENY W/EOB 334, EXCEPT PROVIDER #7830102 BILLING P9000 & MDCR DENIAL - FORCE.
      3. ALL ELSE - IF NO BACKUP OR STATEMENT INDICATING MDCR DENIAL - DENY.

   F. 90862: IF DX IS SCHIZOPHRENIA RELATED (295 - 295.9) - FORCE.

   G. 56301-56302,58600,58605,58611,58615,58670-58671,54690,55250, 55450,56318,00851,00869,5911M,5912M.
      1. IF DONE FOR THE SOLE PURPOSE OF STERILIZATION (DX V25.2 OR V61.5) - FORCE.(DX MAY BE ANYWHERE ON CLAIM) NOTE: (IF FORCING STERILIZATION, ALSO FORCE ALL RELATED SERVICES ON SAME DOS).
      2. IF STERILIZATION DONE FOR MEDICAL REASON - DENY.

H. VITAMIN B-12 (J3420) - IF DX IS FOR PERNICIOUS (281.0), MEGOBLASTIC (281.2, 281.3, 281.9), MACROCYTIC (281.9) FISH TAPE (123.4), OR APLASTIC - (284-284.9) - FORCE. ALL OTHERS - DENY W/EOB 325.

I. DENTAL SERVICES (DESCRIPTION BY PROCEDURE OR DX)
CARE FOR TREATMENT, FILLING, REMOVAL, OR REPLACEMENT OF TEETH, ROOT CANAL THERAPY, SURGERY FOR IMPACTED TEETH AND OTHER SERVICES INVOLVING TEETH - FORCE.

J. PROVIDER #1771203 BILLING IV ANTIOBIOTIC THERAPY - FORCE.

K. DDD SERVICES -ER ANCILLARY CHARGES ARE BEING BILLED WITH THIS
1. "COMPONENT OF DDD PHYSICAL" INDICATED ON CLAIM - FORCE.
2. 0310M - IF OTHER CHARGES ARE BEING BILLED W/THIS PHYSICAL, E.G. URINALYSIS, X-RAYS, DRAWING FEE, ETC, - FORCE.

L. PROCEDURE CODE J1055 - FORCE; IF 90782 BILLED WITH J1055 - FORCE.

M. ABORTIONS/ABORTION RELATED SERVICES (DX 635-639.9 OR V61.7)
1. MOD G7 BILLED ON THE ABORTION CODE (59812-59866, 5915M, 01964) - DENY ABORTION AND ALL RELATED SERVICES ON THE CLAIM FOR THE SAME DATE OF SERVICE W/ANY DX. IF YOU HAVE ONLY RELATED SERVICES W/MOD G7 - DENY.
2. NO MOD G7 BILLED ON THE ABORTION CODES (59812-59866, 5915M, 01964) - FORCE ABORTION &/OR ALL RELATED SERVICES ON THE CLAIM W/ANY DX.
NOTE: RES/ADJ - IF YOU RECIEVE A CLAIM W/ONLY RELATED SERVICES AND NO MOD G7 - DO A HX SEARCH TO FIND THE ABORTION, IF ON ABORTION - DENY SERVICES, IF NOT - FORCE THE SERVICES
3. ALL ELSE - DENY.

N. STEM CELL TRANSPLANTATIONS (38230, 38231, 38240, 38241)
1. 38230/38231/38241 - IF DX IS 140.0-199.1, 203.0, 204.00, 205.00, 205.10, 205.11, 206.00, 207.00, 208.00, 238.6 - FORCE.
2. 38240 - 203.0, 238.6 - FORCE.
3. OTHERWISE - DENY.

O. ZINECARD/DEXRAZOXANE (J1190) - IF (J9000) AND DX 425.0-425.9 OR 428.0 ARE ALSO BILLED ON THE CLAIM - DENY, OTHERWISE - FORCE.

P. PANCREAS TRANSPLANT (48554) - IF BILLED WITH DX 250.00-250.93, V42.0, V43.89 OR 585 ANYWHERE ON THE CLAIM & DOS IS 7/1/99 AND AFTER - DENY, OTHERWISE - FORCE.

Q. GONADATROPIN (84703) IF BILLED W/DX 164.2 - 164.3, 181, 183 - 183.0, 186 - 186.9, 187.8 - 187.9, 198.82, 611.1, 626 - 626.0, 633 - 634.91, V01 - V10.43, V10.47, V71.1 - DENY, OTHERWISE - FORCE.

R. IF NO BACKUP AND NONE OF THE ABOVE APPLY - DENY.

4. IF THERE IS AN INDICATION THAT MEDICARE HAS BEEN BILLED BY EITHER A MEDICARE RA, DMERC RA, OR EOMB AND:

NOTE: IF MEDICARE HAS DENIED THE SERVICE AND THE 0261 EXCEPTION IS NOT FORCEABLE PER THE FOLLOWING TEXT OR MEDICARE BACKUP - AUTH # ON THE CLAIM, O/L TO LOC. 23 UNLESS AUTH # STARTS WITH 87 OR 88, THEN WORK PER THE 261 TEXT. *BJS

A. THE SERVICE HAS BEEN DENIED BY MEDICARE - PT 32 BILLING CODES 11720,11721 FORCE UNLESS MEDICARE DENIAL STATES "ROUTINE FOOT CARE" - THEN DENY W/EOB 334.

B. IF BACKUP DOES NOT MATCH CLAIM:
1. IF FOR SURGERIES (10000-69999, 01000-01999) & MODIFIERS DO NOT MATCH - O'LOC TO 36.

2. MONIES - DO NOT BE CONCERNED IF MONEY FOR EACH LINE ON THE CLAIM DOES NOT MATCH EACH LINE ON THE RA OR VICE VERSA, AS LONG AS THE SPLIT LINES ON ONE ADDS UP TO MATCH THE TOTAL ON THE OTHER.

3. IF EVERYTHING MATCHES BUT THE PROCEDURE CODE
1. 36415 BILLED ON CLAIM - G0001 ON MDCR EOMB - FORCE
2. 00840 BILLED TO MEDICARE AND 5912M ON CLAIM - FOLLOW PRECEEDING INSTRUCTIONS, C, 6 (STERILIZATION)
3. ALL ELSE - O'LOC TO 64 (FOR REVIEW AND TEXT CREATION)

4. ALL ELSE - OVERLOCK TO 21 (RES/MMIS REVIEW)

5. UNABLE TO ESTABLISH ELIGIBILITY - FORCE & OVERCODE 111 ON DETAIL HEADER (AUDREY FINNIGAN).

6. DENIAL INDICATES "INCLUDED" OR "BUNDLED" SERVICE & PROCEDURE IS FOR THE FOLLOWING: IF YOU NOTE AN ACTION CODE AT THE END OF THIS TEXT THAT CONTRADICTS THE FOLLOWING - LET MMIS KNOW.
A. 10000-69999, 1000M-66999M, 99211-99215, 99217-99223, OR 99231-99238, 99291-99292 - DENY WITH EOB 334.
B. 92552-92556 - FORCE UNLESS BILLED WITH 92557, THEN - DENY WITH EOB 334.
C. 92552-FORCE UNLESS BILLED WITH 92553, THEN-DENY WITH EOB 334
D. 92555-FORCE UNLESS BILLED WITH 92556, THEN-DENY WITH EOB 334
E. A4550, A4644, A4645 OR A4646 - DENY WITH EOB 334.
F. A4570 (SPLINT) - FORCE.
G. 94656-94657 - DENY WITH EOB 334.
H. 99052-99054 - FORCE.
I. ANYTHING ELSE MEDICARE DENIES AS INCLUDED OR BUNDLED - OVERLOC TO 22. OTHER PROCEDURES OR CODES MAY BE ADDED TO THIS TEXT AS A RESULT OF FURTHER RESEARCH.

7. STEM CELL TRANSPLANTATION (38230, 38231, 38240, 38241) - MEDICARE DENIED:
A. DIAGNOSIS IS 140.0-199.1, 203.0, 204.00, 205.00, 205.10, 205.11, 206.00, 207.00, 208.00, 238.6 - FORCE. .

B. ALL OTHER DIAGNOSIS - DENY W/EOB 334.

8. DENIAL STATES "DUPLICATE OF A CHARGE PREVIOUSLY PROCESSED" OR SIMILAR STATEMENT - DENY WITH 334.

9. IF THE MEDICARE DENIAL REFLECTS THE NEED FOR THE PROVIDER TO PROVIDE MORE, OR CORRECTED INFORMATION TO MEDICARE - DENY WITH EOB 334. (BELOW, SEE SOME EXAMPLES)

A. "MEDICARE CANNOT PAY FOR THIS BECAUSE THE NAME, ADDRESS, AND/OR IDENTIFICATION # OF THE REFERRING DOCTOR WAS NOT SHOWN ON THE CLAIM."
B. "THE CLAIM FOR MEDICARE BENEFITS MUST BE FILED BY THE AMBULATORY SURGERY CENTER."
C. "YOU DID NOT SIGN THE CLAIM FOR MEDICARE BENEFITS."
D. "THE MEDICAL NECESSITY FORM MUST BE PERSONALLY SIGNED BY THE ATTENDING PHYSICIAN.
E. "YOUR PROVIDER DID NOT SUBMIT THE REQUIRED CLAIM FORM. PLEASE HAVE YOUR PROVIDER RESUBMIT THE CLAIM USING THE PROPER CLAIM FORM."

10. MEDICARE DENIAL EOBS - DO AS STATED BELOW:
CLAIM TYPE "J" - PHYSICIAN
A. "MEDICARE DOES NOT PAY FOR THIS EXAM BECAUSE LESS THAN ONE YEAR HAS PASSED SINCE YOUR LAST EXAM OF THIS KIND" - DENY WITH EOB 334.
B. "PAYMENT WAS NOT MADE FOR THIS SERVICE BECAUSE THE MAXIMUM AMOUNT ALLOWED FOR PHYSICAL THERAPY HAS BEEN MET" - FORCE.
C. "MEDICARE PAYS ONLY FOR SERVICES THAT ARE PROVIDED DIRECTLY TO THE PATIENT" - FORCE.
D. "MEDICARE DOES NOT PAY FOR ROUTINE FOOT CARE/ROUTINE EXAMS" - DENY W/EOB 334.
E. "MEDICARE DOES NOT PAY FOR THIS INJECTION FOR THE DIAGNOSIS STATED ON THE CLAIM" - IF PROCEDURE CODE BEGINS WITH A "J" - FORCE; 90782 ON SAME DOS - FORCE.
F. "MEDICARE DOES NOT PAY FOR THIS MANY SERVICES OR SUPPLIES" - FORCE IF PROVIDER TYPE 73.
G. "THE INFORMATION WE HAVE IN THIS CASE DOES NOT SUPPORT THE NEED FOR THIS MANY VISITS OR TREATMENTS" - DENY WITH EOB 334.
H. "MEDICARE DOES NOT PAY FOR THIS SERVICE WHEN PERFORMED, REFERRED, OR ORDERED BY THIS PROVIDER OF CARE" AND IF LAB PROCEDURE CODES 80000-89999 OR RADIOLOGY 70000-79999 - FORCE.
I. "NO PAYMENT MAY BE MADE FOR THESE CLINICAL LABORATORY SERVICES BECAUSE THEY WERE PERFORMED IN A LAB IN WHICH THE ORDERING/REFERRING PHYSICIAN HAS A FINANCIAL RELATIONSHIP. THE PATIENT CANNOT BE CHARGED FOR ANY OF THESE PROHIBITED CLINICAL LAB SERVICES" - FORCE.
J. "MEDICARE DOES NOT PAY FOR THIS BECAUSE IT IS A TREATMENT THAT HAS YET TO BE PROVED EFFECTIVE." -FORCE
K. IF THE PROCEDURE IS NOT LISTED IN THE "INCLUDED" OR "BUNDLED" SECTION OF THIS TEXT, & MCRE DENIAL STATES:

1. "MEDICARE DOES NOT PAY SEPARATELY FOR THIS SERVICE. THE PATIENT SHOULD NOT BE BILLED SEPARATELY FOR THIS SERVICE. THE PATIENT DOES NOT HAVE TO PAY FOR THIS AMOUNT" - FORCE.
2. "MEDICARE DOES NOT PAY FOR THIS SERVICE BECAUSE IT IS PART OF ANOTHER SERVICE THAT WAS PERFORMED AT THE SAME TIME" - FORCE.

11. MEDICARE REMARKS REASON CODES
(PHYSICIAN CLAIMS ONLY) (BLUE CROSS)

NOTE: IF YOUR CLAIM INDICATES THE FOLLOWING REASON/REMARKS CODE, YOU MAY USE THE CORRESPONDING ADJUDICATION, UNLESS THE PRECEDING TEXT GIVES YOU SPECIFIC INSTRUCTIONS TO DO OTHERWISE.

NOTE: ALTHOUGH THERE MAY BE DIRECTION TO FORCE OR DENY ON THE FOLLOWING REASON/REMARKS CODES, DENY W/EOB 335 IF AN EOMB FROM MEDICARE INDICATES MONEY WAS PAID OR A DEDUCTIBLE WAS ALLOWED.

NOTE: THE FOLLOWING TEXT APPLIES ONLY TO PHYSICIAN CLAIMS. DO NOT APPLY TO MED VENDOR CLAIMS.

NOTE: IF ACTION CODES/REMARKS/REASONS BILLED ON THE MEDICARE EOMB ARE NOT LISTED BELOW - O'LOC TO 21. LOC 21 - SEND ANY NEW REMARKS/REASON CODES TO MMIS FOR UPDATE. COPY OF ACTION CODES FORMERLY ADDRESSED IN THIS TEXT IS FILED BOTH IN MMIS AND PHYSICIAN EXAM ENTRY UNIT.

MEDICARE REMARKS/REASON CODES (MAY BE PRECEDED BY)"PR,CO,OA,CR"

04 --- DENY W/EOB 334
05 --- DENY W/EOB 334
06 --- DENY W/EOB 334
07 --- DENY W/EOB 334
08 --- FORCE
09 --- FORCE
10 --- FORCE
11 --- FORCE
12 --- FORCE
13 --- DENY W/EOB 334
14 --- DENY W/EOB 334
15 --- DENY W/EOB 211
16 --- DENY W/EOB 211
17 --- DENY W/EOB 211
18 --- DENY W/EOB 334
20 --- DENY W/EOB 334
21 --- DENY W/EOB 334
22 --- DENY W/EOB 334
23 --- DENY W/EOB 334
24 --- DENY W/EOB 334
25 --- DENY W/EOB 334
26 --- FORCE & OVERCODE 111 (AUDREY FINNIGAN)
27 --- FORCE & OVERCODE 111 (AUDREY FINNIGAN)
28 --- FORCE & OVERCODE 111 (AUDREY FINNIGAN)

29	---	DENY W/EOB 334
30	---	DENY W/EOB 918
31	---	FORCE & OVERCODE 111 (AUDREY FINNIGAN)
32	---	DENY W/EOB 918
33	---	DENY W/EOB 918
34	---	FORCE
35	---	FORCE
36	---	O'LOC TO 02
37	---	DENY W/EOB 334
38	---	DENY W/EOB 334
39	---	DENY W/EOB 334
40	---	DENY W/EOB 334
41	---	DENY W/EOB 335
42	---	DENY W/EOB 335
43	---	DENY W/EOB 335
44	---	DENY W/EOB 918
45	--	DENY W/EOB 335
46	---	FORCE
47	---	FORCE
48	---	FORCE
49	---	SEE NOTE AT END OF TEXT.
50	---	FORCE
51	---	DENY W/EOB 918
52	---	FORCE
53	---	DENY W/EOB 334
54	---	FORCE
55	---	FORCE
56	---	FORCE
57	---	SEE NOTE AT END OF TEXT
58	---	SEE NOTE
59	---	DENY W/EOB 335
60	---	DENY E/EOB 334
61	---	DENY W/EOB 335
62	---	DENY W/EOB 334
63	---	DENY W/EOB 189
64	---	DENY W/EOB 335
65	---	DENY W/EOB 335
66	---	DENY W/EOB 334
92	---	DENY W/EOB 334
93	---	DENY W/EOB 335.DECISION CHANGE FROM D-334, 8/10/99
95	---	DENY W/EOB 334
96	---	FORCE
97	---	DENY W/EOB 334.DECISION CHANGE (FORCE TO DENY) ON 022097.
100	---	DENY W/EOB 334
107	---	DENY W/EOB 334
109	---	DENY W/EOB 334
110	---	DENY W/EOB 334
111	---	DENY W/EOB 334
112	---	DENY W/EOB 334
113	---	FORCE
114	---	DENY W/EOB 334
115	---	DENY W/EOB 334
116	---	DENY W/EOB 334
118	---	DENY W/EOB 335

119 --- FORCE
120 --- DENY W/EOB 334
122 --- DENY W/EOB 335
125 --- DENY W/EOB 211
B1 --- FORCE
B2 --- DENY W/EOB 335
B3 --- DENY W/EOB 335
B4 --- DENY W/EOB 335
B5 --- SEE NOTE AT END OF TEXT
B6 --- FORCE
B7 --- FORCE
B8 --- SEE NOTE AT END OF TEXT
B9 --- FORCE
B10 --- SEE NOTE AT END OF TEXT.
B11 --- DENY W/EOB 334
B12 --- FORCE
B13 --- DENY W/EOB 334
B14 --- FORCE
B15 --- SEE NOTE AT END OF TEXT
B16 --- DENY W/EOB 211
B18 --- DENY W/EOB 334
B20 --- DENY W/EOB 334
B21 --- DENY W/EOB 334
B22 --- SEE NOTE AT END OF TEXT
B23 --- FORCE
D2 --- DENY W/EOB 211

---- NOTES ----

49 - IF DX IS V70.9,V72.5,V72.6, V72.8 OR V72.9 - DENY W/EOB 336. *EXCEPTION: IF CLAIM OR COMMENTS INDICATE NO MEDICAL DX - FORCE. ALL ELSE - FORCE.

B5 - IF MEDICARE DENIED LINE IN FULL - DENY W/EOB 211, IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY W/EOB 335.

B10 - IF MEDICARE DENIED LINE IN FULL - DENY W/EOB 211, IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY W/EOB 335.

B8 - IF MEDICARE DENIED LINE IN FULL - DENY W/EOB 334, IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY E/EOB 335.

B15 - IF MEDICARE DENIED LINE IN FULL - DENY W/EOB 334, IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY W/EOB 335.
EXCEPTION: PROV # 7035975 (COLUMBIA RIVER MENTAL HLTH) (PT 19) IF COMMENTS STATE (ONLY SVC THIS PERF PROV/BU SENT) OR (1 SVC BY PERF PROV) - FORCE. THERE IS A BACKUP LETTER IN MMIS FILE INDICATING THE PSYCH SERVICE THEY ARE BILLING MAA IS THE ONLY SERVICE BY THE PERF PROV ON THE CLAIM, EVEN THOUGH THERE MAY BE MULTIPLE SERVICES ON THE MDCR EOMB. MAA CANNOT DISTINGUISH DIFFERENT PERF PROV ON THE EOMB, BUT BECAUSE THEY ARE DIFFERENT MAA WILL PAY, WHEN MDCR WOULD NOT.
EXCEPTION: IUD 9911M OR OTHER FAMILY PLANNING PROCEDURES OR DIAGNOSIS - FORCE.

B22 - IF MEDICARE DENIED LINE IN FULL - FORCE, IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY W/EOB 335.

57 - IF 276 EXC(QMB DUAL) POSTING TO CLAIM - FORCE. ALL ELSE, IF MEDICARE DENIED LINE IN FULL & CODE IS A PAP SMEAR OR MAMMOGRAM - FORCE, OTHERWISE DENY W/EOB 334. IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY WITH EOB 335.

58 - IF MEDICARE DENIED LINE IN FULL - FORCE, IF MEDICARE PART PAID/REDUCED PAYMENT ON LINE - DENY E/EOB 335.

TEXT KEY	TEXT DESC
262	TPL SUSPECT

TPL (LOC. 05)
1. IF PROVIDER IS TO BILL INSURANCE - FORCE WITH EOB 090.
2. IF PART PAID BY INSURANCE - FORCE WITH EOB 031.
3. IF FULLY PAID BY INSURANCE - FORCE WITH EOB 032.
4. IF RECOMMEND PAY - FORCE.

THE END

TEXT KEY TEXT DESC
263 INDICATES HEALTH INSURANCE

TPL (LOC 04)

1. MED VENDOR (P) - FORCE MEDICARE AGE RECIPIENTS.
2. IF PROVIDER IS TO BILL INSURANCE - DENY.
3. IF PART PAID BY INSURANCE - FORCE W/EOB 031.
4. IF FULLY PAID BY INSURANCE - DENY W/EOB 032.
5. WHEN THERE HAS BEEN A LAPSE IN PRIVATE INSURANCE (I.E. UNIONS, LOCAL TRUSTS) - FORCE USING EOB 463.
6. IF CLAIM STATES INSURANCE EOB ATTACHED BUT NONE WAS ATTACHED - DENY W/EOB 980. IF WOB RECIEVED WAS FOR THE INCORRECT INSURANCE CARRIER, DENY W/EOB 287. IF MORE THAN ONE INSURANCE EOB, DENY W/EOB 288.
7. IF INVALID DENIAL - PATIENT RESPONSIBILITY - DENY W/EOB 981.
8. IF INVALID DENIAL- INSURANCE REQUESTS NOT MET - DENY W/EOB 982.
9. IF RECOMMEND PAY - FORCE.
10. ITA COURT HEARINGS, REQUIRED BY STATE, ARE NOT COVERED BY INSURANCE-FORCE.
11. IF"HM" IS NOT ON COUPON FOR DOS ON CLAIM - FORCE USING EOB 541.

12. IF CHAMPUS DENIAL IS ATTACHED TO CLAIM &:
    A. EOB IS 026, 046, 107, 108 OR 110 - DENY WITH EOB 868.
    B. EOB IS 075, 077, 079 - PAY WITH INFO EOB 869.

13. TPL ADJUSTMENTS .
    A. WHEN THE INSURANCE EOB DOES NOT CORRESPOND TO THE ADJ CLAIM - DENY W/EOB 974.
    B. WHEN THE INSURANCE EOB SHOWS NO PRINTED DENIAL REASON FOR THE DENIAL CODE - DENY WITH EOB 977.
    C. WHEN THE INSURANCE EOB DENIAL IS IN ERROR - DENY WITH EOB 291.

MANAGED MEDICARE CLAIMS

LOC 55 PROCESSES CLAIMS STATING "MANAGED MEDICARE COPAY". IF A 263 IS POSTING, THE SPECIALIST IN THAT LOCATION WORKS THE CLAIM AND SENDS THE FLATSHEET (AND BACKUP IF ANY) TO THE HEALTH NORTH SUPERVISOR. SHE REVIEWS THE TPL SCREEN TO SEE IF THE INSURANCE INFORMATION IS LOADED CORRECTLY. IF THE INSURANCE NEEDS TO BE CHANGED TO A MANAGED MEDICARE INFORMATION ONLY SCREEN, THE UPDATE IS MADE AND THE FLAT SHEET IS RECYCLED. IF THE INSURANCE IS A RETIREMENT OR SUPPLEMENTAL THE FLAT-SHEET IS RETURNED TO LOCATION 55 FOR THEM TO PROCESSES THE ADJUSTMENT TO RECOUP THE CLAIM.

TEXT KEY	TEXT DESC
265	

DRUG INCLUDED IN NH PER DIEM.

REVIEW AUTH FILE FOR LISTING OF NDC AND ALSO AUTH NOTES FOR INDICATION OF AN EXCEPTION TO POLICY. IF PRESENT - FORCE.

ALL ELSE DENY.

TEXT KEY TEXT DESC
270 COLUMBIA HEALTH PLAN/HEALTH MAINTENANCE OF OREGON (HMOO)

NOTE!! IF PREMIUM CODE 0306M-0309M AND DOS IS PRIOR TO 12/1/90 -
OVERLOC TO LOC 58.

-- IF DATES OF SERVICE 7/1/93 & AFTER GO TO PAGE 6 OF THIS TEXT --

1. COLUMBIA HEALTH PLAN/HMOO DOES NOT COVER THESE SERVICES - FORCE.
   A. PROVIDER TYPE 23 - CASE MANAGEMENT
   B. PROVIDER TYPE 35 - MATERNITY SUPPORT
   C. PROVIDER TYPE 30 - CHIROPRACTORS
   D. PROVIDER TYPE 41 - BLOOD BANKS
   E. OTHER THAN AMBULANCE TRANSPORTATION (PROVIDER TYPES 42,45,50,54, 55, & 96)
   F. INPATIENT PSYCHIATRIC SERVICES "R" & "S" (PT 64 & 65) AND DX IS 2900-31900 OR "J" IN POS (1) AND DX IS 2900-31900 - IF DOS IS 1/1/93 OR AFTER - FORCE; OTHERWISE- DENY.
   G. PROVIDER TYPE 71 - FAMILY PLANNING CLINIC
   H. PROVIDER TYPE 73 - COMMUNITY MENTAL HEALTH
   I. PROVIDER TYPE 74 - ITA
   J. PROVIDER TYPE 75 - ALCOHOL & SUBSTANCE ABUSE
   K. PROVIDER TYPE 84 - HEARING AIDS
   L. NEUROMUSCULAR REHABILITATION IF DENIAL ATTACHED
   M. ORTHOPEDIC SHOES IF DENIAL ATTACHED
   N. BLOOD PRODUCTS & COMPONENTS
   O. EYEGLASSES (SUPREME OPTICAL OR WESTERN OPTICAL)
   P. FITTING, DISPENSING & REPAIR OF EYEGLASSES (CODES 9272M-9276M, 92340-92342,92352-92354,92370-92371)
   Q. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.) &:
      1) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES- (635-636.9 OR V61.7)
      2) IF SPONTANEOUS ABORTION OR MEDICALLY JUSTIFIED - DENY.
   R. ORGAN TRANSPLANTS
   S. SPEECH & PHYSICAL THERAPY IF DENIAL IS ATTACHED
   T. ENTERAL & PARENTERAL SERVICES
   U. CASE MANAGEMENT (PROVIDER TYPE 23)
   V. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN - FORCE.
   W. HOSPICE (PT 63)
   X. 5970M-5987M (1ST STEPS DISCRETIONARY ADD-ON FEE)
   Y. OCCUPATIONAL THERAPY
   Z. NUTRITIONAL COUNSELING (CODES 0900M-0901M)
  ZA. WEIGHT LOSS (REVENUE CODES 942 & 949)
  ZB. DENTAL & DENTAL RELATED SERVICES
  ZC. DRUGS
  ZD. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
  ZE. DEPO-PROVERA FOR BIRTH CONTROL (CODE 9913M) - FORCE.
  ZF. NORPLANT SYSTEM KIT CODE 9910M (THIS IS A DRUG) - FORCE.
  ZG. REMOVAL OF NORPLANT SYSTEM CODES 1798M, 1799M, 11976, 1197M &:
      1) DATE OF SERVICE IS 3/1/92 OR AFTER - FORCE.
      2) DATE OF SERVICE IS BEFORE 3/1/92 - DENY.

ZH. OUTPATIENT CLAIMS FOR DIAGNOSTIC CODES 2900-3190 - COLUMBIA HLTH/ HEALTH MAINTENANCE OF OREGON (HMOO) ALLOWS UP TO $1,000.00 DEDUCTIBLE FOR PSYCHIATRIC SERVICES.
1) IF THERE IS A DENIAL ATTACHED, IF STAMP ON CLAIM "DEDUCTIBLE MET, STATEMENT TO THAT EFFECT WITH CHP SIGNOFF, OR ANY INDICATION THAT THE $1,000.00 DEDUCTIBLE WAS MET - FORCE.
2) IF THERE IS NO DENIAL, STAMP OR STATEMENT ON CLAIM - DENY.

2. IF THE CLAIM HAS AN HMO/DENIAL ATTACHED AND IT STATES:
A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED OR NOT REFERRED - DENY WITH EOB 254.
IF NOT MENTIONED - DENY WITH EOB 763.
FOR DOS - OVERLOC TO LOC 58 FOR RESOLUTION RESEARCH.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY W/EOB 151.
D. IF EOB SHOWS PAYMENT - DENY W/EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - USE OVERCODE 680 AND OVERLOC TO 80.

3. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
B. NON-COVERED SERVICES - (SEE ABOVE) IF LISTED - FORCE. IF NOT LISTED, DENY.
C. CHARGES APPLIED TO DEDUCTIBLE OR CO-PAY - DENY WITH EOB 151.
D. ANY OTHER STATEMENT, DENY.

4. NO EOB ATTACHED/NO STATEMENT ON CLAIM:
A. NON COVERED SERVICES - FORCE.
B. NO COUPON ATTACHED - DENY.
C. COUPON ATTACHED STATING HMO - DENY.

HMO PREMIUM BILLS
A. WHEN THE HMO/HIO HAS BILLED THE WRONG AMOUNT FOR A PREMIUM PAYMENT - DENY WITH EOB(963.DO NOT USE EOB)
B. WHEN THE CSO HAS NOT INDICATED A HMO/HIO ENROLLMENT BY CODING THE MEDICAL ELIGIBILITY SCREEN - DENY WITH EOB(964.DO NOT USE EOB)
C. IF DOS PRIOR TO 12/1/90 & THE RA SHOWS A DUPLICATION OF PREMIUM BILLINGS - DENY W/EOB 041.
D. IF OUR RECORDS INDICATE WE HAVE PAID FEE FOR SERVICE CLAIMS FOR THE DATES OF SERVICE - DENY W/EOB 460.
E. IF TPL SCREEN SHOWS PRIVATE INSURANCE COVERAGE WITH HMO WE PAID PREMIUMS TO - DENY W/EOB 955.

CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT THE HMO PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY W/EOB 229.

- IF DATE OF SERVICE IS 7/1/93 OR AFTER APPLY THE FOLLOWING -

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY HMOO):

A. ALL CLAIM TYPES-
IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT - IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER # 7500051 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5)

B. PHYSICIAN (J CLAIM TYPE)
1) ORGAN TRANSPLANTS
2) PSYC DIAGNOSIS 290.0 THRU 319.0 & POS IS 1 & DOS 1/1/94 OR AFTER.
3) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
4) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
5) ABORTION RELATES SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100, 59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
9) SERVICES FOR CUP, DX CODE 648.33.

C. HOSPITALS - (M,R,S CLAIM TYPES)

1) ORGAN TRANSPLANTS
2) IF INPATIENT & DIAGNOSIS CODES 290.0 THRU 319.0.
3) IF OUTPATIENT CLAIM & DIAGNOSIS CODES 290.0 THRU 319.0 & THERE IS STATEMENT ON CLAIM THAT SAYS $1,000 DEDUCTIBLE MET & DOS IS BEFORE 1/1/94.
3) DENTAL DIAGNOSIS 520 THRU 525.9
4) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
5) REVENUE CODE 942 (DIABETIC COUNSELING)
6) PM&R SERVICES
A) IF DOS BEFORE 3/1/95 - FORCE.
B) IF DOS 3/1/95 OR AFTER & PROVIDER #7500010 - DENY.
7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES (635-636.9 OR V61.7)
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
8) IF CLIENT IS UNDER 21 YRS OLD & STERILIZATION DX CODE V25.2

D. PHARMACY - D CLAIM TYPE
1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 270 IS STILL POSTING - DENY.

A) PRESCRIBED BY FAMILY PLANNING CLINI.
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTE.
C) PRESCRIBED BY HEALTH DEPARTMENT.
D) ABORTION RELATED PRESCRIPTION.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
   H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
271 RECIPIENT NOT ELIGIBLE FOR DOS

ITA - SEE ITA SECTION

1. IF A SCREEN PRINT FROM ACES OR MMIS IS ATTACHED, OR TAKE CHARGE APPLICATION OR ACES.ONLINE SCREEN - O'LOC TO 65.

2. MEDICAL ELIGIBILITY VERIFICATION (MEV)/PC PRINT OUT FROM CSO
   A. IF THE DOS IS WITHIN THE SAME MONTH AS THE "AS OF" DATE - O'LOC TO 65

   B. IF THE DOS IS NOT WITHIN THE SAME MONTH AS THE "AS OF" DATE - DENY WITH EOB 091.

3. AWARD LETTER:
   A. CLIENT NOT ON AWARD LETTER OR AWARD LETTER IS NOT FOR DOS - DENY W/EOB 091.
   B. IF VALID AWARD LETTER COVERING CLIENT AND DOS - O'LOC TO 65

4. IF CLAIM STATES CHILDREN'S PROGRAM - DENY WITH EOB 300, ROUTE CLAIM TO MENTAL HEALTH, OB 42-F. (IF COUPON STATES "CHILDREN'S HEALTH" BUT CLAIM DOES NOT - DO NOT ROUTE TO MENTAL HEALTH - PROCESS IN ACCORDANCE WITH 4-LINE AND TEXT.

5. DENTAL - DENTURES (05110/D5110, 05120/D5120, 0515D, 05211/D5211, 05212/D5212, 05510/D5510, D5520, 0552D, 05610/D5610, 05630/D5630, 0565D, 05650/D5650, 05660/D5660 - IF THE CLIENT IS ELIGIBLE FOR THE DATE OF SERVICE THAT THE MOLD (IMPRESSION) WAS TAKEN, USE THAT DATE SERVICE AND PROCESS.

6. INSTITUTIONS - CHECK TO SEE IF MEDICAL I.D. CARD OR PROOF OF ELIGIBILITY IS ATTACHED COVERING DATES OF SERVICE -
   A. IF NO I.D. CARD OR PROOF OF ELIGIBILITY - DENY.
   B. IF I.D. CARD OR PROOF OF ELIGIBILITY ATTACHED - BUILD ELIGIBLE SEGMENT.

7. ITA -EXAM ENTRY - ALL CLAIM TYPES
   A. CHECK BACKUP FOR FORM 13-628, IF NO FORM ATTACHED, DENY W/EOB 378. IF FORM 13-628 IS ATTACHED, CHECK IF PROPERLY COMPLETED.
      1. SECTION 4 MUST HAVE AN INITAL DETENTION DATE OR REVOCATION DATE & BE SIGNED & DATED. COUNTY DESIGNEE MUST BE INDICATED ON FORM. (CAN BE A COUNTY STAMP)
                AND
      2. DOS ON CLAIM MUST BE WITHIN DETENTION PERIOD. DETENTION PERIOD IS DEFINED AS TIME SPAN A PERSON WAS DETAINED, AS INDICATED BY DETENTION DATE/REVOCATION DATE & DISCHARGE DATE ON ITA FORM.
                AND
      3. DOS ON CLAIM MAY BE ONE DAY PRIOR TO DETENTION DATE OR REVOCATION DATE. ALSO, ALLOW A SPAN OF 30 CALENDAR DAYS FROM INITIAL DETENTION/REVOCATION DATE IF NO DISCHARGE DATE IS INDICATED.
   B. IF FORM PROPERLY COMPLETED & DOS ARE OK - O'LOC TO 65.

(EMC) ROUTE WORKSHEET AND BACKUP TO (ELIG, FRAN/KAREN) WITH NOTE STATING, BUILD "Q" SEGMENT.

C. IF FORM MISSING DATE OR SIGNATURE - DENY W/EOB 378.

D. IF DOS ON CLAIM/LINE DO NOT FALL WITHIN DETENTION PERIOD ON ITA FORM- DENY CLAIM OR LINE W/EOB 058.

LOC 65 - PHYSICIANS AND ALL OTHER CLAIM TYPES

A. CHECK OIS

1. IF FOUND - BUILD ELIGIBLE DATES. EXCEPTION: IF 1-DAY I.D. CARD ATTACHED - CHECK OIS FOR SPAN FOLLOWING THE 1-DAY & ADD ELIGIBLE DATES.

2. IF NOT FOUND - STAGE CLAIM TO BATCH TO CHECK FOR I.D. CARD OR OTHER PROOF OF ELIGIBILITY.
   A. IF NO I.D. CARD OR PROOF OF ELIGIBILITY ATTACHED - DENY.
   B. IF I.D. CARD OR PROOF OF ELIGIBLITY ATTACHED - BUILD ELIGIBLE DATES.

B. ITA - SEARCH PARTIAL PIC & SOCIAL SECURITY # WHEN AVAILABLE

1. IF FOUND - CORRECT PIC ON WORKSHEET & KEY WORKSHEET.

2. IF NOT FOUND -BUILD RECORD ON "Q" PROGRAM, "U" MATCH, "O" MED ELIG CODE FOR TO AND FROM DATES STAMPED ON CLAIM, (IF NO STAMP, BUILD SEGMENT FOR TO AND FROM DATES OF SERVICE). ALSO, PUT AN "I" INDICATOR IN THE ITA FIELD IF IT HAS BEEN OMITTED. CHECK LISTING AT END OF THIS TEXT FOR CASE NUMBER AND ADDRESS.

TEXT KEY	TEXT DESC
274	RECIPIENT EXPIRED.

VERIFY THE DEATH DATA THROUGH ACES AND DOH
1. IF DEATH DATE FOUND - UPDATE THE CLIENT'S RECORD AND NOTIFY THE CSO OF THE DEATH DATE.
2. IF NOT FOUND. USE THE HOSPITAL'S DEATH DATE AND UPDATE THE CLIENT'S RECORD AND NOTIFY THE CSO OF THE DEATH DATE.

TEXT KEY	TEXT DESC
279	NOT ELIGIBLE - MED CODE 6

ELIGIBILITY - CHECK MMIS & CHECK FOR MEDICAL I.D. CARD &:

1. IF MEDICAL I.D. CARD ATTACHED COVERING DOS - BUILD ELIGIBLE DATES OF SERVICE IN MMIS.
2. IF MEDICAL I.D. CARD ATTACHED BUT IT DOES NOT COVER DOS - DENY WITH EOB 091.
3. IF NO MEDICAL I.D. CARD ATTACHED - DENY.

TEXT KEY TEXT DESC
281 RECIPIENT IS GAU OR W

NOTE: IF THE CLAIM HAS BEEN APPROVED BY A MEDICAL CONSULTANT - FORCE.
-- EXCEPTION: DENTAL SEE TEXT ON PG. 3.
-- EXCEPTION: EE-IF AUTH# FORCE IF ONE OF THE FOLLOWING, OTHERWISE PA-2.
-- CLAIM HAS CONSULTANT DENIAL, MANUAL PRICE AT 0.00 WITH EOB 373. IF THE CONSULTANT HAS APPROVED A SERVICE THAT IS NOT COVERED, FORCE & ROUTE COPY OF CLAIM TO DHSQS DIRECTOR, MS 45506 EXCEPT FOR PSYCHOTHERAPY-
SEE NEXT PAGE.

-- CLAIM DOES NOT HAVE A COUPON ATTACHED, OR COUPON DOES NOT COVER DATES OF SERVICE, TREAT AS IF A COUPON WITH GAU NOTATION WAS ATTACHED.

NOTE: ITA - ALL CLAIM TYPES:
1. APPROPRIATE BACKUP ATTACHED
EE - O'LOC TO ELIG (LOC 65) TO BUILD A "Q" SEGMENT.
RES - ROUTE TO ELIG (LOC 65) TO BUILD A "Q" SEGMENT.
2. NO BACKUP - DENY W/EOB 378.

EPSDT CLAIMS (L) - DENY.
PHYSICIAN CLAIMS (J) - THE FOLLOWING ARE NOT COVERED UNDER GAU:
1. PROVIDER TYPES 15, 23, 58 & 75 - DENY.
2. PROVIDER TYPE 40 WITH SPECIALTY 61 - DENY.
3. PROVIDER TYPE 73 - DENY W/EOB 923.
4. OUT OF STATE: DENY WITH EOB 210 EXCEPT;
A. IF PT 43 & REFERRING PROVIDER # IS AN IN STATE PROVIDER - FORCE.
NOTE: PF-4 UNDER THE REFERRING # TO SEE PROVIDERS STATE OF RESIDENCE.
B. IF PT 40 WITH SPECIALTIES 60/70 - FORCE.
C. PROV # 2017390 (SCHMIDT LAB) - FORCE.
5. PROVIDER TYPE 93 (ARNP) MEDICATION ADJUSTMENT (90862) - FORCE, ALL ELSE - DENY.
6. PSYCHOTHERAPY PROCEDURE CODES 90801-90899, 9083M-9084M & DX IS 290-319.9 & POS IS 2,3,4,5,9,11,12,22,23,25,52,60,71,81,99 - DENY EXCEPT:
A. MEDICATION ADJUSTMENT (90862) - FORCE.
B. PRIOR AUTH PRESENT:EE OL 23-RES-IF AUTH COMMENTS STATE ETP-FORCE.
C. IF DX 291.0-291.3 - FORCE.
D. PROVIDER #7023328 WITH ANY POS - FORCE.
E. IF DENYING 90801 - ALSO DENY 99221-99223.
7. RHC (PROV TYPE 88) ENCOUNTER CODE T1015 CROSSWALKS BACK TO THE ORIGINAL ARRAY OF STATE UNIQUE/PROVIDER UNIQUE LOCAL CODES AS OF 10/01/03 AND AFTER - FORCE FOR ANY DATE OF SERVICE. *SR
8. FQHC (MUST BE SPECIALTY 90!) ENCOUNTER CODES 9000M, 9001M, 5900M, 9006M, 9007M, 0200D, 9701M, 9005M & T1015 - DENY.
-- IF 553 POSTS AFTER DENYING 281 - FORCE.
9. ALL ELSE - FORCE.

DENTAL CLAIMS (K)
1. EVEN IF DENTAL SERVICES ARE PAYABLE, DENY ENCOUNTER CODE 0200D AND DENY ENCOUNTER CODE T1015.

2. D3346, D3347, D3348 (RETREATMENT OF ROOT CANALS) - FORCE.
3. D7140 - EXTRACTION - FORCE.
4. D9420 - HOSPITAL CALL - FORCE.
5. IF 4444D (U OF W ADD-ON CODE FOR DISABLED) - DENY WITH EOB 073.
6. ALL ELSE - DENY, EVEN IF AUTHORIZED.

OUTPATIENT CLAIMS (M)
THE FOLLOWING SERVICES ARE NOT COVERED.
1. OUT-OF-STATE - DENY.
2. IN-STATE AND PRIMARY DIAGNOSIS CODE 290 - 319.
   A. IF CLAIM IS FOR LABORATORY SERVICES ONLY: FORCE
   B. IF CLAIM IS NOT "FOR LAB ONLY":
      1) DIAGNOSIS CODE IS 290-301.99, 306-319.99 - FORCE.
      2) DIAG CODE IS 302-305.99 - IF REV CODE 450 PRESENT-FORCE.
      3) ALL ELSE - DENY.
3. ALL ELSE - FORCE.

INPATIENT CLAIMS (R & S)
1. OUT-OF-STATE - DENY.
2. ALL ELSE - FORCE.

MEDICAL VENDOR CLAIMS (P)

--NURSE DELEGATION SERVICES (8900N-8903N) (PT 33 & 44) - OVERLOC
  TO 59. (LOC 59 - REVIEW FOR DENIAL)

THE FOLLOWING SERVICES ARE NOT COVERED:

1. OUT-OF-STATE - DENY, EXCEPT:
   A. MEDICAL SUPPLIES/EQUIPMENT/PROSTHETIC & ORTHOTICS - FORCE.
   B. SEE BOX 33 ON CLAIM - IF SVS DONE IN DR OFFICE IN-STATE - FORCE
      (PROVIDER BILLING OFFICE IS OUT-OF-STATE)
2. PROVIDER TYPE 33 (SPECIAL DUTY NURSING) - DENY.
3. ALL ELSE - FORCE.

TEXT KEY TEXT DESC
282 LCP - ONE DAY SEGMENT

NOTE: ITA CLAIMS - APPLY TEXT FILE POLICY.

NOTE: NON-PROFIT TRANSPORTATION (PT 54 & 96) CLAIMS - FORCE.

NOTE: DRG CLAIMS - KEY ENTIRE PARTICIPATION AMOUNT REGARDLESS OF BILLED AMOUNT. IF PATIENT PARTICIPATION IS GREATER THAN OR EQUAL TO BILLED AMOUNT, KEY 0.00 IN NET BILLED. IF NO COUPON ATTACHED SEE PAGE 3.

NOTE: OUT OF STATE - IF PATIENT IS ON LCP-MNP AND THERE IS NO ONE-DAY COUPON OR PROVIDER NAME IS NOT LISTED OR WRONG PROVIDER NAME IS LISTED OR DOLLAR AMOUNT IS NOT LISTED - DENY, ATTACH BLURB AND ROUTE TO REGION CONTACT. IF PT IS LCP-MIP - DENY WITH EOB 210.

NOTE: ELECTRONIC AND DIRECT ENTRY PROVIDERS MUST INDICATE "X" (BACKUP DOCUMENTS SENT) IN COMMENTS OR LIST THE FOLLOWING INFORMATION IN COMMENTS: 1 DAY COUPON, DATE OF COUPON, PROVIDER NAME AND SPEND-DOWN MONEY AMOUNT (AMOUNT MAY APPEAR IN PT PAY FIELD INSTEAD OF COMMENTS). IF NOT - DENY WITH EOB 224.

NOTE: PLUG IN'S:
- 1 DAY PLUG IN - FORCE.
- STATE ISSUED COUPONS SHOWING SAME DAY ELIGIBILITY SEGMENT IS A PLUG IN - FORCE.
- LOCAL OFFICE HAND TYPED COUPON STATING PLUG IN - FORCE.
- UNABLE TO DETERMINE IF A PLUG IN - ASK YOUR SUPERVISOR.

THE CLAIM MUST HAVE A YELLOW COUPON OR AWARD LETTER ATTACHED FOR THE ONE DAY ELIGIBILITY SEGMENT. THE COUPON OR AWARD LETTER MUST HAVE THE NAME OF THE PROVIDER AND THE AMOUNT OF PATIENT PARTICIPATION. IF THERE IS NO PATIENT PARTICIPATION, THE COUPON OR AWARD LETTER WILL STATE "NO PARTICIPATION", "00" PARTICIPATION OR SOMETHING TO THAT EFFECT.

BE SURE THE DATES OF SERVICE ON THE CLAIM AND THE YELLOW OR WHITE COUPON ARE THE SAME BEFORE APPLYING THE FOLLOWING. IF COUPON INCLUDES THE 1 DAY ELIGIBILITY SEGMENT (I.E. 1 DAY ELIGIBILITY SEGMENT IS 2/10/82, COUPON SHOWS ELIGIBILITY PERIOD 2/10/82 TO 2/28/82) DO NOT DENY THE 1 DAY ELIGIBILITY SEGMENT. SEE TEXT BELOW FOR FURTHER INSTRUCTIONS.

NOTE:
IF MOTHER'S BILL HAS BEEN PAID BY INSURANCE, OR IF THE ALLOWABLE FOR HER BILL IS LESS THAN THE SPEND-DOWN AMOUNT, THE 1-DAY SEGMENT (OR ANY RESIDUAL AMOUNT) MAY BE APPLIED TO THE BABY'S BILL.

1. NO COUPON WHITE OR YELLOW ATTACHED:
   A. ONE DATE OF SERVICE ON LINE(S) - DENY.
   B. SPAN OF DATES, CHECK ELIGIBILITY SCREEN FOR DATE OF 1-DAY SEGMENT
      1) ANY CLAIM TYPE & CLAIM IS FOR BABY, ASSUME SPENDOWN WILL BE TAKEN FROM MOM'S CLAIM & FORCE BABY'S CLAIM.

2) CLAIM TYPES R,S, AND P CLAIMS FOR HOME HEALTH (PT 44) - DENY. IF CLAIM IS FOR BABY'S BILL - FORCE.
3) CLAIM TYPE M -OUTPATIENT- DENY.
4) ALL OTHER CLAIM TYPES SPLIT OUT 1-DAY SEGMENT AND DENY.

2. PROVIDER ON COUPON MATCHES THE PROVIDER ON THE CLAIM; DATE ON COUPON MATCHES DATE OF SERVICE ON CLAIM AND MONEY AMOUNT INDICATED IS $0.00 - FORCE.

3. PROVIDER ON COUPON MATCHES PROVIDER ON CLAIM AND MONEY ON COUPON:
A. CLAIM TYPES V,W,AND O DEDUCT AMOUNT INDICATES ON COUPON OR THE SUM OF THE BILLED AMOUNTS ON ONLY THE 1-DAY SEGMENT LINES (WHICH-EVER IS LESS) FROM THE DEDUCTIBLE OR CO-INSURANCE AND ENTER EOB 046 IN SECOND CLAIM LEVEL EOB FIELD.
B. ALL OTHER CLAIM TYPES ENTER THE AMOUNT INDICATED ON COUPON OR THE SUM OF THE ALLOWED AMOUNTS ONLY ON LINE(S) OF 1-DAY SEGMENT, WHICHEVER IS LESS, ENTER EOB 046 IN SECOND LINE LEVEL EOB FOR EACH LINE EFFECTED. NOTE: DO NOT CHANGE ALLOWED AMOUNTS.
C. EMC CLAIMS: MONEY INDICATED IN PATIENT PAY ON WORKSHEET, CHECK COUPON AND FOLLOW ABOVE INSTRUCTIONS.

4. DATES ON COUPON DON'T MATCH DATES ON CLAIM AND 1-DAY (282) FAILING
A. MULTIPLE DATES ON CLAIM - DENY
B. SPAN OF DATES ON LINE SPLIT OUT AND DENY 1-DAY SEGMENT

5. PROVIDER ON COUPON DOES NOT MATCH THE PROVIDER ON CLAIM:
A. CHECK TO SEE IF NAME LISTED ON COUPON IS A CLINIC (I.E. WENATCHEE VALLEY CLINIC) IF DOCTOR LISTED ON CLAIM IS PART OF CLINIC- FORCE
B. IF DOCTOR NAME IS LISTED ON COUPON AND CLINIC NAME ON CLAIM, CHECK PERFORMING PROVIDER NAME, IF SAME - FORCE, IF NOT DENY.
C. IF UNABLE TO DETERMINE IF PROVIDER IS A PART OF A CLINIC SEE YOUR SUPERVISOR.
EXCEPTIONS:
1) DRS. BETTS, TUBBS, LARSON, GARMEN, GOTSHALL, DRISCOLL, AND WENDLING ARE ALSO KNOWN AS SPOKANE RADIOLOGY, IF COUPON STATES EITHER SPOKANE RADIOLOGY OR DOCTORS NAME - FORCE.
2) THE FOLLOWING SATELLITE OFFICES BILL UNDER WENATCHEE VALLEY CLINIC AND THESE NAMES MAY APPEAR ON THE 1-DAY COUPON - FORCE
- MOSES LAKE CLINIC "MLC"
- FAMILY MEDICINE CLINIC "FMC"
- FAMILY MEDICINE ASSOC. "FMA"
- FAMILY MEDICAL CENTER "FMC"
3) DRS. GROSS LARSEN & WHITNEY HAVE CHANGED THEIR NAME TO DIAGNOSTIC IMAGING - FORCE.
4) R AND S CLAIM TYPE - DENY WITH EOB 385.
5) MEDICAL VENDORS (P) - AMBULANCES OTHER THAN HOSPITAL BASED MUST HAVE THEIR OWN COUPON.
6) ALL OTHER CLAIM TYPES DENY W/EOB 385. EXCEPTION: MULTIPLE DATES OF SERVICE ON 1 LINE SPLIT LINE AND DENY ONE DAY SEGMENT

6. COUPON ATTACHED WITH 1-DAY SEGMENT ON COUPON, NO PROVIDER LISTED, NO MONEY OR BOTH, ALL CLAIM TYPES - DENY CLAIM, ATTACH BLURB TO THE CLAIM CHECKING THE APPROPRIATE BOX(ES), MARK CSO 282 ON BATCH COVER, ROUT CLAIM TO THE APPROPRIATE REGION CONTACT PERSON AS IDENTIFIED ON

THE LIST AT THE END OF THE TEXT.

EXCEPTION: J, P, O, L CLAIM TYPES DENY ONLY 1-DAY SEGMENT LINE(S), CORRECT CLAIM AND BALANCE DUE TO SHOW ONLY THE 1-DAY SEGMENT, MAKE A COPY OF THE CLAIM, AND SEND TO THE CONTACT PERSON AS IN #1 ABOVE.

7. WHITE OR YELLOW COUPON INCLUDING THE 1-DAY SEGMENT--FORCE. MAKE A COPY OF THE CLAIM AND ROUTE TO THE REGION CONTACT AS LISTED AT THE END OF THE TEXT WITH AN EXPLANATION " THE COUPON ATTACHED INCLUDES THE 1-DAY SEGMENT". IF THERE IS A PROVIDER NAME AND MONEY ON THE COUPON AND THE PROVIDER MATCHES THE ONE ON THE CLAIM APPLY THE SPENDDOWN AS USUAL (SEE PAGE 4-#C). IF IT DOES NOT MATCH APPLY JUST THE INSTRUCTIONS LISTED "G" ABOVE.

REGION CONTACT PERSONS

IDENTIFY CSO NUMBER (COUNTY OF RECIPIENT) FROM COUPON OR RECIPIENT ELIGIBILITY FILE. FIND WHICH REGION IT IS UNDER AND ROUTE THE CLAIM TO THE APPROPRIATE REGION CONTACT PERSON LISTED (INDICATING THE CSO NUMBER & NAME ON THE ROUTING SLIP). SEE NEXT PAGE.

REGION 1 - BOB BIONDI, B 32-6

CSO #	CSO NAME	CSO #	CSO NAME
01	OTHELLO/ADAMS	26	NEWPORT/PEND OREILLE
04	WENATCHEE/CHELAN	32	SPOKANE CENTERAL/SPOKANE
09	WENATCHEE/DOUGLAS	33	COLVILLE/STEVENS
10	REPUBLIC/FERRY	38	COLFAX/ WHITMAN
13	MOSES LAKE/GRANT	58	SPOKANE E. VALLEY/SPOKANE
22	DAVENPORT/LINCOLN	59	SPOKANE NORTH/SPOKANE
24	OKANOGAN/OKANOGAN	60	SPOKANE SOUTHWEST/SPOKANE
		73	SPOKANE - DCYFS

REGION 2 - KEN BLACK, B 39-6

CSO #	CSO NAME	CSO #	CSO NAME
02	CLARKSTON/ASOTIN	36	WALLA WALLA/WALLA WALLA
03	PASCO/BENTON	39	YAKIMA/YAKIMA
07	WALLA WALLA/COLUMBIA	50	TOPPENISH/YAKIMA
11	PASCO/FRANKLIN	54	SUNNYSIDE/YAKIMA
12	CLARKSTON/GARFIELD	57	SUNNYSIDE/BENTON
19	ELLENSBURG/KITTITAS	69	YAKIMA

REGION 3 -

CSO #	CSO NAME	CONTACT PERSON	MAILSTOP
15	OAK HARBOR/ISLAND	RAY MASON	B 29-1
28	FRIDAY HARBOR/SAN JUAN	RAY MASON	B 29-1
29	MOUNT VERNON/SKAGIT	RAY MASON	B 29-1
31	EVERETT/SNOHOMISH	MICHELE LOUNSBURY	N 31-1
37	BELLINGHAM/WHATCOM	LINDA WEED	B 37-1
52	MTLAKE TERRACE/SNOHOMISH	ELEANOR SHIPLEY	N 52-1
63	ANACORTES - CLOSED		
65	SMOKEY POINT	SCOTT FIELD	B 65-1
68	SKY VALLEY		N 68-1

REGION 4 - CAROL HATTERSLEY N 44-3

CSO #	CSO NAME	CSO #	CSO NAME

40	EASTSIDE/KING	45	FEDERAL WAY/KING/SOUTH
41	RAINIER/KING	46	CAPITOL HILL/KING
42	KING NORTH/KING	47	BILLTOWN/KING
43	KENT/KING	55	WEST SEATTLE/KING
44	BURIEN/KING	56	CENTRAL SERV./KING
		74	KING NORTH/LAKE CITY

REGION 5 - SHANNON PARSONS N27-5

CSO #	CSO NAME
18	BREMERTON/KITSAP
48	PIERCE SOUTH/PIERCE
49	PIERCE NORTH/PIERCE
51	PUYALLUP VALLEY
66	LONG TERM CARE/PIERCE
67	PIERCE WEST/PIERCE

REGION 6 - BILL GREEN OR PAT HENNING, KR-23

CSO #	CSO NAME
05	PORT ANGELES/CLALLAM
06	VANCOUVER/CLARK
08	KELSO LONGVIEW/COWLITZ
14	ABERDEEN/GRAYS HARBOR
16	PT TOWNSEND/JEFFERSON
20	WHITE SALMON/KLICKITAT
21	CHEHALIS/LEWIS
23	SHELTON/MASON
25	SOUTH BEND/PACIFIC
30	STEVENSON/SKAMANIA
34	OLYMPIA/THURSTON
35	CATHLAMET/WAHKIAKUM
53	ORCHARDS/CLARK
61	ELMA/GRAYS HARBOR
62	GOLDENDALE/KLICKITAT
64	FORKS/CLALLAM

THE END

TEXT KEY TEXT DESC
283 LCP/MN - NONCOVERED SERVICE

NOTE: IF THE COUPON INDICATES OTHER THAN "LCP/MN" - FORCE.
IF THERE IS NO COUPON ATTACHED, OR COUPON DOES NOT COVER DATE OF SERVICE - TREAT AS IF COUPON WITH NOTATION LCP/MN WERE PRESENT.

NOTE: EXAM ENTRY, IF AUTHORIZATION # ON CLAIM - OL TO 23. IF MEDICAL CONSULTANT HAS SPECIFICALLY APPROVED SERVICE - FORCE.

NOTE: IF THE CLAIM IS FOR ITA OR BLIND - FORCE.

NOTE: IF ANYTHING OTHER THAN WHAT IS ADDRESSED IN THE FOLLOWING TEXT SUSPENDS - FORCE.

PHYSICIAN CLAIMS (J)

THE FOLLOWING SERVICES ARE NOT COVERED UNDER LCP/MN AND SHOULD BE DENIED UNLESS OTHERWISE INDICATED.

1. SPEECH SERVICES (92506 THRU 92508). OUTPATIENT SERVICES (INCLUDES OFFICE)
   A. IF DATE OF SERVICE IS BEFORE 4/1/90 - DENY.
   B. IF DATE OF SERVICE IS 4/1/90 OR AFTER &:
      1) RECIPIENT IS UNDER 21 YEARS OLD & REFERRING PROVIDER # PRESENT - FORCE; IF NO REFERRING # - DENY.
      2) RECIPIENT IS 21 OR OVER - DENY.

2. PT 36 (NEUROMUSCULAR CENTERS)
   A. IF DATE OF SERVICE IS BEFORE 4/1/90 - DENY.
   B. IF DATE OF SERVICE IS 4/1/90 OR AFTER &:
      1) RECIPIENT IS UNDER 21 YEARS OLD & SERVICES ARE FOR SPEECH, PHYSICAL OR OCCUPATIONAL THERAPY & REFERRING PROVIDER # PRESENT - FORCE; IF NO REFERRING # - DENY.
      2) ALL ELSE - DENY.

3. SCHOOL MEDICAL SERVICES (PT 58) - DENY.

4. OCCUPATIONAL THERAPY SERVICES (PT 40, SPECIALTY 66) - DENY.

5. MUSCLE TESTING BILLED AS A NEUROLOGICAL TEST AND NOT AS PHYSICAL THERAPY - FORCE.

MEDICAL VENDOR CLAIMS (P)
THE FOLLOWING ARE NOT COVERED UNDER LCP/MN - DENY:

1. PHYSICAL THERAPY (PROVIDER TYPE 34).

2. HEARING AIDES
   A. 5002V THRU 5004V, V5050,5047V-5051V-ADULT - DENY
   B. 5020V - 5046V - CHILDREN (CSHCN) - FORCE.

3. DAY HEALTH (9801H THRU 9806H) - THESE CODES END 8/31/95.
(NEW CODES EFF 9/1/95 ARE 0801H THROUGH 0808H AND 0820H, 0821H)

4. CHIROPRACTIC SERVICES (A2000, 2000A-2011A)
A. IF DATE OF SERVICE IS BEFORE 4/1/90 - DENY.
B. IF DATE OF SERVICE IS 4/1/90 OR AFTER &:
1) RECIPIENT IS UNDER 21 YEARS OLD & REFERRING PROVIDER #
PRESENT - FORCE; IF NO REFERRING # - DENY.
2) RECIPIENT IS 21 OR OVER - DENY.

OUTPATIENT CLAIMS (M)
THE FOLLOWING SERVICES ARE NOT COVERED UNDER LCP/MN AND SHOULD BE DENIED.

1. SPEECH THERAPY 92506-92508
A. IF DATE OF SERVICE IS BEFORE 4/1/90 - DENY.
B. IF DATE OF SERVICE IS 4/1/90 OR AFTER &:
1) RECIPIENT IS UNDER 21 YEARS OLD & REFERRING PROVIDER #
PRESENT - FORCE; IF NO REFERRING # - DENY.
2) RECIPIENT IS 21 OR OVER - DENY.

2. PHYSICAL THERAPY 97010-97799
A. IF DATE OF SERVICE IS BEFORE 4/1/90 - DENY.
B. IF DATE OF SERVICE IS 4/1/90 OR AFTER &:
1) RECIPIENT IS UNDER 21 YEARS OLD &:
A) REFERRING PROVIDER # PRESENT - FORCE.
B) NO REFERRING PROVIDER # PRESENT - DENY.
2) RECIPIENT IS 21 OR OVER - DENY.

3. MUSCLE TESTING BILLED AS A NEUROLOGICAL TEST AND NOT AS PHYSICAL THERAPY - FORCE.

MEDICARE NON-INSTITUTIONAL X/OVER CLAIMS (O)
1. O'LOC TO 83 THE FOLLOWING:
A. HEARING AIDES (5000V THRU 5005V, V5050) - O'LOC TO 83.
B. PHYSICAL THERAPY - PT 34 OR SPECIALTY 76 (64550,95831-95834,
95851-95852,97010-97799,97601-97602,0001M,0002M,M0006-M0008)
1. IF RECIPIENT IS UNDER 21 YEARS OLD - O'LOC TO 83
2. IF RECIPIENT IS 21 OR OVER - O'LOC TO 83.
C. SPEECH THERAPY- PT 36 OR 37/SPEC 64 & 76 (69210,92506-92510,
92525-92526,92541-92547,92551-92553,92555-92557,92567-92569,
92579,92582,92584-92589,92597-92598,92610,97532-97533)
1. RECIPIENT IS UNDER 21 YEARS OLD - O'LOC TO 83.
2. RECIPIENT IS 21 OR OVER - O'LOC TO 83.
D. OCCUPATIONAL THERAPY - SPECIALTY 66 (0002M,64550,97003,97110
97112,97504,97520,97530,97532,97533,97535,97537,97703)
1. RECIPIENT IS UNDER 21 YEARS OLD - O'LOC TO 83
2. RECIPIENT IS 21 AND OVER - O'LOC TO 83.

2. FORCE EVERYTHING ELSE.

TEXT KEY TEXT DESC

284 MIP - NONCOVERED SERVICE

APPLY THE FOLLOWING:

1. ITA - ALL CLAIM TYPES
   A. APPROPRIATE BACKUP ATTACHED
      EE - O'LOC TO ELIGIBILITY (LOC 65) TO BUILD "Q" SEGMENT.
      RES - ROUTE CLAIM/BACKUP TO ELIGIBILITY TO BUILD "Q" SEGMENT.
   B. NO BACKUP ATTACHED - DENY W/EOB 378.

2. COUPON COVERING DOS IS ATTACHED & LEGEND ON COUPON IS OTHER THAN: MIP, EMERGENCY HOSPITAL, EMERGENCY HOSPITAL & AMBULANCE ONLY OR AMBULANCE ONLY - FORCE.
   EXCEPTION: OUT OF STATE CLAIMS & LEGEND IS "NO OUT OF STATE CARE" DENY W/EOB 210.

3. IF TAKE CHARGE APPLICATION OR COPY OF ACES ONLINE ATTACHED O'LOC TO 65.

4. OUT OF STATE CLAIMS - NOT MENTIONED IN #2 ABOVE - DENY W/EOB 210.

5. PROVIDER TYPE 93 W/SPEC OF 16 (OB/GYN) - SERVICES ARE OTHER THAN DELIVERIES OR OB CARE - FORCE.

6. CATARACT SURGERY (66830-66985) IN POS (3) - FORCE. THE CSO OR A MEDICAL CONSULTANT HAS PUT THEM ON THE MI PROGRAM WHEN THE CLIENT IS LEGALLY BLIND. SEE MEMO 95-40 FROM JANE BEYER. ALSO, FORCE RETINAL DETACHMENT (67101-67112).

7. FQHC ENCOUNTER CODES 5900M, 9000M, 9001M, 9005M, 9006M, 9007M,9701M, T1015 - IN POS OTHER THAN 1,2,5,21,22 OR 23 & THE OTHER SVCS ON THE CLAIM IN POS 1,2,5,21,22 OR 23 ARE NOT POSTING 284 - DENY THE ENCOUNTER W/EOB 581. *SR

8. PROVIDER TYPE 95 (RN/SURGICAL ASSIST) BILLED IN POS 1, 2 OR 5 - FORCE.

9. IF CLAIM INDICATES "NON HOSPITAL BASED EQUIPMENT" & X-RAY OR LAB PROCEDURES ARE ON THE CLAIM IN POS 3 - FORCE. IF EMERGENCY ROOM SERVICES IN POS 5 - FORCE. (IN THIS SITUATION, THE HOSPITAL MUST REFER THE PATIENT TO ANOTHER SITE FOR X-RAY OR LAB SERVICES DUE TO LACK OF EQUIPMENT AT THE HOSPITAL. IF IN DOUBT IF SERVICES ARE X-RAY OR LAB- SEE YOUR SUPERVISOR.)

10. IF DENTAL CLAIM AND POS IS 1, 2, OR 5 AND PERFORMING PROVIDERS SPECIALTY IS 09 - FORCE.

11. IF GENERAL DENTIST (PT 27 WITH SPECIALTY 19) AND POS 1, OL TO 83.

12. EVEN IF THE MEDICAL CONSULTANT, DENTAL CONSULTANT OR DENTAL DESIGNEE HAS APPROVED A SERVICE THAT IS NOT COVERED - DENY.

CLAIMS DENIED BY MEDICAL CONSULTANT - DENY WITH EOB 373.

13. PROVIDER TYPE 80 W/SPECIALTY 46 ---FORCE

14. PROVIDER TYPE 25 W/SPECIAL AGREEMENT TO PERFORM SERVICES IN POS 1,2, OR 5 & DX IS EMERGENT (F-4 UNDER DX TO CHECK INDICATOR FOR DOS) - FORCE.

15. PROVIDER TYPE 62 W/SPECIALTY 86 - FORCE

16. ALL ELSE - DENY.

TEXT KEY	TEXT DESC
285	

TEXT KEY TEXT DESC

286 RECIPIENT FILE INDICATES DETOX PROGRAM.

PHYSICIANS (J)
1. IF PROCEDURE CODES OTHER THAN 0025M OR 0026M ARE BILLED - DENY.
2. ITA: PAY 3 WORKING DAYS FROM DETENTION DATE. DENY WHEN BEYOND THE FIRST 3 DAYS WITH EOB 942.

HOSPITAL INPATIENT (S) AND OUTPATIENT (M)
1. ITA CLAIMS - DENY 194.
2. IF CLAIM HAS DETOX COUPON BUT PROVIDER IS NOT USING THEIR DETOX PROVIDER # - DENY 983.
3. IF AN AWARD LETTER OR A COUPON INDICATING OTHER THAN DETOX IS ATTACHED TO THE CLAIM, SEND A COPY OF THE COUPON AND/OR AWARD LETTER TO ELIGIBILITY.
4. IF NONE OF THE ABOVE APPLY TO THE HOSPITAL CLAIM - DENY.

DRG CLAIM (R) DELETE (SAME AS B)
1. ITA CLAIMS - DENY 194.
2. HARDCOPY CLAIMS: IF PROVIDER NUMBER BEGINS WITH A "36" DENY 333 AND PUT IN AN "S" BATCH - OTHERWISE DENY.
3. ELECTRONIC CLAIMS: IF PROVIDER NUMBER BEGINS WITH A "36" DENY WITH EOB 113. OTHERWISE DENY.

THE END

TEXT KEY TEXT DESC

299 THIS AUDIT APPLIES TO THE CLIENT, NOT THE PROVIDER - EXCEPT FOR CHIROPRACTORS.

AFTER REVIEW OF TEXT, HX, BACKUP DOCUMENTATION, AUTH # & NO JUSTIFICATION TO WARRANT PAYMENT - DENY.

EXCEPTION: IF HX BATCH RANGE IS (953-957) & PROCEDURE ON CLAIM IS SAME OR RELATED & CARRIER CODE ON HX CLAIM IS (1111) OR ADJ-R IS (E) - FORCE. THERE MAY ALSO BE AN EOB OF 928 ON HX CLAIM WHICH INDICATES PROVIDER SENT MONEY BACK (CLAIM PD IN ERROR).

PHYSICIAN (J)

NOTE: EFF 9/12/98, THIS EDIT WILL POST ON ALL MODIFIERS.
SAME DOS: ANY COMBO OF THE FOLLOWING MAY BE FORCED - PT 22 (ASC) VS SURGEON VS ASSIST VS ANESTHESIA. ALL ELSE - REVIEW BEFORE MAKING DECISION. IF UNSURE - SEE TRAINER/SUP.

NOTE: SURGERIES OR ANESTHESIA (10000 - 69999 OR 00100 - 01999) - O'LOC TO 36 FOR REVIEW OF THIS TEXT & HX OF CLAIM.

NOTE: EFF 9/12/98, THIS EDIT WILL POST ON ALL STERILIZATIONS, VASEC-TOMIES, HYSTERECTOMIES (SAME OR DIFFERENT CODE)

1. A PORTION OF THE PROCEDURES THAT WILL HIT THIS AUDIT ARE TOTAL "ECTOMIES" WHILE SOME ARE PARTIALS. IF A RECIPIENT WOULD HAVE A PARTIAL, THEY CAN HAVE ANOTHER PARTIAL BUT NOT A TOTAL & VISA VERSA
   A. TOTAL PROCEDURE VS TOTAL PROCEDURE - DENY
   B. TOTAL PROCEDURE VS PARTIAL PROCEDURE - DENY
   C. PARTIAL PROCEDURE VS PARTIAL PROCEDURE - FORCE

2. IF PROCEDURE CODE 9020M - ALLOW UP TO 2 PER LIFETIME.

3. 56301,56302,58600,58605,58611,58615,5912M,00851,(STERILIZATIONS) WHEN STERILIZATION PROCEDURE HAS TO BE REDONE AFTER A DELIVERY BECAUSE PREVIOUS SURGERY WAS NOT SUCCESSFUL - FORCE.

4. 1650M-1655M (DIABETES EDUCATION PROGRAM) - OVERLOC TO 83.
LOC 35 (ALLOW 6 IN A CALENDAR YEAR) PER DIAB ED MEETING 4/11/00.

5. 2175M - DASA DCFS REFERRED INITIAL SCREEN - DENY

6. 64550 (APPLICATION OF TRANSUCUTANEOUS ELECTRICAL NERVE STIMULATOR) PAY ONLY 1 PER CLIENT. DENY ALL OTHERS. (CRITERIA FOR PAYING IF FOR DIFFERENT INJURIES CHANGED BY DR. FISHER, 4/2/99)

7. PSYCHOLOGICAL EVALUATION (0070M) -
   A. IF "I" IN ITA FIELD - PAY TWO EVALUATIONS PER DETENTION.
      IF MORE THAN TWO - DENY.
      (A DETENTION IS USUALLY 90 DAYS)

B. IF NO "I" IN ITA FIELD - DENY.

8. PNEUMOCCOCAL VACCINE (90669) - ALLOW UP TO 4 MAX IN A LIFETIME.
DENY OVER MAX W/EOB 339. EXCEPTION: SEE NOT BELOW.
EXCEPTION: DO NOT COUNT ANY LINES IF MOD 1H/SL IS/SHOULD BE PRESENT.
EXCEPTION: DO NOT COUNT ANY LINES IF AUTH INDICATING ETP FOR OVER MAX.
NOTE: IF SAME DOS IN HX & 1 CLAIM HAS MOD SL & 1 CLAIM HAS MOD 1H - PAY FIRST CLAIM BILLED & DENY SECOND CLAIM W/EOB 102.

9. HIV/AIDS COUNSELING (9020M) - ALLOW UP TO 2 MAX IN A LIFETIME, DENY W/EOB 339 IF OVER MAX.

10. CANCER SCREENS (G0103,G0104,G0105,G0106,G0107,G0120)
A. G0103 - ALLOW 1 IN A 12 MO PERIOD.
B. GO107 - ALLOW 1 SET OF 3 (3 UNITS OR 3 LINES) SIMULTANEOUS, IN A 12 MO PERIOD.
C. G0105 & G0120 - ALLOW 1 OF EACH IN A 24 MO PERIOD.
D. G0104 & G0106 - ALLOW 1 OF EACH IN A 48 MO PERIOD.
IF MORE THAN THE ABOVE LIMITS ARE BILLED - DENY W/EOB 339.

11. HEP A/B VACCINE ADULT (TWINRIX) (90636) - ALLOW UP TO 3, DENY ALL OTHERS W/EOB 339.

12. 01962 BILLED:
A. PRIOR TO 1/1/02 (ANES FOR DIAG/THERA NERV BLOCK/INJ) - FORCE.
B. 1/1/02 AND AFTER (EMERGENT HYSTERECTOMY) - DENY.
13. J1825 - ALLOW 1 TEACHING OF ADMIN - DENY ALL ELSE W/EOB 339.
(THIS DECISION WAS MADE BY DR.COYNE TO FOLLOW MDCR POLICY) ANY QUESTIONS OR APPEALS, SEE SANDY A/MMIS.

DENTAL (K)
1. ONLY ONE EXTRACTION OR ROOT CANAL ALLOWED PER TOOTH
A. SUPERNUMERARY (SN) - FORCE.
B. SAME TOOTH VS SAME TOOTH - DENY.

2. PULPOTOMY (03220/D3220)
A. IF APPROVAL PRESENT - FORCE.
B. IF NO APPROVAL - DENY.

3. D5130, D5140 - IMMEDIATE DENTURES - DENY.

4. ORTHODONTIC BANDING (0835D, 0836D, 0837D, 0838D, 0840D, 0841D, 0856D, 0866D 0868D, 0870D, 0872D) EXAM - PA2. RES - IF AUTH SPECIFICALLY APPROVES AN ADDITIONAL BANDING - FORCE, OTHERWISE DENY.

5. 4442D - UNIV OF WA COMPREHENSIVE ORTHODONTIC TREATMENT - SPECIAL AGREEMENT - DENY.

6. 5556D - EARLY INTERCEPTIVE ORTHODONTIC - SPECIAL AGREEMENT WITH ODESSA BROWN - DENY.

MEDICAL VENDORS (P)

1. IF AUTHORIZATION ON CLAIM/COMMENT, CHECK FOR APPROVAL AND ADJUDICATE ACCORDINGLY.

2. PROTHETIC ITEMS: L5510, L5520 - ONE PER LIMB IN LIFETIME. IF USING MODIFIERS LT,RT - FORCE.

3. 64550 - APPLICATION OF SURFACE (TRANSCUTANEOUS) NEUROSTIMULATOR: PAY ONLY 1 PER CLIENT, UNLESS FOR DIFFERENT INJURIES (USE DIAGNOSIS FOR DETERMINATION) FORCE.

MEDICARE X-OVERS (O) (BOTH P & J) - FORCE

EPSDT (L)

PNEUMOCCOCAL VACCINE (90669) - ALLOW UP TO 4 MAX IN A LIFETIME,
DENY W/EOB 339 IF OVER. EXCEPTION: SEE NOT BELOW.
EXCEPTION: DO NOT COUNT ANY LINES IF MOD 1H/SL IS OR SHOULD BE PRESENT.
EXCEPTION: DO NOT COUNT ANY LINES IF AUTH INDICATING ETP FOR OVER MAX.
NOTE: IF SAME DOS IN HX & 1 CLAIM HAS MOD SL & 1 CLAIM HAS MOD 1H - PAY FIRST CLAIM BILLED AND DENY SECOND CLAIM W/EOB 102.

ALL CLAIM TYPES:

IF NOT SPECIFICALLY ADDRESSED OR UNSURE - OVERLOC TO 83

TEXT KEY TEXT DESC
300 NO PROVIDER MASTER RECORD - NO SYSTEM EOB

1. THIS IS A NUMBER IN THE SYSTEM THAT HAS NOT BEEN USED YET BUT COULD BE USED ACCORDING TO OUR NUMBERING SYSTEM.
   A. HARD COPY CLAIMS:
      1. DO AN ALPHA SEARCH ON THE PROVIDER'S NAME AND IF APPROPRIATE - CORRECT THE PROVIDER NUMBER.
      2. IF A GOOD NUMBER CANNOT BE FOUND - PUT ON THE DUMMY NUMBER AND FOLLOW THE TEXT IN 301.
   B. ELECTRONIC CLAIMS - KEY 9999905 AND WORK PER 416 TEXT.
2. IF A PROVIDER IS USING A "BILLING FIRM" OR THE FORMS ARE PREPRINTED - CONTACT THE PROVIDER AND DISCUSS THE INCORRECT NUMBER ON THE FORMS.
3. IF THERE ARE A LARGE AMOUNT OF ELECTRONIC CLAIMS, ALL FOR ONE PROVIDER - CONTACT THE PROVIDER TO FIX THE PROBLEM.

THE END

TEXT KEY TEXT DESC

301 NOTE: CLAIMS PROCESSING - SEE TEXT STARTING ON PAGE 6. *SR

PROVIDER TYPE	COMPATIBLE SPECIALTIES	CATAGORY OF SERVICE
15 - INDIAN HEALTH	70	84
17 - SPECIAL EYE CARE	47	98
18 - E.R. PHYSICIAN	01,02	29
19 - PSYCHIATRIST	35 - PEDIATRIC PSYCHIATRY	26
	36 - PSYCHIATRY	26
20 - PHYSICIANS	01 - GENERAL PRACTICE	20
	02 - GENERAL SURGERY	21
	06 - CARDIOVASCULAR DISEASE	
	10 - GASTRONENTEROLOGY	
	11 - AVIATN MED, INTERNAL MED	23
	29 - PULMONARY DISEASE	
	41 - INTERNAL MEDICINE	
	16 - OB-GYN	24
	24 - ORTHOPEDIC SURGERY	25
	36 - PSYCHIATRY	26
	40 - PEDIATRICS	28
ALL OTHERS - 03,04,07,08,13,14,18,22,23,24		30
25,28,30,32,33,34,44,47,64,70,82,83,84,85,89	(IF EPSDT 63)	

PROVIDER TYPE	COMPATIBLE SPECILITIES	CAT OF SVS
21 - PHYS OPERATORY	SAME AS PROV TYPE 20	30
22 - AMBULATORY SURG CENTER	47	30
23 - CASE MANAGEMENT	52,53,54,55	85
24 - HEALTH DEPARTMENT	44	85
25 - RADIOLOGY	30,32,82	27
26 - PHARMACIST	87	48,49,50,51
27 - DENTIST/DENTAL HYGENIST	09,12,19	40,41
28 - OPTOMETRIST	88	70
29 - OPTICIAN	88	70,71
30 - CHIROPRACTOR	98	72
31 - PSYCHOLOGIST	62	75
32 - PODIATRIST	48	73
33 - NURSES SERVICE	87	75
34 - PHYSICAL THERAPIST	65	75
36 - SPEECH & HEARING	64,76	75
37 - AUDIOLOGIST/SPEECH PATH.	64,76	75
38 - PROSTHETIST/ORTHOTIST	51	74
39 - DME SUPPLIER	51	74
40 - OTHER PROVIDERS	87	75
41 - BLOOD BANKS	87	85
42 - TRANSPORT BY PERSON	59	79
43 - LAB FACILITY	22,69	61
44 - HOME HEALTH FACILITY	87	62, 12
45 - TAXI	59	78
46 - N.H. - ECF	86	90
47 - N.H. - ICF	86	91
48 - ANESTHESIOLOGIST	05	22

49 - NURSE ANESTHETIST	05		75
50 - CABULANCE	59		77
51 - AMBULANCE	59		76
53 - AIR AMBULANCE	59		76
54 - NON-PROFIT TRANSPORT	59		79
55 - ITA TRANSPORTATION	59		95
57 - HOSPITAL - TYPE I	77,78,79,80,81		02,OP=12
58 - HOSPITAL - TYPE II	77,78,79,80,81		02,OP=12
59 - HOSPITAL - TYPE III	77,78,79,80,81		02,OP=12
61 - HOSPITAL - FULL CARE TYPE III (NOT ABOVE)	86,37.92.93		02,OP=12
62 - HOSPITAL - OP	77,78,79,80,81,86		12
64 - HOSPITAL - PSYCH	86	01=IH	11=OH
65 - CHILDRENS IP PSYCH	86		01
66 - EPSDT CLINIC	70		63
71 - FAMILY PLAN CLINIC	70		97
73 - VOL - COMM MNTL HLTH	70		98
74 - INVOL - COMM MNTL H	70		95
75 - SUBSTANCE ABUSE	70		98
78 - OXYGEN - CONTRACT	87		81
79 - OXYGEN - NON-CONTRACT	87		81
80 - N.H. - SNF	86		90
81 - INHALATION THERAPY (RESP) CONTRACT	67		81
82 - INHALATION THERAPY (RESP) NON-CONTRACT	67		81
83 - OXYGEN	87		81
84 - HEARING AIDS	51		82
85 - PHARMACY UNIT DOSE	87		51
86 - CONGREGATE CARE	86		94
87 - DAY HEALTH CARE	70		98
88 - RURAL HEALTH	70		83
89 - IMR FACILITY	86		93
93 - ADVCD REG NURSE PRACT	16		85
94 - MIDWIFE	15, 17		85
95 - MIDWIVES/CRN	01		85
96 - ASST. NON-DESIG MED TRANSPORTATION, NON-PROFIT TRANSPORT	59		79
97 - CORRESPONDENCE ONLY	N/A		N/A
99 - NON-PAYMENT PROVIDER (TAPE INTERMEDIARY)	99		N/A

NOTE

P/T 61 W/SPEC 92/93 FOR DETOX ADD CAT OF SVS	96
P/T 18, 20; T/S 3; PROC. CODES 0025M, 0026M	96
PROVIDER #S 2020436 EFFECTIVE 070197 (GLASS CONTRACT)	71
2017390 EFFECTIVE 070195 (GLASS CONTRACT)	71
2012482 EFFECTIVE 070191 (GLASS CONTRACT)	71

CLAIMS PROCESSING:

A. IF A FQHC (SPECIALTY 90) IS BILLING & THE PROVIDER'S FILE

1. DOES NOT STATE "FQHC X-OVER" ON THE 1ST OR 2ND PAGE ADDRESS - OVERLOC TO LOCATION 69 (PE).

2. DOES STATE "FQHC X-OVER" ON THE 1ST OR 2ND PAGE ADDRESS - FORCE THE 301 EXCEPTION.

B. IF A PROVIDER TYPE 34 (PHYSICAL THERAPIST) IS BILLING ON A CLIAM TYPE "M" WITH A MEDICARE DENIAL ATTACHED - DENY W/EOB 437. *SR

C. IF 301 IS POSTING BECAUSE YOU HAVE FORCED 127 AND USED EOB 119 TO DENY THE LINE - FORCE 301.

D. HOSPITAL X-OVER COMING IN ON TAPE (MEDIA 2):

IF THE DATES OF SERVICE ARE DURING THE STAY OF A NURSING HOME PATIENT - DENY 984.

PROVIDER ENROLLMENT:
IF THE PROVIDERS NUMBER DOES NOT CROSS TO A HOSPITAL NUMBER (EXAMPLE: NURSING HOME, FREE STANDING SPEECH AND HEARING, PSYCH, ALCOHOL/DETOX- DENY 301 WITH EOB 437. IF THE UNIT IS OPERATED BY AND IS IN THE HOSPITAL IT SHOULD BE CROSSED TO THE HOSPITAL NUMBER. EXCEPTION TO THIS WOULD BE A PHYSICAL THERAPY FACILITY OUTSIDE OF THE HOSPITAL - THEIR MEDICARE CERTIFICATION WILL INDICATE PART A COVERAGE - FORCE

ID-ONLY PROVIDER NUMBER:
IF THE PROVIDER NUMBER USED FOR BILLING PURPOSES IS AN "IDENTIFICATION ONLY" NUMBER (HOLD=30 ON PG.2 OF PROVIDER MASTER FILE SCREEN)- DENY CLAIM 367.

IF THE DATE(S) OF SERVICE ON THE CLAIM ARE "PRIOR" TO THE "ENROLLMENT STATUS" AND "CATEGORY OF SERVICE" DATES SHOWN ON THE PROVIDERS SCREEN, AND YOU HAVE CHECKED THE ORIGINAL DOCUMENTS USED TO ENROLL THE PROVIDER, AND OUR RECORDS ARE CORRECT, DENY THE CLAIM. HOWEVER, IF EXC 422 IS FORCED, FORCE EXC. 301.

CLAIMS PROCESSING:
IF THE PROVIDER:

1. BILLS ELECTRONICALLY AND THE PROVIDER NUMBER IS MISSING, THE SYSTEM WILL PLUG THE DUMMY NUMBER 0011601 - DENY 968.

2. USES A "INCORRECT PROVIDER #" FOR CLAIM FORM SUBMITTED - DENY 328.

#1 EXAMPLE: HOSPITALS FREQUENTLY USE THE "3" SERIES PROVIDER NUMBER ON ANY CLAIM THEY SUBMIT. WHEN THEY SUBMIT PHYSICIAN CHARGES (IE., EMERGERNCY ROOM PHYSICIAN), THEY MAY NOT USE THE EMERGENCY ROOM PHYSICIAN NUMBER. THIS SITUATION SHOULD BE DENIED WITH EOB 328.

#2 EXAMPLE: PROVIDER IS BILLING DIRECT ENTRY -(IDENTIFIED BY A 1 AS THE FIRST DIGIT ON ICN) AND PROVIDER NUMBER IS NOT COMPATABLE WITH CLAIM TYPE/PROCEDURE/REV CODES - DENY WITH EOB 328.

3. BILLS WITH NO PROVIDER #, ENTER 9999905 AND DENY 328.

PROVIDER ENROLLMENT:
IF PROVIDER TYPE 20 BILLING DETOX PROCEDURE CODES 0025M AND/OR 0026M-
UPDATE THE PROVIDER MASTER FILE WITH A 96 IN THE CATEGORY OF SERVICE
FIELD.

TEXT KEY	TEXT DESC
304	INVALID PERFORMING PROVIDER NUMBER

CHECK PROVIDER MASTER FILE, PAGE 3 AND SEE IF I.D. NUMBERS MAY BE ONE DIGIT OFF, NUMBER TRANSPOSED, ETC.

1. CORRECT IF ERROR FOUND.
2. IF NO ERROR AND NAME IS IN PERFORMING PROVIDER FIELD/OR COMMENTS - KEY 8999500.
3. ALL ELSE - DENY.

TEXT KEY TEXT DESC

306

PROVIDER NOT ACTIVE FOR CURRENT DATE. - NO SYSTEM EOB

IF YOU ARE TRYING TO TAKE MONEY BACK:
1. CHECK TO SEE IF THE PROVIDER HAS AN ACTIVE NUMBER. IF SO, PROCESS THE CLAIM AS A GROSS ADJUSTMENT USING THE ACITVE NUMBER.
2. IF THERE IS NO ACTIVE NUMBER DELETE THE CLAIM AND RETURN IT TO THE ORIGINATOR. MAKE A NOTE ON THE CLAIM "PROVIDER TERMINATED".

NURSING HOME CLAIMS ONLY:
1. CHECK THE PROVIDER SUMMARY - IF THE PROVIDER HAS CLAIMS IN THE SYSTEM - FORCE THE EXCEPTION CODE AND PROCESS THE CLAIM.
2. IF THERE ARE NO CLAIMS IN THE SYSTEM - DELETE THE CLAIM(S) AND ROUTE TO THE HEAD OF TPL.

TEXT KEY TEXT DESC
310

NOTE: IF THERE ARE NO UNITS LISTED ON THE EOMB CHECK THE CLAIM FOR UNITS AND IF IT MATCHES THE DATES OF SERVICE, USE THAT NUMBER. IF THERE ARE NO UNITS LISTED ON THE CLAIM ALLOW ONE PER DAY FOR EACH DATE OF SERVICE BILLED.

NOTE: IF THE RURAL HEALTH IS NOT SHOWING A PER DIEM RATE - FORCE.

NOTE: ENCOUNTER PROCEDURE CODES OR REVENUE CODES ARE NOT REQUIRED.

NOTE: IF EXCEPTION 301 IS POSTING - FORCE 301.

EFFECTIVE MAY 27, 2004: ONLY USE THIS UPDATED TEXT FOR PRICING RHC-(PROVIDER TYPE 88/SPEC 70) RURAL HEALTH CENTER MEDICARE CROSSOVERS, PER MARY WENDT.

EXAM ENTRY - USE THE MEDICARE EOMB BACK UP TO FIND:
A. ENCOUNTER RATE - MAY BE LISTED AS REIMBURSMENT OR PER DIEM RATE.
B. ENCOUNTER UNITS - MAY BE NEXT TO ENCOUNTER RATE OR SHOWN AS COVERED DAYS.
C. MEDICARE'S PAID AMOUNT. USE ZERO IF NO MEDICARE PAYMENT.
USE THIS FORMULA FOR PRICING:
"MEDICARE'S ENCOUNTER RATE" MULTIPLIED BY "ENCOUNTER UNITS" MINUS "MEDICARE'S PAID AMOUNT" EQUALS "MEDICAID'S PAYMENT"
"A" X "B" - "C" = PAYMENT

ALL ELSE - USE THE ORIGINAL TEXT BELOW. *SR

EFFECTIVE JAN 1, 1994.
THIS TEXT IS FOR PRICING RURAL HEALTH/FQHC CROSS-OVER CLAIMS.
1. EXAM ENTRY - USE THE MEDICARE EOMB BACKUP TO FIND:
A. ENCOUNTER RATE - MAY BE LISTED AS REIMBURSMENT OR PER DIEM RATE.
B. ENCOUNTER UNITS - MAY BE NEXT TO ENCOUNTER RATE OR SHOWN AS COVERED DAYS.
C. AMOUNT BILLED TO MEDICARE - MAY BE CALLED COVD CHARGES.
D. DEDUCTIBLE
E. CO-INSURANCE
F. AMOUNT PAID BY MEDICARE - MAY BE CALLED NET REIMBURSMENT.

1) ENTER THE CO-INSURANCE ON THE SCREEN WHICH IS THE LESSER OF:

A) 20% OF (ENCOUNTER RATE TIMES ENCOUNTER UNITS); HOWEVER, IF ENCOUNTER RATE IS A %, "A" DOES NOT APPLY.
B) 20% OF (AMOUNT BILLED TO MEDICARE),
C) CO-INSURANCE DUE, AS INDICATED BY PROVIDER ON THE FACE OF THE CLAIM
D) CO-INSURANCE DUE, AS INDICATED ON MEDICARE'S EOMB.

2) ENTER THE DEDUCTIBLE UP TO THE LESSER OF:

A) ENCOUNTER RATE TIMES THE UNITS.
B) AMOUNT BILLED TO MEDICARE.

C) DEDUCTIBLE DUE, AS INDICATED BY THE PROVIDER ON THE FACE OF THE CLAIM.
D) DEDUCTIBLE DUE, AS INDICATED ON MEDICARE'S EOMB.

NOTE: FQHC RURAL HEALTH PROVIDER TYPE 88, SPECALTY 90: AS OF MAY 1, 1993, NO DEDUCTIBLE IS ALLOWED - PAY ONLY THE CO- INSURANCE AS DESCRIBED ABOVE.

3) THE TOTAL CO-INSURANCE AND DEDUCTIBLE ENTERED SHOULD NOT EXCEED THE LESSER OF:

A) THE ENCOUNTER RATE TIMES THE UNITS, OR
B) AMOUNT BILLED TO MEDICARE.

NOTE: IF THE TOTAL DOES EXCEED EITHER A OR B, THEN REDUCE THE DEDUCTIBLE TO THE LESSER AMOUNT.

2. ELECTRONIC CLAIMS - DENY WITH EOB 226. THESE CLAIMS MUST BE BILLED ON THE UB-92, WITH MEDICARES EOMB ATTACHED.

TEXT KEY	TEXT DESC
312	SEALANTS ARE COVERED ON TOOTH NUMBERS A, B, I, J, K, L, S, T, 2, 3, 14, 15, 18, 19, 30 & 31 WHEN THE OCCLUSAL "O" SURFACE IS ONE OF THE SURFACES BILLED AND ON TOOTH NUMBERS 7 & 10 WHEN THE "L" SURFACE IS ONE OF THE SURFACES BILLED. 1. IF AUTHORIZATION NUMBER EE PA-2. RES - IF AUTHORIZED - FORCE. 2. ALL ELSE - DENY.

TEXT KEY TEXT DESC
313 UNABLE TO DETERMINE CATEGORY OF SERVICE

THE FOLLOWING CHART SHOWS APPROPRIATE "CLAIM FORM", "PROVIDER TYPE" AND "CLAIM TYPE" COMPATABILITY. IF THE PROVIDER HAS USED INCORRECT PROVIDER NUMBER FOR THE "CLAIM FORM" SUBMITTED, DENY WITH EOB 328 AND PA2 EXCEPTION CODE 332.
SEE "UNUSUAL SITUATION" EXAMPLES AT END OF CHART BEFORE YOU DENY.

CLAIM TYPE	BILLING FORM	PROVIDER TYPE	PROVIDER NUM BLOCK ON FORM
J	HCFA1500 TOS 3	15 - INDIAN HEALTH	BLOCK 33
P	HCFA1500 TOS 9	17 - SPECIAL EYE CARE (NA)	BLOCK 33
J	HCFA1500 TOS 3	18 - EMERGENCY PHYSICIANS	BLOCK 33
J	HCFA1500 TOS 3	19 - PSYCHIATRIST	BLOCK 33
J	HCFA1500 TOS 3	20 - PHYSICIAN	BLOCK 33
J	HCFA1500 TOS 3	21 - PHYS. OPERATORY (NA)	BLOCK 33
J	HCFA1500 TOS Z	22 - AMBULATORY SURG. CTR.	BLOCK 33
J	HCFA1500 TOS 3	23 - CASE MANAGEMENT	BLOCK 33
J	HCFA1500 TOS 3	24 - HEALTH DEPARTMENT	BLOCK 33
J	HCFA1500 TOS 3	25 - RADIOLOGY	BLOCK 33
D	525-106	26 - PHARMACY	UPPER LEFT
P	HCFA1500 TOS 9	26 - PHARMACY (MED SUPPLIES)	BLOCK 33
K	ADA DENTAL CLAIM	27 - DENTIST/DENTAL HYGENIST	BLOCK 44
J	HCFA1500 TOS 3	27 W/ SPEC. 09 - ORAL SURGEON	BLOCK 33
J	HCFA1500 TOS 3	28 - OPTOMETRIST	BLOCK 33
P	HCFA1500 TOS 9	29 - OPTICIAN	BLOCK 33
P	HCFA1500 TOS 9	30 - CHIROPRACTOR	BLOCK 33
J	HCFA1500 TOS 3	31 - PSYCHOLOGIST	BLOCK 33
J	HCFA1500 TOS 3	32 - PODIATRIST	BLOCK 33
P	HCFA1500 TOS 9	32 - PODIATRIST	BLOCK 33
P	HCFA1500 TOS 9	33 - NURSE SERVICES	BLOCK 33
P	HCFA1500 TOS 9	34 - PHYSICAL THERAPIST	BLOCK 33
J	HCFA1500 TOS 3	35 - MATERNITY SUPPORT SVS	BLOCK 33
J	HCFA1500 TOS 3	36 - NEUROMUSCULAR CENTER	BLOCK 33
J	HCFA1500 TOS 3	37 - AUDIOLOGIST/SPEECH PATH	BLOCK 33
P	HCFA1500 TOS 9	38 - PROSTHETIST/ORTHOTIST	BLOCK 33
P	HCFA1500 TOS 9	39 - DME SUPPLIER	BLOCK 33
J,P	HCFA1500 TOS 3 & 9	40 - OTHER PROVIDERS	BLOCK 33
	---SPECIAL 57 I.V. THERAPY IS THE ONLY ONE THAT TOS 9		
J	HCFA1500 TOS 3	41 - BLOOD BANKS	BLOCK 33
P	HCFA1500 TOS 9	42 - PRIVATE TRANSPORTATION	BLOCK 33
J	HCFA1500 TOS 3	43 - LAB FACILITY	BLOCK 33
P	HCFA1500 TOS 9	45 - TAXI	BLOCK 33
TAD	SYSTEM GENERATED	46 - NURSING HOME - ECF	N/A
TAD	SYSTEM GENERATED	47 - NURSING HOME - ICF	N/A
J	HCFA1500 TOS 3	48 - ANESTHESIOLOGIST	BLOCK 33
J	HCFA1500 TOS 3	49 - NURSE ANESTHESTIST	BLOCK 33
P	HCFA1500 TOS 9	50 - CABULANCE	BLOCK 33
P	HCFA1500 TOS 9	51 - AMBULANCE	BLOCK 33
P	HCFA1500 TOS 9	53 - LICENSED AIR AMBULANCE	BLOCK 33

P	HCFA1500 TOS 9	54 - NON-PROFIT TRANSPORT	BLOCK 33
P	HCFA1500 TOS 9	55 - ITA TRANSPORTATION	BLOCK 33
J	HCFA1500 TOS 3	58 - SCHOOL MED SERVICES	BLOCK 33
R&S	UB-82/UB-92	59 - HOSPITAL - TYPE III	BLOCK 8/51
R&S	UB-82/UB-92	61 - HOSPITAL - FULL CARE	BLOCK 8/51
M	UB-82/UB-92	62 - HOSPITAL - OUTPATIENT	BLOCK 8/51
M	UB-82/UB-92	63 - HOSPIAL - HOSPICE	BLOCK 8/51
S	UB-82/UB-92	64 - HOSPITAL - PSYCHIATRIC	BLOCK 8/51
S	UB-82/UB-92	65 - CHILDRENS IH PSYCH	BLOCK 8/51
L	HCFA1500 TOS 3	66 - HEALTHY KIDS/EPSDT	BLOCK 33
P	HCFA1500 TOS 9	71 - FAMILY PLANNING CLINIC	BLOCK 33
(AFTER 10-1-93 PT 71 CAN BILL AS TOS 3 - CLAIM TYPE J)			
J	HCFA1500 TOS 3	73 - VOL MENTAL HEALTH	BLOCK 33
J	HCFA1500 TOS 3	74 - INVOL MENTAL HEALTH	BLOCK 33
J	HCFA1500 TOS 3	75 - CHEMICAL DEPENDENCY	BLOCK 33
P	HCFA1500 TOS 9	78 - OXYGEN - CONTRACT	BLOCK 33
P	HCFA1500 TOS 9	79 - OXYGEN - NON-CONTRACT	BLOCK 33
TAD	SYSTEM GENERATED	80 - NURSING HOME - SNF	N/A
P	HCFA1500 TOS 9	80 - NURSING HOME - SNF	BLOCK 33
P	HCFA1500 TOS 9	81 - RESP. THERAP. CONTRACT	BLOCK 33
P	HCFA1500 TOS 9	82 - RESP. THERAP. NON-CONT	BLOCK 33
P	HCFA1500 TOS 9	83 - OXYGEN - CONTRACT (NA)	BLOCK 33
P	HCFA1500 TOS 9	84 - HEARING AIDS	BLOCK 33
D	525-106	85 - UNIT DOSE PHARMACY	UPPER LEFT
TAD	SYSTEM GENERATED	86 - CONGREGATE CARE (NA)	N/A
P	HCFA1500 TOS 9	87 - DAY HEALTH	BLOCK 33
J	HCFA1500 TOS 3	88 - RURAL HEALTH CENTER	BLOCK 33
TAD	SYSTEM GENERATED	89 - NURSING HOME - IMR	N/A
		90 - MANAGED HEALTH CARE	
J	HCFA1500 TOS 3	93 - ADVANCED REG NURSE PRACT	BLOCK 33
J	HCFA1500 TOS 3	94 - MIDWIFE	BLOCK 33
J	HCFA1500 TOS 3	95 - REG. NURSE SURGICAL ASST.	BLOCK 33
P	HCFA1500 TOS 9	96 - ASSORTED NON-DESIGNATED MEDICAL TRANSPORTATION	BLOCK 33
N/A	NO CLAIMS	97 - CORRESPONDENCE ONLY	N/A
		98 - LIEN HOLDER	
		99 - SUBMITTER #/INTERMEDIARY TAPE/MAIN/PC	

HCFA1500 BILLING FORMS
BLOCK "26" IS FOR THE PROVIDERS "INTERNAL" USE. THEY MAY PUT DSHS "IDENTIFICATION" NUMBERS IN BLOCK "25". THESE "IDENTIFICATION" NUMBERS ARE "NOT" TO BE USED FOR BILLING PURPOSES.

EXAMINERS: "UNUSUAL SITUATION" PROVIDER NUMBER EXAMPLES:

1. NURSING HOMES: (PROVIDER NUMBER BEGINNING WITH "4") SOME NON-CONTRACT OXYGEN WILL BE BILLED ON THE HCFA1500.

2. HOSPITALS: PROPER BILLING FORM IS THE UB-92 AND THE PROVIDER NUMBERS WILL BEGIN WITH A "3". IF HOSPITALS SUBMIT "OTHER THAN" HOSPITAL CHARGES (IE., EMERGENCY ROOM PHYSICIAN, ETC.) ON ANY OTHER "CLAIM FORM", THEY MUST HAVE A SEPARATE PROVIDER NUMBER. PHYSICIAN X-OVERS HAVE BEEN ASSIGNED A PROVIDER NUMBER BEGINNING WITH "93", THEY WILL USUALLY HAVE A PROVIDER

NUMBER BEGINNING WITH "7" FOR THEIR EMERGENCY ROOM PHYSICIAN CHARGES WHICH WOULD BE BILLED ON THE HCFA 1500.

3. UNITED CEREBRAL PALSY #4468401 - FORCE EXEPTION CODES 313 AND 301 FOR IMMUNIZATION - HEPATITIS B VACCINE.

4. DENTAL SERVICES BILLED ON A HCFA:
   A. DOS PRIOR TO 10/01/03 - DENY W/ EOB 933
   B. DOS 10/01/03 OR AFTER AND PROVIDER SPECIALTY IS OTHER THAN 09-ORAL SURGEON - DENY W/ EOB 933 *C

PROVIDER ENROLLMENT ONLY:

ON PAGE 2 OF THE PROVIDER MASTER SCREEN, A HOLD REVIEW "30" WILL INDICATE THAT THIS PROVIDER IS FOR IDENTIFICATION ONLY.

BE SURE THE MASTER PROVIDER FILE IS CORRECT. CHECK "PROVIDER TYPE" "PROVIDER SPECIALTY", "CATEGORIES OF SERVICE", "ENROLLMENT STATUS".IF ALL OF THE ABOVE ARE CORRECT, AND THE CORRECT PROVIDER NUMBER HAS BEEN USED ON THE CLAIM, FORCE EXCEPTION CODE 313 AND GIVE THE WORKSHEET TO SUPV. AFTER YOU HAVE PROCESSED. USUALLY EXCEPTION CODE 301 APPEARS WITH EXCEPTION CODE 313, IF SO, AND THE PROVIDER'S FILE IS CORRECTLY LOADED, FORCE 301 ALSO.
-- NOTE -- IF THE PROVIDER HAS USED AN "INCORRECT" PROVIDER NUMBER FOR THE CLAIM FORM SUBMITTED, AND THE "CORRECT" NUMBER IS ON FILE AND PROPERLY LOADED, YOU CAN DENY THE CLAIM WITH EOB 328. THIS EOB TELLS THE PROVIDER THAT HE HAS USED THE WRONG PROVIDER NUMBER ON THE CLAIM FORM AND THAT IF IT IS NECESSARY, HE MAY APPLY FOR AN APPROPRIATE PROV NUM.

IF THE CLAIM IS IN THE WRONG BATCH (I.E. PHYS IN MED VENDOR) DENY 333. IF THE SVS IF FOR CONTRACT PROVIDER AND OTHERS BILL - DENY 711. EXAMPLE 9272M.

TEXT KEY TEXT DESC

317 SERVICES RENDERED OUT-OF-STATE.

---HOSPITALS (M,R,S) CLAIMS - IF YOU HAVE AN EXCEPTION THAT TELLS YOU TO ADJUDICATE PER THE 317 TEXT - OVERLOC TO 72---

ALL CLAIM TYPES - ALL POLICY APPLIES AS FOR IN-STATE PROVIDERS EXCEPT:

WHEN DETERMINING IF A DX IS EMERGENT UNDER CERTAIN SECTIONS IN THIS TEXT, USE THE FOLLOWING GUIDELINES: YOU MAY USE THE "PA-IND" ON THE PDDD FILE.

CLAIMS FROM FOREIGN COUNTRY PROVIDERS ARE TO BE DENIED WITH EOB 307 AND ROUTED TO PRU. NOTE: IF THERE IS A PRU STAMP OR A PRU EXAMINER INITIAL - PROCESS AS NORMAL, DO NOT ROUTE TO PRU AS THEY HAVE ALREADY REVIEWED THE CLAIM.

ELIGIBILITY EXCEPTIONS - DO THE FOLLOWING:
A. IF PIC NOT ON CLAIM - SEARCH BY CASE NUMBER, SOCIAL SECURITY NUMBER, OR PARTIAL PIC. IF NOT FOUND - DENY ELIGIBILITY EXCEPTIONS.
B. RECIPIENT NOT ELIG - DENY ELIG EXCEPTIONS.
C. COUPON ATTACHED - ROUTE TO ELIG UNIT.

ATTENDING/PERFORMING/PRESCRIBING/ORDERING/REFERRING PROVIDER # - ENTER 8999500 IN APPROPRIATE FIELD.

MISSING DIAGNOSIS CODE - CHECK CLAIM/BACKUP, IF ICD-9 CODE NOT FOUND, SEE 000 TEXT FOR DIAGNOSIS CODES PERTAINING TO CLAIM TYPE, PROCEDURE OR PROVIDER TYPE AND ENTER APPROPRIATE DUMMY CODE. IF NOT FOUND - DENY MISSING DIAGNOSIS EXCEPTION.

INVALID DIAGNOSIS CODE - CHECK YOUR KEYING - IF OK AND THE FIFTH DIGIT IS ZERO TRY DROPPING - IF STILL INVALID - DENY.

1. HCFA 1500 USERS - PHYSICIAN/MED VENDOR
   A. FOR PROPER PLACE OF SERVICE, SEE 000 TEXT AND CONVERT TO MATCH PROCEDURE BILLED. IF NURSING HOME CALL, USE POS (8). ANY QUESTIONS ASK YOUR SUPERVISOR.
   B. (PHYSICIAN ONLY) SURGERIES W/ALLOWED AMT OVER $150.00 & NON-EMERGENT DIAGNOSIS OVERLOC TO 34 (NOTE: IF THERE IS AN EMERGENT DIAGNOSIS SOMEWHERE ON THE CLAIM FOR THAT DOS FORCE).
   C. ALL ELSE FORCE.

2. HOSPITAL CLAIMS (UB-92)

   A. DETERMINE APPROPRIATE CLAIM TYPE:
      1) ADMITS OF APPROXIMATELY 24 HOURS ARE TO BE PROCESSED AS OUTPT CLAIMS. CHANGE BILL TYPE TO 131.
      2) CLAIMS OF MORE THAN 24 HOURS AND SERVICES ARE FOR AN INPATIENT ADMIT (IDENTIFIED BY ROOM CHARGES OR AS LATE CHARGES) ARE TO BE PROCESSED AS AN "S" CLAIM, BILL TYPE 111.

B. NET CHARGE - CORRECT NET CHARGE IF OUT OF BALANCE FROM PATIENT PAY OR NON COVERED CHARGES

C. REVENUE CODES - M & S CLAIMS. (M - ALSO SEE #4 BELOW. S - SEE #5 BELOW ALSO)

--NOTE: PRIOR TO 5/1/95, REVENUE CODES ARE TO BE CONVERTED PER 317 TEXT. AFTER 4/30/95 DOS, CODES ARE TO BE ENTERED AS BILLED ON THE UB-92. WORK PER EXCEPTION CODES THAT SUSPEND.

1) PROFESSIONAL FEES (REV CODES 960-989)
   A) ONE EMERGENCY ROOM PROFESSIONAL FEE IS ALLOWED. CONVERT TO 599 AND MANUALLY PRICE AT $ 23.03. DO NOT EXCEED THE AMOUNT BILLED. IF MORE THAN ONE ER PRO-FEE, ONLY CONVERT AND PRICE THE HIGHEST ONE.
   B) OTHER PHYSICIAN PROFESSIONAL FEES; DO NOT CONVERT CODES AND DENY LINE EXCEPTION WITH EOB 318.
2) OCCUPATIONAL THERAPY (REV CODE 430) REFER TO 377 TEXT FILE. IF ALLOWED CONVERT TO 499. IF NOT ALLOWED DO NOT CONVERT AND DENY LINE EXCEPTION WITH EOB 325.
3) PSYCHOLOGICAL TEST OR (REV CODE 910); DO NOT CONVERT CODE - DENY LINE EXCEPTION WITH EOB 325.
4) GROUND AMBULANCE - CONVERT TO 499 - PRICE AS FOLLOWS:
   A) DOS ON/AFTER 1/1/90 = $73.81
   B) DOS ON/AFTER 7/1/92 = $75.25
   C) DOS ON/AFTER 1/1/93 = $79.00
5) REVENUE CODE 253 (TAKE HOME DRUGS) - CONVERT TO REVENUE CODE 499.
6) AIR AMBULANCE - (DO NOT FORCE EXCEPT 317 UNLESS STATED WITHIN THIS TEXT FILE)-
   EXAM ENTRY ONLY:
   A) IF AUTHORIZATION NUMBER BEGINNING WITH 7 IS ON CLIAM ENTER AND PA-2.
   B) IF MULTIPLE AUTHORIZATION NUMBERS (I.E. 7 @ AND OTHER AUTHORIZATION #) ENTER OTHER AUTH # AND PA-2.
   C) IF NO AUTHORIZATION NUMBER ON CLAIM - OVER LOC TO LOC 43 AND PA-2 THE CLAIM.
   D) IF AUTHORIZATION NUMBER ON CLAIM DOES NOT BEGIN WITH A 7 - ENTER AUTH NUMBER AND OVERLOC TO LOC 43 AND PA-2.

--NOTE-- 3A AND 3B - ROUTE CLAIM TO DUS MS-5540, ATTN TRANSPORTATION- NOTE ON ROUTING SLIP- OUT OF STATE AIR AMBULANCE.

RESOLUTIONS ONLY: (HOSPITALS)
   A) ACCESS AUTHORIZATION NUMBER AND MANUALLY PRICE LINE(S) PER AUTHORIZATION FILE NOTES. IF PRICING INFORMATION IS NOT ON FILE, OVERLOC TO LOC 43 AND PA-2. ROUTE THE CLAIM TO DUS FOR PRICING INFORMATION (SEE NOTE 3A/3B ABOVE). CONVERT REVENUE CODE TO 499 AFTER PRICING.
   B) CLAIMS RETURNED FROM DIS - IF 7 NUMBER ONLY - ENTER NUMBER AND PRICE TRANSPORTATION LINE. IF 2 AUTH NUMBERS ENTER THE AUTH NUMBER THAT DOES NOT BEGIN WITH A 7 - USE THE 7 NUMBER TO OBAIN PRICING INFORMATION. CONVERT

REVENUE CODES(S) AFTER PRICING.
C) FOLLOW REMAINDER OF TEXT TO DETERMINE IF EXCEPTION 317 IS FORCEABLE.

3. OUTPATIENT CLAIMS:

--NOTE: PRIOR TO 5/1/95, REVENUE CODES ARE TO BE CONVERTED PER 317 TEXT. AFTER 4/30/95 DOS, CODES ARE TO BE ENTERED AS BILLED ON THE UB-92. WORK PER EXCEPTION CODES THAT SUSPEND.

A. REVENUE CODES
1) CPT-4 PROCEDURE CODES ARE TO BE KEYED WITHOUT CONVERSION FOR LAB, X-RAY, AND THERAPY - EXCEPT: REV CODE 430 OCCUPATIONAL THERAPY (SEE PREVIOUS SECTION).
2) IF NO PROCEDURE CODE GIVEN FOR LAB, X-RAY AND THERAPY, KEY IN REV CODE AND DENY LINE EXCEPTION.
3) IF PROCEDURE CODE IS NOT VALID - DENY LINE EXCEPTION.
4) ALL OTHER REV CODES, NOT ADDRESSED IN THIS SECTION OR # 3 ABOVE, CONVERT TO 499.
B. ALL POLICIES APPLY AS IN-STATE, EXCEPT AS FOLLOWS:
1) FORCE EXC 176 (ONE DATE OF SERVICE PER CLAIM)
2) OUTPATIENT SURGERY OR SHORT STAY:
A) EXAM ENTRY: DX IS NON-EMERGENT, PA-2 IF AUTH # IS PRESENT. IF REIMBURSEMENT IS OVER $150 AND MEDICAL RECORDS ATTACHED - OVERLOC TO LOC 34, IF MEDICAL RECORDS NOT ATTACHED - DENY WITH EOB 239. IF REIMBURSEMENT IS UNDER $150 - FORCE.
RES: CLAIMS WITH AUTHORIZATION NUMBERS- REVIEW AUTH FILE TO DETERMINE IF SERVICES HAVE BEEN APPROVED. IF APPROVED-FORCE, IF NOT APPROVED - DENY 373. IF FILE IS UNCLEAR, ROUTE CLAIM AND WORKSHEET TO NCC'S AT MAILSTOP: 45540 FOR CLARIFICATION.

CLAIMS REVIEWED BY NCC'S (LOCATION 34) & APPROVED AS INDICATED BY A "Y" IN THE LMC APPROVAL FIELD ON THE WORKSHEET - ENTER THE "Y"; GIVE EOB 373 IN THE SECOND EOB SLOT & FORCE. IF NOT APPROVED - DENY W/EOB 023/373. NO AUTH NUMBER WILL BE ASSIGNED IN THIS SITUATION.

B) EMERGENT DIAGNOSIS - FORCE.

C. ALL ELSE FORCE.

4. DRG/INPATIENT CLAIMS

--NOTE: PRIOR TO 5/1/95, REVENUE CODES ARE TO BE CONVERTED PER 317 TEXT. AFTER 4/30/95 DOS, CODES ARE TO BE ENTERED AS BILLED ON THE UB-92. WORK PER EXCEPTIONS THAT SUSPEND.

A. REVENUE CODES (CONTINUED FROM SECTION 3) - VALID REVENUE CODES (EFFECTIVE 8/1/96 THROUGH 4/30/95) CONVERT AS FOLLOWS: ROOM CHARGES: 190-ACUTE, 193-INTENSIVE, 196-PSYCH, 599-ER PHYS, 499-ANCILLARY.

B. ADMIT TYPE, ADMISSION SOURCE, PATIENT STATUS, OR ADMIT DIAGNOSIS NOT INDICATED, ENTER:

ADMIT TYPE - 2 (URGENT)
ADMISSION SOURCE - 7 (EMERGENCY ROOM)
PATIENT STATUS - 01 (DISCHARGED)
ADMIT DIAGNOSIS - USE PRIMARY DIAGNOSIS (FIELD 67)

C. PSYCH SERVICES-
ITA (I): IF 88 NUMBER IS PRESENT CONVERT CLAIM TO VOLUNTARY "V" AND FORCE. IF NO 88 AUTH NUMBER PRESENT - EXCEPTION 586 IS POSTING - FORCE 317 AND DENY 586. NO 586 POSTING - DENY 317 WITH EOB 854.
VOLUNTARY (V): IF 88 NUMBER IS PRESENT - FORCE. IF NO 88 NUMBER PRESENT - EXCEPTION 586 IS POSTING- FORCE 317 AND DENY 586. IF NO 586 POSTING - DENY 317 WITH EOB 854.

D. EXAM ENTRY: NON-EMERGENT DIAGNOSIS; IF PRIOR AUTH # PRESENT- PA-2. IF THE APPROVED EXTENSION REQUEST ATTACHED - FORCE. IF NO APPROVAL OR EXTENSION REQUEST BUT MEDICAL RECORDS ATTACHED - OVERLOC TO LOC 34. IF NONE OF THE ABOVE - DENY WITH EOB 239.
RESOLUTIONS: CLAIMS WITH AUTH NUMBERS - REVIEW AUTH FILE TO DETERMINE IF SERVICES HAVE BEEN APPROVED. IF SO - FORCE, IF NOT APPROVED - DENY 373. IS FILE IS UNCLEAR, ROUTE CLAIM & WORKSHEET TO NCC'S AT MAILSTOP; 45540 FOR CLARIFICATION.

CLAIMS REVIEWED BY NCC'S (LOCATION 34) & APPROVED AS INDICATED BY A "Y" IN THE LMC APPROVAL FIELD ON THE WORKSHEET - ENTER THE "Y", GIVE EOB 373 IN THE SECOND EOB SLOT & FORCE. IF NOT APPROVED - DENY WITH EOB 023/373. NO AUTH NUMBER WILL BE ASSIGNED IN THIS SITUATION.

E. EMERGENT DIAGNOSIS - FORCE.

END

NOTE: CLAIMS CONTROL WILL STAGE ALL LOCATION 34 WORKSHEETS/CLAIMS AND ROUTE TO QFFS/BEV ATTERIDGE FOR REVIEW. AFTER REVIEW/PRICING/ETC, SHE WILL RETURN ALL CLAIM TYPES TO RENEE MORGAN/CLAIMS PROCESSING FOR DISPERSING AND/OR FINAL ADJUDICATION.

TEXT KEY	TEXT DESC
321	CAREMARK PHARMACY, PROVIDER # 6008239, WILL BE BILLING FOR CLOZARIL (NDC 78-0161-00). DO NOT PAY CAREMARK IF THEY BILL FOR ANY OTHER DRUG/NDC. PA2 ANYTHING ELSE.

TEXT KEY	TEXT DESC
325	IF THERE IS NO INDICATION ON THE CLAIM OF ACCIDENT THAT MIGHT HAVE INSURANCE AND TOTAL ALLOWABLE AMOUNT FOR SERVICES RELATED TO INCIDENT ARE LESS THAN $100.00. FORCE 325 EXCEPTION

TEXT KEY TEXT DESC

326 PROCEDURE CODE NOT COVERED UNDER PROGRAM

PHYSICIANS (J)
1. IF CLAIM/COMMENTS STATE (PERMANENT CONDITION) & THE PDDD FILES INDICATES (*BUNDLED):
   A. IF BILLED CHARGES ARE $50 OR UNDER - MANUAL PRICE AS BILLED.
   B. IF BILLED CHARGES ARE OVER $50 & INVOICE IS ATTACHED, MANUAL PRICE PER INVOICE, IF NO INVOICE, DENY W/EOB 196. IF ANY QUESTIONS - SEE SANDY A/MMIS.
2. IF ONLY (BUNDLED) ON PDDD - TREAT AS ACUTE OR TEMPORARY & DENY.
3. AUTH # - SEE EXCEPTION 611.

MEDICARE X-OVERS (O)

NOTE: READ ALL OF THE TEXT BEFORE ADJUDICATING.

1. PDD FILE DESCRIPTION OF PROC CODE IS UNUSED HCPCS CODE:
   A. HARDCOPY & PROCEDURE IS CPT ANESTHESIA (00100 - 01999) - DENY W/EOB 248.
   B. ALL ELSE - O'LOC TO 83.

2. PDD FILE DESCRIPTION OF PROCEDURE CODE IS NOT COVERED (6) -
   A. MPI IS "0", "2", OR "3" - DENY.
      EXCEPTION: IF CLAIM/COMMENTS STATES (PERMANENT CONDITION) & THE PDDD FILE INDICATES (*BUNDLED) - FORCE.
   B. MPI IS "1" - WORK EXC 430 OR 452 & PA-2 EXCEPTION 326.

3. PDD FILE DESCRIPTION OF PROCEDURE CODE IS MANUAL PRICE (5) - PA-2.

4. IF "Q" (QMB) IN ALLOWED SOURCE FIELD - FORCE.

5. IF PROCEDURE CODE 0005M (DUMP CODE) - O'LOC TO 83.

6. ALL ELSE - IF NO DIRECTION ABOVE - O'LOC TO 83.

BUNDLED SERVICES (X-OVER (O) CLAIMS TOS"3" SUSPENDED CLAIMS, PHYSICIAN (J) AND OUTPATIENT (M) ARE SET TO AUTO DENY)

MEDICARE HAS IDENTIFY SOME SERVICES AS BUNDLED. THESE SERVICES ARE PART OF A PREVIOUS SERVICE OR FOLLOWUP TO A PREVIOUS SERVICE AND THE PAYMENT FOR THESE SERVICES WAS INCLUDED IN THE ORIGINAL FEE, EVEN IF DONE BY A DIFFERENT PROVIDER.

IMMUNE GLOBULINS (90281,90283,90291,90379,90384,90385,90386,90389) - DENY W/EOB 302. THERE IS A "J" CODE AVAILABLE.

ALL ELSE - DENY.

TEXT KEY	TEXT DESC
327	F. Y. I.: THIS TEXT FILE IS HERE ONLY TO EXPLAIN THE HISTORY OF THIS EXCEPTION. WHEN THE OUTPATIENT FEE SCHEDULE WAS IMPLEMENTED AND WE BEGAN USING PROCEDURE CODES THAT REQUIRED APPROVAL, IT CHANGED THE CONCEPT OF HOSP AUTHORIZATION. BEFORE, AUTH WAS GIVEN TO APPROVE A STAY OR A BILLING AS A WHOLE, BUT NOW WE WANT TO APPROVE INDIVIDUAL SERVICES. THE OP HOSP RECORD ONLY CONTAINS A CLAIM LEVEL APPROVAL INDICATOR NOT LINE LEVEL INDICATORS AS THE NON-INSTITUTIONAL CLAIM RECORD DOES. THEREFORE WHEN A PRIOR AUTH NUMBER IS GIVEN AUTHORIZING EVEN ONE OF THE OP SERVICES BILLED AND THE CLAIM MAKES A MATCH TO IT, THE CLAIM LEVEL INDICATOR IS SET TO APPROVED AND THE WHOLE CLAIM, REGARDLESS OF OTHER SERVICES BILLED OR WHETHER OR NOT THOSE SERVICES REQUIRE APPROVAL, IS APPROVED. EXC 353 WOULD WORK ON NON-INST. CLAIMS, AS IT WOULD STILL POST TO THE LINES THAT NEEDED APPROVAL, BUT THIS AND THE OTHER APPROVAL APPROVAL EXCEPTIONS WERE SET TO BE BYPASSED IF A NUMBER GREATER THAN 0 WAS IN THE PA NUMBER FIELD. IN MAY '88 MPAS IS PURSUING SYSTEM CHANGES TO START POSTING THE APPROVAL EXCEPTIONS AGAIN REGARDLESS OF WHAT IS IN THE PA FIELD, HOWEVER THIS WILL NOT SOLVE THE OP HOSP PROBLEM. TO SOLVE THIS MPAS WILL BE ADDING A LINE ITEM LEVEL APPROVAL INDICATOR TO THE OP CLAIM RECORD. IN THE INTERIM, CONTROL CODE 02 WILL BE PUT ON ALL THOSE OP SERVICES THAT REQUIRE PRIOR APPROVAL BECAUSE EXC. 327 WILL STILL POST TO EACH LINE ON THE CLAIM EVEN THOUGH SOME SERVICES WILL MAKE A MATCH ON THE PA RECORD. THIS IS NOT TRUE OF EXC 353 (PRIOR APPVL) BECAUSE IT WILL SEE THE CLAIM LEVEL APPROVAL INDICATOR AND BE SATISFIED EVEN THOUGH THE APPROVAL WAS NOT FOR THAT PARTICULAR SERVICE 10/11/87 NO ONE COULD REMEMBER WHY CONTROL CODE 02 WAS ON OP P.T. CODES, SO IT WAS REMOVED AND THE EXCEPTION WAS TURNED OFF. IN MAY '88 THE SCENE OF THE CRIME WAS FINALLY RECREATED AND THE CONTROL CODE 02 PUT BACK ON THE PROCEDURE CODES AND THIS EXCEPTION WAS TURNED BACK ON FOR M CLAIM TYPE. 09/20/88 SYSTEM CHANGES WERE COMPLETED TO PUT LINE ITEM APPROVAL INDICATORS ON "M" CLAIMS. I TOOK THE 02 OFF PT/SPEECH THERAPY AND MRI'S.

TEXT KEY TEXT DESC

328 PROCEDURE TO RECIPIENT AGE.

IF CLIENT AGE OVER 99 YEARS - FORCE.

PROC CODES: 43520, 56000-59899, 5941M-5948M, 5957M-5959M O'LOC TO 83.

NOTE: EXAM ENTRY: IF AN AUTHORIZATION # PRESENT - O'LOC TO 23, UNLESS SOMETHING IN TEXT ALLOWS YOU TO FORCE IT.
LOC 23: REVIEW THE AUTHORIZATION SCREEN

NOTE: EXAM ENTRY: IF A CONSULTANT SIGNATURE PRESENT AND TEXT DOES NOT GIVE SPECIFIC DIRECTION - PUT A "Y" IN LMC & O'LOC TO 23.
LOC 23: REVIEW FOR PAYMENT OR DENIAL USING EOB INFO
EOB 373.

HEARING AIDS - SEE PAGE 12.

EPSDT (L):----------SEE PAGE 2 PHYSICIANS (J):----SEE PAGE 2
DENTAL (K):----------SEE PAGE 8 MED VENDOR (P):----SEE PAGE 12
MEDICARE CROSSOVER (O):SEE PAGE 16 OUTPATIENT (M):----SEE PAGE 16

EPSDT (L)

1. SCREENING CODES 99381,99391, INTERPERIODIC SCREEN 0252M, VACCINES THAT ARE IDENTIFIED ON PDDD AGE AS BILLABLE FOR CLIENTS UNDER 1 YR - FORCE IF BABY ON PARENTS PIC, UNLESS EXCEPTION LISTED BELOW:
2. PNEUMOCOCCAL 90669
   A. MOD 1H/SL OR AUTH ON CLAIM - FORCE;
   B. NO MONIES ON LINE - WORK 184/577 EXCEPTION FIRST.
   C. OTHERWISE, DENY W/EOB 023.
3. SYNAGIS (90378) SEE PHYSICIANS
4. ALL ELSE - DENY.

PHYSICIAN CLAIMS (J)

NOTE: PROCEDURES THAT ARE IDENTIFIED ON PDDD AGE AS BILLABLE FOR CLIENTS UNDER 1 YR - FORCE IF BABY ON PARENTS PIC, UNLESS EXCEPTION IS LISTED BELOW.

1. 0122D (FLUORIDE VARNISH)
   IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD. NON DD PATIENTS - DENY.
2. 92582 (CONDITIONING PLAY AUDIOMETRY, PEDIATRIC)
   A. IF MEDICAL CONSULTANT'S APPROVAL ON CLAIM OR AUTH # - FORCE.
   B. IF PATIENT IS MENTALLY CHALLENGED/UNABLE TO COMMUNICATE ABOVE THE LEVEL OF A 12 YR OLD CHILD - FORCE. (IE) DDD, DIAGNOSIS, BACKUP.
3. 92950 (CARDIOPULMONARY RESUSCITATION) - DENY WITH EOB 340. (PROVIDERS SHOULD BE USING 99152)
4. 31525 (LARYNGOSCOPY) EXCEPT NEWBORN
   A. IF NOT NEWBORN (OVER 4 WEEKS OLD) - FORCE

B. IF NEWBORN (UP TO 4 WEEKS OLD) - DENY.

5. STRABISMUS PROCEDURES (67311-67340)
DOS 9/1/94 THROUGH 6/30/00: (67311-67340)
EE: DENY W/EOB 325. EXCEPT: IF AUTH # OR CLAIM FOR ASSIST (MOD 80/81/82) OR ANESTHESIOLOGIST (PROV TYPE 48/49) - O'LOC TO 23.
RES: IF AUTH ON CLAIM IS FOR SERVICES BILLED AND CLAIM IS FOR:
SURGEON - SEE A & B BELOW.
ASSIST OR ANESTHESIOLOGIST
A. CHECK SYSTEM FOR AUTH #, IF AUTH # AVAILABLE - REVIEW BEFORE ADDING TO CLAIM.
B. CHECK STATUS ON LINE
1) STATUS IS "D" - DENY W/EOB 242
2) STATUS IS "A"
A) SERVICE DOES NOT MATCH - DENY W/EOB 251
B) SERVICE MATCHES
1. DOS NOT ON AUTH - DENY W/EOB 245
2. DOS ON AUTH FILE - FORCE.
DOS 7/1/00 AND AFTER: (67311-67340)
EE: IF 67343 IS BILLED IN COMBO W/67311-67340 & AUTH # FOR THOSE SERVICES - FORCE 328 EXCEPTION FOR 67343, OTHERWISE- DENY W/EOB 325.
EE: CODES 67311-67340 - DENY W/EOB 828, EXCEPT IF AUTH # OR CLAIM IS FOR ASSIST (MODS 80/81/82) - O'LOC TO 23.
RES: IF AUTH # ON CLAIM AND SERVICE/DATES MATCH - FORCE EXCEPTION 328. IF EXCEPTION 353 IS STILL POSTING, WORK 353.

6. BLEPHAROPLASTIES (67901 - 67908)
DOS PRIOR TO 7/1/00
EE: DENY W/EOB 325, EXCEPT IF AUTH # ON CLAIM, THEN O'LOC TO 23.
RES: IF AUTH ON CLAIM IS FOR SERVICES BILLED, ADD TO CLAIM & FORCE 328, OTHERWISE, DENY W/EOB 251.
DOS 7/1/00 & AFTER
EE: IF AUTH # ON CLAIM, FORCE 328 & O'LOC THE 353 EXCEPTION TO LOC 23, OTHERWISE - DENY W/EOB 828.
RES: IF AUTH ON CLAIM IS FOR SERVICES BILLED, EXCEPTION 353 SHOULD NOT BE POSTING, OTHERWISE - DENY 353 W/EOB'S 251/828.

7. EPIPHYSEAL PROCEDURES (25450,25455,27185,27475,27477-27485,27742 27730-27740) DENY W/EOB 325. EXCEPT: IF AUTH # OR CLAIM IS FOR ASSIST (MOD 80/81/82) OR ANESTHESIOLOGIS (PROV TYPE 48/49) - PA-2. RES: IF AUTH IS FOR SERVICES BILLED - FORCE, IF ASSIST OR ANESTHESIOLOGIST - CHECK SYSTEM FOR AUTH #, IF AUTH # OR CLAIM IS FOR ASSIST (MOD 80/81/82) OR ANESTHESIOLOGIST (PROV TYPE 48/49) - PA-2.
RES: IF AUTH ON CLAIM IS FOR SERVICES BILLED AND CLAIM IS FOR:
SURGEON - SEE A & B BELOW.
ASSIST OR ANESTHESIOLOGIST
A. CHECK SYSTEM FOR AUTH #, IF AUTH # AVAILABLE - REVIEW BEFORE ADDING TO CLAIM.
B. CHECK STATUS ON LINE
1) STATUS IS "D" - DENY W/EOB 242
2) STATUS IS "A"
A) SERVICE DOES NOT MATCH - DENY W/EOB 251
B) SERVICE MATCHESON) - IF DX OTHER THAN (605,607.1,607.81) -

1. DOS NOT ON AUTH - DENY W/EOB 245.
2. DOS ON AUTH FILE - FORCE.

8. 54152, 54160 (CIRCUMCISION) - IF DX OTHER THAN (605,607.1, 607.81) - DENY THE 328 & USE EOB 331 IN 2ND SLOT, OTHERWISE DENY.

9. 0400M - 0421M (MATERNITY SUPPORT) - DENY.

10. 90669 (PNEUMOCCOCAL VACCINE)
A. MOD 1H/SL OR AUTH ON CLAIM - FORCE.
B. NO MONIES ON LINE - WORK 184/577 EXCEPTION FIRST.
C. OTHERWISE, DENY W/EOB 023.

11. 90732 (PNEUMOCCOCAL VACCINE) - DENY W/EOB 302.

12. 90378 (SYNAGIS)
1. IF NON-COVERED FOR DOS ON PDDD & NO AUTH # ON CLAIM - USE INFO EOB 055.(326 EXCEPTION SHOULD BE DENIED, NO AGE GETS SYNAGIS DURING OFF SEASON).
2. IF COVERED FOR DOS ON PDDD FILE - EE: IF AUTH. # ON CLAIM, O/L TO LOC. 23. NO AUTH # - DENY.

LOC. 23: CHECK AUTH SCREEN FOR PROCEDURE/UNITS, IF APPROVED, ETC. - FORCE. (AGE 1 & OVER REQUIRES APPROVAL DURING ON SEASON. *BJS

13. EXAM ENTRY: IF A CONSULTANT SIGNATURE PRESENT AND TEXT DOES NOT GIVE SPECIFIC DIRECTION - PUT A "Y" IN THE LMC AND PA2. RESOLUTIONS: REVIEW FOR PAYMENT OR DENIAL USING INFO EOB 373.

14. CRITICAL/PEDIATRIC/INTENSIVE CARE SERVICES
A. 99291/99292:
1. DOS PRIOR TO 1/1/03 - FORCE ANY AGE.
2. DOS 1/1/03 & AFTER - DENY.
B. 99293/99294/99295/99296/99297/99298/99299
1. BABY ON PARENTS PIC - FORCE.
2. ALL ELSE - DENY.

15. 0076M/0079M (MATERNITY CASE MANAGEMENT) - DENY WITH EOB 153.
16. T1017 (INFANT CASE MNGMT BILLED BY PROVIDER TYPE 35-MSS)
IF DOS IS UP TO THE END OF THE MONTH OF BABY'S 1ST BIRTHDAY - FORCE. ALL ELSE DENY.
NOTE: THIS SERVICE SHOULD NOT BE BILLED ON MOM'S PIC.
17. 97802,97803 (MEDICAL NUTRITION THERAPY,AGES 21-60) - IF AUTH # FOR SERVICES ABOVE - FORCE.
18. IF OTHER THAN THE ABOVE - DENY.

DENTAL CLAIMS (K)

1. D1203 (FLUORIDE)
A. IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING
1) DOS PRIOR TO 11-1-02 - CHANGE PROCEDURE CODE TO 0121D WITH INFO EOB 359.
2) DOS 11-1-02 - 9-30-03 - FORCE.
3) DOS 10-1-03 AND AFTER - DENY

B. NON DDD PATIENT AGE 19-65 - IF AUTHORIZED
070197 TO 063000 - MANUAL PRICE AT $13.13
070100 TO 093003 - FORCE
C. NON DD PATIENT AGE 65 OR OLDER AND DOS 7-1-00 TO 9-30-03 - FORCE.
D. ALL ELSE - DENY.

2. D1204 (FLUORIDE-ADULT)
A. IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, AND AGE 19 OR OVER - FORCE
B. NON DDD PATIENT AND AGE 19 OR OVER - IF AUTHORIZED - FORCE.
C. ALL ELSE - DENY.

3. 0122D & 0123D (FLUORIDE VARNISH)
IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD. NON DD PATIENTS - DENY.

4. D2140-D2161 AND D2385-D2387 HAVE AN AGE RESTRICTION DUE TO THE THE DESCRIPTION. IF THE PROVIDER STATES THAT THE PATIENT ALREADY HAS PERMANENT TEETH, OR SERVICES FOR PERMANENT TEETH ARE ALSO BEING BILLED - FORCE. OTHERWISE - DENY.

5. D4210 - GINGIVECTOMY/GINGIVOPLASTY:
A. DOS PRIOR TO 8-1-03 - FORCE.
B. DOS 8-1-03 OR AFTER - IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD.

5. 0923D - ORAL SEDATION - IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD.

6. D9230 - NITROUS OXIDE - IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD.

7. D9920 - BEHAVIOR MANAGEMENT
A. DOS 1-1-01 TO 6-30-01 - FORCE.

B. DOS 7-1-01 AND AFTER:
1) IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD.
2) IF NOT A DDD PATIENT (NO EXCEPTION 498 POSTING) - DENY.

8. D9951 (OCCLUSAL ADJUSTMENT)
A. CLAIM IS AUTHORIZED - FORCE.
B. CLAIM NOT AUTHORIZED - DENY 323.

9. CLAIMS WITH AUTHORIZATION # - PA2 TO RES - RES FINALIZE.
10. D4341,D4342,0435D OR D4910 (PERIODONTAL SCALING & ROOT PLANING AND PERIO MAINTENANCE) - IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD. NON DD PATIENTS - DENY.

11. 0998D (BEHAVIOR MGMT)
A. IF DDD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD.

B. IF NOT DDD PATIENT (NO EXCEPTION 498 POSTING) - DENY.

12. 4420D-4422D (LIMITED VISUAL ORAL ASSESSMENT)
IF DD PATIENT INDICATED BY EXCEPTION 498 POSTING, FORCE AND ENTER A "D" IN THE ITA INDICATOR FIELD.

13. EXAM ENTRY: IF AN AUTHORIZATION # PRESENT - PA-2 UNLESS SOMETHING IN TEXT ALLOWS YOU TO FORCE IT. RESOLUTIONS: REVIEW THE AUTH SCREEN.

14. EXAM ENTRY: IF A CONSULTANT SIGNATURE PRESENT AND TEXT DOES NOT GIVE SPECIFIC DIRECTION - PUT A "Y" IN THE LMC AND PA2. RESOLUTIONS REVIEW FOR PAYMENT OR DENIAL USING INFO EOB 373.

15. ALL ELSE - DENY.

MEDICAL VENDOR (P)

1. LENSES (0069V, 0073V) - DENY.

2. SCRATCH RESISTANT LENS COATING (0168V, 0169V, 1161V, 1162V) IF DDD CLIENT (INDICATED BY EXCEPTION 498 POSTING) - FORCE. ALL ELSE - DENY.

3. ADULT DAY HEALTH (0801H-0821H, NEW), (9801H-9809H, OLD) - EXAM ENTRY - IF USING THE WRONG CODE FOR AGE - DENY.

4. HEARING AIDS--DOS PRIOR TO 10/1/03---
A. CHILDREN'S CODES: 5052V,5053V,5054V,5055V,5056V,5057V,5058V,
(AGES 17 & UNDER) 5059V, 5060V,5061V,5062V,5063V,5064V,5065V,
5066V,5067V,5068V,5069V,5021V,5040V,5042V,
5044V,5046V.
1. EE- CHECK FIELD 23 (PRIOR AUTHORIZATION) FOR A (CSHCN) OFFICE OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS STAMP AND SIGNATURE BY THE CSHCN COORDINATOR.
2. IF NO STAMP - DENY W/329
3. IF NO SIGNATURE WITH STAMP - DENY WITH EOB 329.
4. IF STAMP AND SIGNATURE PRESENT-CHECK FOR INITIAL OF (CSHCN COORDINATOR) ON EACH LINE ITEM - IF INITIAL IS NOT PRESENT - DENY THE LINE ITEM WITH EOB 329.
5. IF STAMP AND SIGNATURE AND ALL LINES ARE INITIALED BY (CSHCN COORDINATOR)- PUT H IN ITA FIELD. *C
6. IF LINE ITEM STATES - DENIED WITH INITIALS/DENY WITH EOB 593
7. IF LINE ITEM STATES - DENIED AND NO INITIALS ARE ON THE LINE - DENY WITH EOB'S 329/593.
8. IF ALL CRITERIA ARE MET - FORCE.

NOTE:
ONLY (CSHCN) STAMP ACCEPTED READS:
DEPARTMENT OF HEALTH CSHCN COORDINATOR

- CHECK BOX 19 (ITA)- IF "H" KEY IN & FORCE
B. IF THE CLAIM IS FOR AN ADULT (18 AND OVER) AND BILLING CHILDREN'S CODE LISTED ABOVE - DENY, UNLESS PRIOR AUTHORIZATION PRESENT.

IF AUTHORIZATION PRESENT - OVERLOC TO 23.

C. ADULT CODES (18 AND OVER) 5047V-5051V, V5050(RR), 5002V-5004V & CLAIM IS FOR A CLIENT 17 OR UNDER - DENY.

----HEARING AIDS FOR DOS ON OR AFTER 10/1/03----
A. CLIENTS 17 AND UNDER & CODES V5014, V5030, V5040, V5050, V5060, V5100, V5130, V5140, V5246, V5247, V5252, V5253, V5264 & V5274 ARE ON THE CLAIM.
1. CHECK BOX 19 IF "H" KEY IN & ENTER CLAIM. EMC CLAIMS - CHECK COMMENTS FOR INITIALS CSHCN & IF PRESENT KEY H IN ITA & ENTER.
2. CHECK BOX 23 FOR CSHCN STAMP & SIGNATURE.
3. CHECK FOR INITIAL OF CSHCN COORDINATOR ON EACH LINE ITEM.
4. IF STAMP & SIGNATURE AND ALL LINES ARE INITIALED PUT AN "H" IN ITA AND ENTER CLAIM.
5. IF ANY OF ELEMENTS FROM #2 & #3 ARE MISSING - DENY W/329.
6. IF THE CSHCN COORD. INDICATES TO DENY A LINE - DENY LINE W/593.
B. CLIENTS 18 AND OLDER & CODES V5040, V5100, V5130, V5140 & V5274 ARE ON THE CLAIM.
1. IF CLAIM HAS AUTHORIZATION NUMBER - OVERLOC TO 23.
2. IF NO AUTHORIZATION NUMBER - DENY.
C. ALL ELSE OR ANY QUESTIONS - OVERLOC TO 67.

5. DIAPERS - NO PRIOR AUTH # ON CLAIM
A. DIAPERS 4610A-4612A
1) PRIOR TO DOS 8/15/00, AGES 3 YRS & UP -FORCE.
2) PRIOR TO DOS 8/15/00, AGES 0-2 YRS - DENY.
3) DOS 8/15/00 & AFTER, AGES 3-18 YRS - FORCE
4) DOS 8/15/00 & AFTER, AGES 19 YRS & UP - DENY.
B. DIAPERS 4620A, 4625A AND 4630A
1) PRIOR TO DOS 8/15/00, AGES 3 YRS & UP - FORCE
2) PRIOR TO DOS 8/15/00, AGES 0-2 YRS - DENY.
3) DOS 8/15/00 & AFTER, AGES 3-18 YRS - DENY
4) DOS 8/15/00 & AFTER, AGES 19 YRS & UP - FORCE.
C. REUSABLE PANTS-4795A 1P OR RR MOD.-PRIOR TO DOS 6/1/03-FORCE
D. PANT LINER/INSERT 4796A-PRIOR TO 6/1/03-FORCE
E. DISPOSABLE PANT-4797A-PRIOR TO 6/1/03-FORCE
6. ALL ELSE - DENY.

OUTPATIENT (M)

1. IF CLAIM FOR BABY ON MOMS PIC - FORCE.
2. 90378 (SYNAGIS)
A. IF NON COVERED FOR DOS ON PDDD & NO AUTH # ON CLAIM - USE INFO EOB 055. (EXCEPTION 326 SHOULD BE DENIED, NO AGE GETS SYNAGIS DURING OFF SEASON UNLESS APPROVAL)
B. IF COVERED FOR DOS ON PDDD FILE - DENY, UNLESS AUTH, THEN CHECK AUTH SCREEN FOR PROCEDURE/UNITS, IF APPROVED, ETC - FORCE. (AGE 1 & OVER REQUIRES APPROVAL DURING ON SEASON).
3. OTHERWISE - DENY.

MEDICARE X-OVER (O) - EFFECTIVE 5/15/96 PROCESSING DATE - MEDICAID AUDITS/LIMITS DO NOT APPLY TO X-OVER CLAIMS - (PRIOR AUTH, INVALID AGE TO PROCEDURE, ECT). NEW AUDITS ARE BEING DEVELOPED FOR MEDICARE HCPC

CODES VS STATE ASSIGNED. IF THE AUDIT/EDIT IS OTHER THAN TIMELINESS, ELIGIBILITY OR PROVIDER NUMBER PROBLEM - OVERLOC 35

TEXT KEY TEXT DESC

330 ASSISTANT/CO SURGERY/TEAM NOT ALLOWED FOR THIS PROCEDURE.

PHYSICIAN:

1. 5947M - DENY W/EOB 036.
2. PT 95 - DENY.
3. IF AUTH # PRESENT - OVERLOC TO 36.
   (LOC 36 - SEE EXCEPTION 368)
4. ALL ELSE - DENY. (NOTE) NO EXTRA PAYMENT FOR HIGH RISK (MOD TG) IS MADE FOR ASSIST AT DELIVERY.

LOC 36:
IF NOTES PAGE ON AUTH STATE SERVICES AUTHORIZED FOR AN ASSISTANT - AND SERVICE IS PAYABLE - MANUAL PRICE CLAIM AT 20% OF GLOBAL FEE FOR THE APPROPRIATE POS. REMEMBER TO CONSIDER MULTI SURGERY POLICY.

X-OVER'S (O) TOS 3: *T

1. MODIFIER 62(CO-SURGEON) OR 66(SURGICAL TEAM):
   EE - 0'LOC TO 09
   RES LOC 09:
      A. IF MEDICARE PAID - LOOK AT MAX ALLOWED FOR DOS & MULTIPLY MAX ALLOWED X 62.5% = NEW MAX ALLOWED.
         1. IF OUR ALLOWED IS LESS - DENY 330 W/EOB 030.
         2. IF OUR ALLOWED IS MORE:
            A. SUBTRACT MDCR PD FROM OUR NEW ALLOWED.
            B. MANUAL PRICE LINE W/PAYMENT DUE.
            C. IF MDCR PD MORE THAN WE ALLOW - DENY 330 W/EOB 030.
      B. IF MEDICARE DENIED (453 EXC) - DENY W/EOB 095.

2. MODIFIER 80/81/82 (ASSIST SURGEON) -
   A. IF 453 EXC AUTO DENY ON SAME LINE - FORCE.
   B. IF CLAIM BEING TOTALLY DENIED AT HEADER OR ON ALL LINES - FORCE.
   C. ALL ELSE - O'LOC TO 83

TEXT KEY TEXT DESC

331 PROCEDURE REQUIRES A MANUAL PRICE.

AMBULATORY SURGERY CENTERS/PT 22 - SEE PAGE 15.
DENTAL - SEE PAGE 16
MED VENDOR - SEE PAGE 21

OUTPATIENT CLAIMS - SEE PHYSICIAN CLAIMS SECTION, IF TEXT DOES NOT COVER SITUATION, THEN OVERLOC TO 83.
EXCEPTION FOR M CLAIMS - 90656 - OL TO 67
ANY CODES NOT ADDRESSED BELOW (EXCEPT CLAIM TYPE P) - OVERLOC TO 83.
EXCEPTION TO ABOVE - IF PDDD FILE STATES (MEDICARE X-OVER ONLY) FOR "J"S SEE TEXT.

PHYSICIAN CLAIMS (J) TOS - 3

1. R0076 - TRANSPORTATION OF PORTABLE EKG TO FACILITY/LOCATION, PER PATIENT. IF BILLED WITH 93000 OR 93005 - MANUAL PRICE AT 45% OF BILLED AMT. ALL ELSE - DENY W/EOB 325.

2. 0800M - ANTI-HEMOPHILIC FACTOR (E.G., KOATE, MONOCLATE) - THIS CODE NEEDS TO BE MANUALLY PRICED AT THE CORRECT AMOUNT LISTED BELOW. LOOK FOR THE CORRECT UNITS ON THE CLAIM FORM. THE DATES LISTED BELOW ARE DATE OF SERVICE.

   EFF JULY 1, 02 - $.91 EFF JULY 1, 01 - $.90 EFF JULY 1, 00 - .88
   EFF JULY 1, 99 - $.86 EFF JULY 1, 97 - $.85 EFF JULY 1, 95 - .82
   EFF JULY 1, 98 - $.84 EFF JULY 1, 96 - $.84 EFF JULY 1, 94 - .80

   THE CORRECT AMOUNT OF UNITS WILL BE LISTED ON THE CLAIM (THIS WILL NOT BE THE ONE UNIT LISTED IN THE UNITS COLUMN. USE EOB 852 WHEN MANUALLY PRICING.
   PAY THE M/P OR THE BILLED AMOUNT WHICHEVER IS LESS. USE YOUR CALCULATOR AS THESE ARE LARGE MONEY AMOUNTS AND CHECK WITH YOUR SUPERVISOR IF YOU HAVE ANY QUESTIONS.

3. 0228B - (IV SUPPLY NOT OTHERWISE CLASSIFIED - TOS 3) OVERLOC TO 47.

4. 0355M, 0357M - OVERLOC TO 83.

5. DIABETIC EDUCATION VALID FOR FOLLOWING CODES AND PROVIDERS:
   1650M, 1651M, 1652M, 1653M, 1654M, 1655M AND;
   S9445, S9460, S9465

NOTE: (NOW IN NUMERIC ORDER)		EFFECTIVE:	THRU:	
1285006	DARRINGTON HOSPITAL GUILD	08/01/95	08/01/95	
1771609	NORTHWEST DIABETES CENTER, BELLINGHAM	09/01/00	12/31/03	
7002595	NORTH MASON MED CLINIC, BELFAIR	07/01/02	12/31/05	
7014012	ROCKWOOD CLINIC PS, SPOKANE	07/01/00	12/31/06	*S
7033897	YAKIMA VALLEY FARMWORKERS CL,TOPPENISH	08/01/02	12/31/05	
7033913	YAKIMA VALLEY FARM WORKERS CL, YAKIMA	08/01/00	12/31/03	

7033939	COMM HLT CARE,PARKLAND CL, TACOMA, WA	01/01/03	12/31/05	
7033939	COMM HLT CARE,DOWNTOWN CL, TACOMA, WA	01/01/03	12/31/05	
7033939	COMM HLTH CARE,DOWNTOWN CL, TACOMA, WA	01/01/03	12/31/05	
7033939	COMM HLTH CARE,TILLICUM CL, LAKEWOOD	01/01/03	12/31/05	
7033939	COMM HLTH CARE,SOUNDVIEW CL, TACOMA	01/01/03	12/31/05	
7033939	COMM HLTH CARE,SUMNER CL, SUMNER	01/01/03	12/31/05	
7033939	COMM HLTH CARE, LAKEWOOD CL,TACOMA	01/01/03	12/31/05	
7033939	COMM HLTH CARE,EASTSIDE CL, TACOMA	01/01/03	12/31/05	
7033939	COMM HLTH, SPANAWAY, WA	01/01/03	12/31/05	
7033962	COMM HLTH CTR KING,AUBURN CL, AUBURN	07/01/01	12/31/04	
7033970	COMM HLTH CTR KING,KENT CLINIC,KENT	07/01/01	12/31/04	
7033988	COMM HLTH CTR KING,EASTSIDE CL,REDMOND	07/01/01	12/31/04	
7034028	YVFWC/FAMILY MED CTR, WALLA WALLA	10/01/00	12/31/03	
7034036	COMM HLTH CTR OF SNOHOMISH, EVERTT	07/01/99	12/31/02	
7034051	INTERNATIONAL COMM HLTH, SEATTLE	12/01/99	12/31/05	
7034077	CHEWELAH COMM HLTH CNTR, CHEWELAH	03/01/02	12/31/04	
7034085	45TH STREET CLINIC	02/01/98	12/31/00	
7034093	CHEWELAH COMM HEALTH, CHEWELAH	03/01/02	12/31/04	
7034127	SPRINGDALE COMM HEALTH, SPRINGDALE	03/01.02	12/31/04	
7034135	KETTLE RIVER COMM HEALTH CNTR, ORIENT	03/01/02	12/31/04	
7034150	NORPORT COMM HEALTH CNTR, NORTHPORT	03/01/02	12/31/04	
7034168	PIKE MARKET MED CLINIC	08/01/97	12/31/06	*S
7034176	PUGET SOUND NEIGHBORHOOD, RAINER PK	02/01/96	12/31/02	
7034184	SEA-MAR CHC/MT. VERMON	07/01/98	12/31/04	
7034192	SEA-MAR CHC SMOKEY POINT/ARLINGTON	01/01/03	12/31/05	
7034218	SEA-MAR SEATTLE	11/01/95	12/31/01	
7034226	SEATTLE INDIAN HEALTH BOARD	06/01/96	12/31/05	
7034580	PUGET SOUND NEIGHBORHOOD HIGH POINT	02/01/96	12/31/02	
7038540	INTERFAITH FAMILY HLTH CENT,BELLINGHAM	05/01/01	01/01/02	
7038557	PACIFIC MEDICAL CENTER	11/01/97	12/31/02	
7047053	LOWER ELWHA KLALLAM TRIBE, PORT ANGLES	05/01/00	12/31/06	*S
7047228	YAKIMA NEIGHBORHOOD HEALTH	02/01/97	12/31/05	
7052582	COLUMBIA VALLEY COMM, WENATCHEE	08/01/99	12/31/05	
7053366	COMM HLTH CTR, FED WAY CL, FEDERAL WAY	07/01/01	12/31/04	
7058423	SEA-MAR BELLINGHAM	02/01/96	12/31/04	
7060643	FAMILY HEALTH CTR OF OKANOGAN	05/01/97	12/31/00	
7062284	MOSES LAKE COMM HLTH CTR, MOSES LAKE	05/01/00	12/31/06	*S
7063415	SAMARITAN HLTHCARE/ASSOC,MOSES LAKE	04/01/02	12/31/03	
7064678	SELKIRK COMM HLTH CNTR, IONE	03/01/02	12/31/04	
7067150	SEATTLE-KING CO NORTH PUB HD,SEATTLE	07/01/03	12/31/06	
7069040	PACIFIC NW MATERNAL-FETAL MED, TACOMA	02/01/02	06/30/02	
7069461	PENINSULA COMM HEALTH SERVICES	11/01/01	12/31/04	
7070675	LA CLINICA DEL CARINO, HOOD RIVER, OR	07/01/99	12/31/02	
7071269	SEA-MAR TACOMA	02/01/98	12/31/00	
7076862	KLICKITAT VALLEY HEALTH SERVICES	02/01/02	02/01/02	
7079668	COMMUNITY HLTH ASSOC. OF SPOKANE	07/01/98	12/31/04	
7079676	COMM HLTH ASSOC SPOKANE - NE CLINIC	01/01/02	12/31/04	
7083298	DARRINGTON CLINIC	08/01/95	12/31/02	
7086150	YAKAMA NATION, TOPPENISH, WA	03/01/03	12/31/05	
7094550	PROVIDENCE HOOD RIVER MEM, HOOD RIVER	02/01/01	12/31/04	
7096431	MARY BRIDGE CHILDRENS HLTH, TACOMA	03/01/03	12/31/05	
7097348	COMM HLTH ASSOC SPOKANE-VALLEY CLINIC	01/01/02	12/31/04	
7097447	KIRKPATRICK FAMILY CARE, LONGVIEW	11/01/00	12/31/03	
7098320	NATIVE HEALTH OF SPOKANE, SPOKANE	12/01/00	12/31/06	

7105950	COMM HLTH ASSOC SPOKANE-MAPLE CLINIC	01/01/02	12/31/04
7110182	INTERFAITH FAMILY HLTH CNTR,BELLINGHAM	01/01/02	12/01/03
7113186	PACIFIC NW MATERNAL-FETAL MED, TACOMA	07/01/02	12/31/04
	(PROV # CHANGE FOR BILLING-SEE 7117997)		
7115934	PSNHC RANIER BEACH CLINIC, SEATTLE	01/01/03	12/31/05
7115959	PSNHC RANIER BEACH MED CLINIC, SEATTLE	01/01/03	12/31/05
7115967	PSNHC 45TH STREET CLINIC, SEATTLE	01/01/03	12/31/05
7115975	PSNHC HIGH PT MEDICAL CLINIC, SEATTLE	01/01/03	12/31/05
7115983	PSNHC GREENWOOD MED CLINIC, SEATTLE	01/01/03	12/31/05
7117997	PACIFIC NW MATERNAL FETAL MED, TACOMA	09/01/03	12/31/04
	(PROV # CHANGE FOR BILLING-SEE 7113186)		
7300015	NORTHSIDE INTERNAL MED ASSOC, SPOKANE	01/01/03	12/31/05
7300445	SW WASHINGTON MEDICAL CENTER	01/10/94	12/31/01
7312101	GROUP HEALTH, SPOKANE	08/01/01	12/31/04
7401425	CHC LA CLINICA, PASCO	07/01/03	12/31/06
7776503	EVERETT CLINIC, EVERETT	10/01/03	12/31/06
7820509	WENATCHEE VALLEY CLINIC, WENATCHEE	01/01/99	12/31/04
7833106	THE POLYCLINIC, SEATTLE	10/01/02	12/31/05
7900202	PUGET SOUND FAMILY PHYSICIANS,EDMONDS	05/01/01	12/31/03

IF NOT ONE OF THE PRECEDING PROVIDERS OR THE DATE IS PRIOR TO THE EFFECTIVE DATE OR AFTER THE THRU DATE - DENY W/EOB 711.
MANUAL PRICE EACH UNIT AT:
A. $45.68 OR THE BILLED AMT, WHICHEVER IS LESS FOR 7/1/02 DOS & AFTER.
B. $45.00 OR THE BILLED AMT, WHICHEVER IS LESS THRU 6/30/02 DOS.
C. $40.00 OR THE BILLED AMT, WHICHEVER IS LESS THRU 6/30/00 DOS.

6. 90799 - UNLISTED THERAPEUTIC INJECTIONS.
- DENY - EOB 302. IF BILLED FOR SYNAGIS/PALVIZUMAB - DENY W/EOB 325.

7. 96100, 96110, 96111, 96115, 96117 (PSYCHOLOGICAL TESTING)
A. PROVIDER # 7049190/7106982/7011349 - SEE PROVIDER SPECIAL AGREEMENT FOR ADJUDICATION AND PRICING.
B. ALL OTHER PROVIDER OR SPEC AGREE HAS ENDED.
1) DOS PRIOR TO 7/1/02 - DENY W/EOB 350 UNLESS AUTH #, SEE BELOW
2) DOS 7/1/02 & AFTER:
A) NO AUTH # ON CLAIM - DENY W/EOB 023.
EXCEPTION: 96100 & DOS IS 7/1/03 & AFTER:
EE:
1. IF "I" IN ITA FIELD, PRICE PER BELOW. *S
2. ALL ELSE, PA-2.
RES: IF AUDIT 088 IS POSTING & DENYING, DO NOT WORK 331.
IF FORCING 088 & AUTH ON CLAIM - SEE BELOW.
IF AUDIT 088 IS NOT POSTING - PRICE PER DOS BELOW.
B) AUTH # ON CLAIM FOR DOS BILLED:
1. EPA # 870001201 - PRICE PER BELOW.
2. OTHER AUTH # ON CLAIM - PRICE PER BELOW & E-MAIL KERRY DANSEREAU/DMM W/ICN & AUTH # & ADVISE HER TO USE UNIT(S)

DOS PRIOR TO 7/1/03 - $41.18
DOS 7/1/03 & AFTER - $43.00

NOTE: IF AUTH # BEGINS W/88, TREAT AS NO AUTH FOR SERVICES & DENY PER #2A ABOVE. THESE ARE RSN #'S & OUR AUTH FOR THESE SHOULD BEGIN W/80 IN ORDER TO COMPLY W/2 ABOVE.

8. J7610-J7999 (DME INHALATION)
IF PDDD STATES (MEDICARE X OVER ONLY) - DENY W/EOB 325.

9. J9999 (UNLISTED CHEMOTHERAPY)
A. EE:
1) BILLED AMT IS OVER $1100:
A. INVOICE IS ATTACHED, DRUG NAME, DOSAGE, STRENGTH IS ON CLAIM/COMMENTS - O'LOC TO 14.
B. IF ANY OF THE ABOVE ARE MISSING - DENY W/EOB'S 196/436.
2) BILLED AMT IS UNDER $1100:
A. DRUG NAME, DOSAGE, STRENGTH & NDC # IS ON CLAIM/COMMENTS - O'LOC TO 14.
B. IF ANY OF THE ABOVE ARE MISSING - DENY W/EOB 436.
B. RES/ADJ - (LOC 14)
A. BILLED AMT IS OVER $1100: COMPARE POS SYSTEM NDC PRICING AND INVOICE PRICING & PAY THE LESSER COMPUTAION.
B. BILLED AMT IS UNDER $1100: PRICE PER POS SYSTEM.

PRICE PER POS SYSTEM USING NDC AWP ALLOWANCE X UNITS BILLED X ABOVE ALLOWED % FOR DOS = ALLOWED AMT. SEE EXAMPLE BELOW:
.26 (POS AWP) X 10 (UNITS BILLED) X 95% = $2.31 (ALLOWED AMT)

ALLOWABLE % PER DOS:
CLAIMS W/DOS THRU 6/30/03 = 89% OF AWP.
CLAIMS W/DOS 7/1/03 DOS & AFTER = 86% OF AWP.

ANY QUESTIONS SEE MMIS/SANDY A.

10. 9802M-9805M - USE OF FACILITY - USE OF CAST ROOM, OPERATING ROOM, RECOVERY ROOM, SURGERY SUPPLIES, ANESTHESIA MATERIALS ARE NOT COVERED EXCEPT BY SPECIAL AGREEMENT. IF THE DESCRIPTION AND/OR TIME IS NEEDED AND NOT INDICATED DENY WITH EOB 801.

A. CHECK PROVIDER TEXT TO SEE IF THE PROVIDER HAS A SPECIAL AGREEMENT
1) IF SO, MANUALLY PRICE AT THE APPROVED FEE.
2) IF NOT, DENY W/EOB 350.
3) IF NOT IN ACCORD WITH SPECIAL AGREEMENT - DENY W/EOB 170 UNLESS 343/345 INSTRUCTIONS STATE "OVERLOC TO 18" - THEN PA2 THIS EXCEPTION.

B. FACILITIES CHARGES FOR VASECTOMIES AND ROUTINE CIRCUMCISION OF THE NEWBORN ARE NOT COVERED UNDER THE PROGRAM - DENY W/EOB 325.

11. OTHER SPECIAL AGREEMENTS NOT LISTED IN "H" - FOLLOW THE DIRECTIONS IN THE PROVIDERS SPECIAL AGREEMENT NOTES.

12. 5746M - PROVIDER # 7047566, PAY $639.62. PROVIDER #7037971, PAY $125.00, PROVIDER #7827702, PAY $296.00, PROVIDER #7827702, PAY $296.00, PROVIDER #1021575, PAY $639.62, PROVIDER #1057512, PAY

$639.62, PROVIDER # 1045574, PAY $639.62.

13. 5747M - PROVIDER #7047566, PAY $348.07. PROVIDER #7037971, PAY $125.00, PROVIDER #1046028, PAY $225.00, PROVIDER #7827702, PAY $296.00, PROVIDER #7827702, PAY $296.00, PROVIDER #1057512, PAY $348.07, PROVIDER #1085182, PAY $348.07. PROVIDER #1057512, PAY $348.07, PROVIDER #1047844, PAY $100.50. PROVIDER #7301047, PAY $100.50, PROVIDER #1045574, PAY $348.07.

14. T1015 - CLINIC VISIT/ENCOUNTER, ALL INCLUSIVE *SR
THE PROVIDER TYPES LISTED BELOW APPLY TO BILLING PROVIDER NUMBERS.
A. PROVIDER TYPES 15, 88 OR ANY PROV # W/SPECIALTY 90- O'LOC TO 83.
B. PROVIDER TYPE 71 - DENY WITH EOB 757.
C. PROVIDER TYPE 75 - IF MISSING MODIFIER HF, SE OR HX - DENY WITH EOB 036. ALL ELSE - OVERLOC TO 83.
D. CROSS-OVER (CLAIM TYPE "O") - OVERLOC TO 83.
E. ALL ELSE DENY WITH EOB 711.

15. 77499 (UNLISTED THERAPEUTIC RADIOLOGY)
A. IF PROVIDER #7029556/7102007 (AUP) BILLING FOR A STEREOTACTIC RADIOSURGERY, PAY UP TO $2800.00.
B. IF OTHER THAN ABOVE - IF REPORT OVERLOC TO 14. IF NO REPORT OR DESCRIPTION - DENY WITH EOB 190.

16. V0130-V2615, V2700-V2799 (MEDICARE EYE CODES)
IF PROVIDER TYPE 20 OR 28, DENY W/EOB 925.

17. 01999 (UNLISTED ANES):
A. IF NO REPORT ATTACHED - DENY W/EOB 190.
B. IF REPORT ATTACHED - O'LOC TO 14. LOC 14 - REVIEW & SEND TO 0MD/LAURA PIERPOINT/DR. BAUMGARTNER/45506 FOR REVIEW & PRICE. IF DR. B DOES NOT ASSIGN A BASE, SEND TO MMIS/SANDY A FOR A BASE.

18. A9900/L7510/L7520 - MISC SUPPLY CODE A9900 REPLACED THE 2 "L" CODES AND THE "A" CODE WAS BACK DATED FOR EFF DATE AND;
L3170 (ORTHOTIC)
A. EE:
1) IF AUTH # - O'LOC TO 23.
2) NO AUTH # - DENY W/EOB 023.
B. RES LOC 23 - CHECK STATUS ON LINE:
1) STATUS IS "D" - DENY W/EOB 251.
2) STATUS IS "A":
A) SERVICE DOES NOT MATCH - DENY W/EOB 251.
B) SERVICE MATCHES:
1. DOS NOT ON AUTH # - DENY W/EOB 245.
2. DOS ON AUTH FILE - IF TOS 3 PHYSICIAN (J)
A. UNITS/$ AVAILABLE - MANUAL PRICE PER AUTH NOTE SCREEN W/INFO EOB 373 & E-MAIL DEEDEE HOWEN/DMM TO USE $/ UNITS WHICHEVER. INCLUDE THE ICN FROM THE CLAIM FOR HER REVIEW.
B. NO UNITS/$ AVAILABLE - DENY W/EOB 246.
ANY QUESTIONS - SANDY/MMIS OR ROUTE TO MMIS/SANDY/45564.

19. 5963M -

A. IF PLACE OF SERVICE 4, DENY W/EOB 968. PROVIDER MUST MAIL CLAIMS DIRECTLY TO PROGRAM MANAGER FOR REVIEW & PROCESSING.
B. IF PLACE OF SERVICE 9, DENY WITH EOB 324.
C. ALL OTHER PLACES OF SERVICE - WORK THE 365 EXCEPTION.

20. S0077 - IF MIDWIFE (PT 94) AND NO EXPEDITED AUTH - DENY W/EOB 711. OTHERWISE, (PT 20 OR 94) IF NO INVOICE ATTACHED - DENY W/EOB 196. IF INVOICE ATTACHED, ROUTE TO SANDY R./MMISS

21. S5011 - IF NO INVOICE ATTACHED - DENY W/EOB 196.
IF INVOICE ATTACHED, ROUTE TO SANDY R./MMISS
NOTES FOR SR/MMISS
PT 20 OR 94 - NEEDS NAME OF IV SOLUTION ON INVOICE. - BIRTH CENTER

22. T1002 WITH MOD HD - THE PROVIDER IS TRYING TO BILL FOR MSS.
DENY WITH EOB/711.

23. T2022 IF MOD OTHER THAN HA - DENY W/036. ALL ELSE - O'LOC TO 67.

24. IF NOT ADDRESSED ABOVE AND THE PDDD FILE STATS (MEDICARE X-OVER ONLY FOR DOS) - DENY W/EOB 248. *SR

AMBULATORY SURGERY CENTERS (PT 22/TOS Z)

1. L8699 - IF DESCRIPTION ON CLAIM OR BACK UP SAYS REFURBISHED COCHLEAR IMPLANT OR SPEECH PROCESSOR, OR THIS CODE IS BEING BILLED ALONG WITH 69930-OVERLOC TO LOC 83, OTHERWISE DENY WITH EOB'S 324/325.

2. 69999 - UNLISTED
IF NO REPORT OR DESCRIPTION - DENY WITH EOB 190, OTHERWISE OVERLOC TO 83 FOR PRICING.

3. IF NOT ADDRESSED ABOVE AND THE PDDD FILE INDICATES (MEDICARE X-OVER ONLY) - DENY W/EOB 248.

DENTAL CLAIMS (K)

1. 0515D/D5899 - DENTURES/PARTIALS WHERE PATIENT DIED, MOVED, OR DIDN'T COME BACK - EXAM ENTRY - IF CONSULTANT HAS ENTERED A PRICE ON THE CLAIMS, MANUALLY PRICE AT THAT AMOUNT WITH INFO EOB 373. IF NO AUTH DENY W/ 023. IF AUTH # - PA-2. RES- LOOK AT AUTH FILE FOR PRICE - IF NO PRICE OVERLOC TO 25.

2. D0999 - IF PROVIDER NUMBER 5019880 (HARBORVIEW) WITH PERFORMING PROVIDER 5036660 (SNELL) - PRICE AT $34.00. ALL ELSE DENY W/325.

3. D5960 SPEECH AID PROSTHESIS MODIFICATION - IF CONSULTANT HAS ENTERED A PRICE ON THE CLAIM, MANUALLY PRICE AT THAT AMOUNT WITH EOB 373. IF AUTH # - PA-2. RES - LOOK AT AUTH FILE FOR PRICE - IF NO PRICE OVERLOC TO 25.

4. D7880 - OCCLUSAL ORTHOTIC DEVICE - EXAM ENTRY - IF CONSULTANT HAS ENTERED A PRICE ON THE CLAIM, MANUALLY PRICE AT THAT AMOUNT WITH INFO EOB 373. IF NO AUTH # - DENY WITH EOB 023. IF AUTH # - PA-2.

RES - LOOK AT AUTH FILE FOR PRICE - IF NO PRICE OVERLOC TO 25.

5. D9220 - GENERAL ANESTHESIA - CHECK CLAIM FOR ANESTHESIA TIME
   A. TIME NOT INDICATED - DENY W/EOB 230.
   B. TIME INDICATED, CHECK BOX 61 (OR EMC COMMENT FIELD) TO SEE IF ANESTHESIA PERFORMED BY ATTENDING PHYSICIAN/SURGEON/DENTIST, OR BY SECOND PROVIDER. NOTE: THE FOLLOWING PROVIDERS ARE ONLY DOING THE ANESTHESIA, NOT DENTAL PROCEDURES - USE THE "DIFFERENT PROVIDER" COLUMN FOR PRICING:
      5024930 - EUGENE PESTER
      5029194 - NORTHWEST OFFICE ANESTHESIA - MARVIN GEE
      5032768 - DONALD LEE
      5038542 - DAVID DORMANS - PUGET SOUND OUTPATIENT
      5039573 - ANESTHESIOLOGY FOR OUPATIENTS
      5044599 - EASTERN WA DENTAL SURGERY
      5044615 - MARK BOTTORFF

(TOTAL UNITS COLUMN IS 5 BASE UNITS PLUS TIME UNITS)

TEXT CONTINUES ON NEXT PAGE.

TOTAL UNITS	MINUTES	SAME PROVIDER EFFECTIVE DOS 7/1/02-12/31/02	SAME PROVIDER EFFECTIVE DOS 1/1/03 -	DIFFERENT PROVIDER EFFECTIVE DOS 7/1/02-12/31/02	DIFFERENT PROVIDER EFFECTIVE DOS 1/1/03-
6	01-15	47.10	60.69	94.20	121.38
7	16-30	54.95	70.81	109.90	141.61
8	31-45	62.80	80.92	125.60	161.84
9	46-60	70.65	91.04	141.30	182.07
10	61-75	78.50	101.15	157.00	202.30
11	76-90	86.35	111.27	172.70	222.53
12	91-105	94.20	121.38	188.40	242.76
13	106-120	102.05	131.95	204.10	262.99
14	121-135	109.90	141.61	219.80	283.22
15	136-150	117.75	151.73	235.50	303.45
16	151-165	125.60	161.84	251.20	323.68
17	166-180	133.45	171.96	266.90	343.91
18	181-195	141.30	182.07	282.60	364.14
19	196-210	149.15	192.19	298.30	384.37
20	211-225	157.00	202.30	314.00	404.60
21	226-240	164.85	212.42	329.70	424.83
22	241-255	172.70	222.53	345.40	445.06
23	256-270	180.55	232.65	361.10	465.29

TOTAL UNITS	MINUTES	SAME PROVIDER EFFECTIVE DOS 7/1/00-6/30/01	SAME PROVIDER EFFECTIVE DOS 7/01/01-6/30/02	DIFFERENT PROVIDER EFFECTIVE DOS 7/1/00-6/30/01	DIFFERENT PROVIDER EFFECTIVE DOS 7/01/01-6/30/02
6	01-15	45.30	46.47	90.60	92.94
7	16-30	52.85	54.21	105.70	108.43
8	31-45	60.40	61.96	120.80	123.92
9	46-60	67.95	69.71	135.90	139.41
10	61-75	75.50	77.45	151.00	154.90

11	76-90	83.05	85.20	166.10	170.39
12	91-105	90.60	92.94	181.20	185.88
13	106-120	98.15	100.69	196.30	201.37
14	121-135	105.70	108.43	211.40	216.86
15	136-150	113.25	116.18	226.50	232.35
16	151-165	120.80	123.92	241.60	247.84
17	166-180	128.35	131.67	256.70	263.33
18	181-195	135.90	139.41	271.80	278.82
19	196-210	143.45	147.16	286.90	294.31
20	211-225	151.00	154.90	302.00	309.80
21	226-240	158.55	162.65	317.10	325.29
22	241-255	166.10	170.39	332.20	340.78
23	256-270	173.65	178.35	347.30	356.27

5. D2999, D3999, D4999, D5899, D5999, D6999, D7999, D8999, 21299, 41899, 0075D (UNSPECIFIED CODES) AND ANY OTHER SUSPENDING CODES:

   A. NITROUS OXIDE - DOS PRIOR TO 7-1-01 DENY WITH EOB 325. DOS 7-1-01 OR AFTER DENY WITH EOB 302.
   B. ETHYL CHLORIDE - DENY W/EOB 325.
   C. PREMEDICATION - ANTIBIOTICS ONLY ALLOWED- ALL ELSE DENY W/EOB 325
   D. FLUORIDE HOME USE OR MOUTH RINSE - DENY W/EOB 325.
   E. SURGERY CODES (11044 - 64600) OVERLOC TO 14 (SMC) EXCEPT: 31367 - 31382, 38700, 38724, 42410, 42415, 60000 - 60282 ARE PAID A ASSISTANT FEE ONLY - OVERLOC TO 83.
   F. TEMPORARY FILLING - DENY W/EOB 325.
   G. PERIDEX RINSE OR PERIDEX - DENY WITH EOB 325.
   H. IF THE DESCRIPTION OF SERVICES DOES NOT INDICATE WHAT SERVICE WAS RENDERED - DENY W/EOB 190.
   I. IF THE PROVIDER IS BILLING FOR A PROCEDURE CODE THAT IN FACT THERE IS AN APPROPRIATE CODE IN THE DENTAL FEE SCHEDULE - DENY W/EOB 340.
   J. IF NONE OF THE ABOVE AND NO AUTH # PRESENT (NOTE: 870000999 IS AN INDICATION BY THE PROVIDER THAT THE CLAIM IS A TRAUMA CLAIM, IT IS NOT AUTHORIZATION) OR CONSULTANT SIGNATURE AND PROCEDURE CODE REQUIRES APPROVAL - DENY W/EOB 023. IF CONSULTANT SIGNATURE PRESENT AND A PRICE INDICATED, ENTER WITH INFO EOB 373. IF CONSULTANT SIGNATURE AND NO PRICE INDICATED - PA-2. IF AUTH # PA-2. RES, IF APPROVAL AND NO PRICE INDICATED - ROUTE TO QU AT MS 45506.

MEDICAL VENDORS - (P CLAIM TYPE)

1. DOUBLECHECK CLAIM TO MAKE SURE PA# WAS NOT MISSED.
   RES: EMC CLAIMS-CHECK REMARKS FIELD ON WORKSHEET.
   KEY PRIOR AUTH NUMBER AT HEADER LEVEL IF NO SPECIFIC LINE IS INDICATED.

2. CHECK PDDD FILE, IF MEDICARE X-OVER ONLY OR X-OVER ONLY

   DENY W/EOB 947.

3. CHECK 6 SCREEN OF RECIPIENT FILE TO SEE IF CLIENT HAS PCCM (PRIMARY CARE CASE MANAGEMENT) IF THERE IS A "P" IN THE "PCOP

TYPE" COLUMN FOR DOS THEN MANUALLY PRICE AT 85% OF BILLED AMOUNT.

4. NO PRIOR AUTHORIZATION# ON CLAIM:

0009A-(BRIDGE/FERRY TOLLS)
A) NO INVOICE-DENY W/EOB 199
B) INVOICE ATTACHED-PRICE PER INVOICE W/INFO EOB 552.

0012A-(AMBULANCE EXTRA ATTENDANT)
* JUSTIFICATION FOR EXTRA ATTENDANT*
A) PATIENT VIOLENT OR DIFFICULT TO CONTROL
B) MORE THAN ONE PATIENT REQUIRED MONITORING OR MEDICAL ATTENTION BEING TRANSPORTED.
C) OBESITY
D) INVOLUNTARY TRANSPORT (ITA)

E) IF THE SERVICE IS JUSTIFIED AS LISTED ABOVE EITHER BY A STATEMENT ON CLAIM OR IN ATTACHED REPORT-MANUALLY PRICE AT $18.67.
F) IF THE SERVICE HAS NO DOCUMENTED JUSTIFICATION-DENY W/EOB 332.

5. 4570B- DENY W/EOB 152.

6. 7999E - O'LOC TO 47
RES: WHEN RETURNED, WORK PER INSTRUCTIONS WITH INFO EOB 373.

7. E0482- NO PRIOR AUTHORIZATION # DENY W/EOB 023.

8. E1399 (DME-MISC) DOS 1/1/99-6/30/03 DENY W/EOB 947.

9. J0000 - J8999 (DRUGS) - DENY W/EOB 947.

10. IF NOT ADDRESSED ABOVE AND NO PRIOR AUTHORIZATION# ON CLAIM DENY W/EOB 023.

PRIOR AUTHORIZATION # ON CLAIM:

A.) E1399 DOS 1/1/98 THROUGH 6/30/03 DENY W/EOBS 947/237
(QUS AUTHORIZED THIS CODE IN ERROR - IS MEDICARE XOVER ONLY.)

B.) REVIEW NOTES ON PRIOR AUTHORIZATION SCREEN FOR PRICING *DC
1) INSTRUCTIONS. MANUALLY PRICE CLAIM PER THESE INSTRUCTIONS USING INFO EOB 373.
2) IF COMMENT ON DETAIL LINE "INCLUDED"-DENY W/EOBS 324/373.
3) IF COMMENT ON DETAIL LINE "DENIED"-DENY W/EOBS 242/373.
4) IF COMMENT ON DETAIL LINE "PENDING" -DENY W/EOBS 198/373.
5) IF COMMENT REFERS TO UNITS, CHANGE UNITS TO AUTHORIZED AMOUNT W/INFO EOB 373.

C. PRIOR AUTH # ON CLAIM AND NOT ADDRESSED ABOVE - OL TO 23.

RES ONLY:
A. PRIOR AUTH#'S BEGINNING WITH "87"(EXPEDITED AUTH):
1) PROC CODE & TOS MATCH- PRICE PER NOTES IN AUTH FILE, IF

UNABLE TO PRICE PER NOTES, OVERLOC TO 83.
2) IF PROC CODE, PROVIDER# OR TOS DO NOT MATCH AUTH FILE DENY W/EOB 251/828.

B. ALL OTHER PRIOR AUTH 3'S:
1) IF PROC CODE BILLED DOES NOT MATCH CODE AUTH'D-DENY W/EOB 251.
2) IF AUTH FILE OR PROC CODE PENDING ('P' OR 'M') DENY W/EOB 198
3) IF PROC CODE OR AUTH FILE DENIED ('D')-DENY W/EOB 242.
4) IF PROCEDURE CODE INCLUDED ('I')-DENY W/EOB 324.
5) IF 'R' STATUS ON AUTH FILE AT HEADER OR ON PROC CODE -DENY W/EOB 198.
6) IF UNABLE TO PRICE PER AUTH FILE SEND CLAIM WITH QUESTIONS TO APPROPRIATE PERSON IN QUS MS-45506 FOR REVIEW AND INSTRUCTION. (SEE TRAINER OR SUPERVISOR FOR APPROPRIATE PERSON.) WHEN CLAIM IS RETURNED, MANUALLY PRICE OR DENY PER INSTRUCTION W/INFO EOB 213.
7) IF ANY FURTHER QUESTIONS - SEE TRAINER OR SUPERVISOR.

4. MED VENDOR ADJUSTMENTS:
NO PRIOR AUTH# WORK ACCORDING TO PREVIOUS TEXT.
PRIOR AUTH#-REVIEW AUTH FILE AND WORK ACCORDINGLY
AUTH FILE MUST BE MANUALLY UPDATED ON ADJUSTMENTS, THE SYSTEM WILL NOT AUTOMATICALY USE OR UN-USE MONIES.
AFTER ADJUDICATING ADJUSTMENT- SEND DEAD WORKSHEET INDICATING WHAT UPDATES NEED TO BE DONE TO QUS.
IF PA# APPEARS INVALID BUT ON ORIGINAL WAS A VALID # THEN SEND TO QUS OR APPROPRIATE AUTH UNIT TO "REBUILD PURGED AUTH FILE".
QUESTIONS? SEE UNIT MANUAL/TRAINER/SUPERVISOR.

TEXT KEY TEXT DESC
332 INVALID PROVIDER TYPE TO PROCEDURE CODE

EXAM ENTRY:
1. IF PA# IS PRESENT - OVERLOC TO 23, UNLESS SOMETHING IN TEXT ALLOWS CLAIM TO BE FORCED.
2. IF EPA# (EXPEDITED PRIOR AUTH) (#87...) WORK AS IF NO PA# WERE PRESENT - EXCEPTION: PT 20, SEE PT 20 SECTION OF TEXT.

RES/LOC 23 -
1. IF EPA# (#87...) WORK AS IF NO AUTH # PRESENT.
2. ALL OTHER AUTH #'S - REVIEW AUTH:
   A. AUTH NOT VALID - RESEARCH SYSTEM FOR VALID AUTH
      1) VALID - ENTER VALID AUTH # ON CLAIM AND PROCESS PER BELOW AFTER REVIEW OF AUTH FILE.
      2) NO VALID AUTH # ON SYSTEM - DENY W/EOB 237.
   B. STATUS ON AUTH # IS "D" - DENY W/EOB 242.
   C. STATUS IS "A":
      1) SERVICE DOES NOT MATCH - DENY W/EOB 251.
      2) SERVICE MATCHES:
         A) DOS NOT ON AUTH # - DENY W/EOB 245.
         B) DOS ON AUTH FILE - FORCE.

332 IS POSTING IN COMBO W/EITHER 326/331/378 EXCEPTION, WORK THE 326/331/378 FIRST.

CROSSOVERS - SEE PAGE 10.
EPSDT - SEE PAGE 11.
MED VENDORS - SEE PAGE 12.

DENTAL - PROCEDURE CODES 99201 - 99245
1. DOS PRIOR TO 10-16-03
   A. IF PROVIDER OR PERFORMING PROVIDER SPECIALTY IS 12 (ORTHODONTIST) FORCE.
   B. ANY OTHER SPECIALTY - DENY.
2. DOS 10-16-03 OR AFTER - DENY.

PHYSICIAN CLAIMS:

1. PROVIDER TYPE 15 (INDIAN HEALTH - 5999M) ENCOUNTER IS AN ALL INCLUSIVE FEE. SERVICES OTHER THAN THE ENCOUNTER - DENY 347.
2. PROVIDER TYPE 18 (EMERGENCY ROOM PHYSICIANS).
   A. AFTER HOURS CHARGES (99050, 99052, 99064) SUNDAY & HOLIDAY CHGS (99054, 99025) - DENY 317.
   B. ASSISTANT SURGERY - FORCE. @
   C. DELIVERY/ANTEPARTUM CODES (59400,59410,59425,59426,59430,59510, 59514,59515,59610,59614,59618,59620,59622,5951M-5955M,5935M, 5947M,5959M,5930M,5941M-5954M,5944M-5948M) - DENY.
   D. ALL OTHER SURGICAL PROCEDURES (10000-69999, 2960M, 2977M - O'LOC TO 83.
   E. EYE EXAMS (92012, 92014) - IF THERE IS A REPORT OR JUSTIFICATION ON THE CLAIM--OVERLOC TO LOCATION 67.

F. LABORATORY SERVICES - BILLED W/MOD 26 - FORCE, ALL OTHERS - DENY W/EOB 318. @
G. ECHOCARDIOGRAPHY (93307-93312,93314-93350) & CARDIAC CATHS (93501,93505-93529,93561-93562) & VASCULAR STUDIES (93875-93990)-MOD 26 - FORCE, OTHERWISE - DENY W/EOB 318. @
H. CARDIOGRAPHY (93227) - FORCE.
I. RADIOLOGY SERVICES - BILLED W/MOD 26 - FORCE, ALL OTHERS - DENY W/EOB 318. @
J. IF BILLING FOR ADMIN CODES (90471 OR 90472) AND IMMUNIZATION CODES ARE ON THE CLAIM NOT POSTING 332 - FORCE THE ADMIN CODE.

3. PROVIDER TYPE 19 (PSYCHIATRIST)
A. MENTAL HEALTH ENCOUNTER CODE (9700M) SHOULD BE BILLED WITH PSYCHOTHERAPY SERVICES. IF BILLING MEDICAL ENCOUNTER CODE - 9000M OR T1015-CHECK DIAGNOSIS. IF FOR DISEASE OR ILLNESS-FORCE. IF FOR PSYCHOTHERAPY DENY WITH EOB 739.

4. PROVIDER TYPE 20 (PHYSICIAN)
A. 00100 - 01999:
1) PERFORMING PROVIDER IS PROV TYPE 48/49, OR SPECIALTY OF THE PP IS A 5 - FORCE.
2) PROV # 7096431 - (MARY BRIDGE) SEE SPECIAL CONTRACT/AGREEMENT SCREEN.
3) EPA #'S 870001201 - 870001250 ARE ON THE CLAIM - FORCE.
B. 9274M - 9277M & PROVIDER SPECIALTY 18 IF DOS ARE PRIOR TO 7/1/03-FORCE.

5. PROVIDER TYPE 24:
A. PREVENTIVE COUNSELING (99401) DX IS V65.44 AND DOS IS 7-1-03 OR AFTER - FORCE.
6. PROVIDER TYPE 25 (RADIOLOGIST)
A. J3490 - DENY W/EOB 344.
B. SUPPLIES SUCH AS CONTRAST MEDIA AND OPAQUE MATERIAL ARE INCLUDED IN THE X-RAY PROCEDURE - DENY W/EOB 344. EXCEPT: IF AMIPAQUE, METRIZAMIDE, OMNIPAQUE, PANTOPAQUE, OR IOHEXOL IS BILLED AS CONTRAST MATERIAL, PAY IN ADDITION TO THE CAT SCANS & MYELOGRAMS.
1) OTHER THAN 90799 - DENY W/EOB 302.
2) OTHER THAN THE CONTRAST MATERIALS LISTED AND BILLING FOR MYELOGRAMS, OVERLOC TO 83.
3) IF BILLING FOR THE INJECTION OF MEDICATION UNDER 99070 DENY 324 WHEN DONE WITH MRI'S.
C. 99070 -
1. SURGICAL TRAY:
A. DENY W/ 859 DOS 7/1/02 FORWARD.
B. DENY W/ 302 DOS 6/30/02 AND PRIOR.
2. IF BILLING CONTRAST MATERIALS - DENY WITH EOB 302.
D. 36415 - ROUTINE VENIPUNCTURE - FORCE.

7. PROVIDER TYPE 28 (OPTOMETRISTS)
A. OPTOMETRIST IS BILLING SURGERY CODE W/MODIFIER 55 - FORCE.
B. IF CODES 99231-99233, 99251-99255, 99261-99263 - IF DX IS FOR A A MEDICAL PROBLEM - FORCE.
D. IF CODES 92506 OR 92507 - DENY.
E. PROCEDURE IS A MEDICARE CODE (V0130-V2599)-DENY W/EOB 925.
F. ALL OTHER MEDICARE CODES - (CHECK PDDD FILE) - DENY.

G. IF PROCEDURE IS FOR SPEECH/AUDIOLOGY (CHECK PDD FILE) - DENY.
H. ALL ELSE- OVERLOC TO 67.

8. PROVIDER TYPE 31 (PSYCHOLOGISTS)
A. FOR PROVIDER #7021546 (ROUBOS) - SEE SPECIAL AGREEMENT.

9. PROVIDER TYPE 32 (PODIATRIST - DPM). TREATMENT IS LIMIT TO ANKLE AND FOOT.
A. 95831 & 95851 - DENY W/EOB 324. HOWEVER, IF RANGE OF MOTION BILLED ALONE - DENY.
B. PHYSICAL THERAPY BILLED BY PODIATRIST - DENY.
C. 93720--93727 PLETHYSMOGRAPHY - DENY.
D. 76801-76999 OR 93922-93965 (UTRA SOUND/DOPPLER STUDIES) - DENY.
E. ALL ELSE;
1. ANY DX ON CLAIM FOR SAME DOS IS FOR THE FOOT/ANKLE/NAIL - FORCE. (IE- DX IS FOR PLANTAR AREA,BUNIONS, CORNS, OVERGROWTH, ETC).
2. ANY DX ON CLAIM FOR SAME DOS IS FOR DIABETES OR ARTERIO-SCLEROSIS - FORCE.
3. DESCRIPTION OF PROCEDURE INCLUDES FOOT OR ANKLE - FORCE.
F. ALL ELSE OL TO 83

10. PROVIDER TYPE 35 (MAT. SUPPORT/INFANT CASE MANAGEMENT)
A. AS OF DATE OF SERVICE 10/01/03 & FORWARD, IF MODIFIER HD IS MISSING, DENY WITH EOB 036.
B. ALL ELSE DENY.

11. PROVIDER TYPE 37 (SPEECH LANGUAGE PATHOLOGY/AUDIOLOGY)
A. 92586 AND PROVIDER SPECIALTY IS 64 - FORCE DATES OF SERVICE @ 07/01/01 AND AFTER.
B. 92611 AND PROVIDER SPECIALTY IS 64/76 - FORCE DOS 07/01/03 & AFTER.

12. PROVIDER TYPE 40 (OTHER PROVIDERS)
A. SPEC 61 - DENY.
B. SPEC 66 -
1. 97755 - O'LOC TO 83
2 97113 - BEFORE 4/1/04 - DENY. 4/1/04 & AFTER - FORCE. @
3. ALL ELSE DENY.
C. ALL ELSE O'LOC TO 83.

13. PROVIDER TYPE 41 (BLOOD BANKS) - 36415 FORCE.

14. PROVIDER TYPE 43 (LABORATORY OR LABORATORY SERVICES)
A. PROVIDER #7176308 BILLING BLOOD BANK SERVICES ON MEDICARE X-OVER (MEDICARE USING SAME MEDICARE PROVIDER NUMBER FOR BLOOD BANK AND LAB)- FORCE.
B. STAT CHARGE BY DESCRIPTION OR COMMENT UNLISTED LAB CODES LISTED IN 368 TEXT (PAGE 4 UNDER MODIFIER 91/1L) MP AT 0.00 W/EOB 158.ALSO M/P @ 0.00 THOSE PROCEDURES LISTED W/EOB 036. IF BILLED W/PROCEDURES OTHER THAN THOSE LISTED IN 368 TEXT, M/P THE UNLISTED LAB CODES AT 0.00 W/EOB 319.
C. 99199 - IF BILLING STAT CHARGES - DENY W/EOB 302.

15. PROVIDER TYPE 48/49 (ANESTHESIOLOGIST) (CRNA)
    A. 99001 - DENY 324.
    B. PT 48 OR 49 - ANES BASE ON PDDD FILE FOR DOS - O'LOC TO 83.
    C. PT 49 - IF PT 48 ON PDDD FILE - O'LOC TO 83.

16. PROVIDER TYPE 58 (SCHOOL MEDICAL) - OVERLOC TO 83.

17. PROVIDER TYPE 71 (FAMILY PLANNING)
    A. IF CLAIM INCLUDES AN ABORTION (59840-59841, 9801M, 9810M, 9811M) DENY CLAIM AT HEADER WITH EOB 711.
    B. J3490 - ENTER CLAIM - EXCEPTION 332 WILL GO AWAY
    C. 99401 - IF DOS IS 7-1-03 OR AFTER - FORCE.

18. PROVIDER TYPE 88 (RURAL HEALTH CLINICS) ARE ISSUED A UNIQUE STATE ASSIGNED CODE. THESE CODES ARE ALL INCLUSIVE FEES. *SR
    NOTE: BEGINNING WITH DATES OF SERVICE 10/01/03 & AFTER, PT 88'S WILL ALL BILL WITH PROCEDURE CODE T1015. THIS ENTIRE PROGRAM IS HIPAA CROSSWALKED BACK TO THE OLD STATE UNIQUE ASSIGNED/LOCAL PROCEDURE CODES. SEE THE PROCESSING CODE ON P. 2 OF THE CLAIM.
    A. ENCOUNTER FEE/RURAL HEALTH VISIT ON CLAIM & OTHER SERVICES - PAY THE ENCOUNTER AND DENY OTHER SERVICES WITH EOB 324.
    B. NO ENCOUNTER FEE/RURAL HEALTH VISIT ON CLAIM - DENY ENTIRE CLAIM WITH EOB 347.

19. PROVIDER TYPE 93 (ARNP)
    A. IF BILLING FOR PROCEDURE CODES THAT ARE LOADED FOR THE FOLLOWING SPECIFIC PROVIDER TYPES ONLY-DENY. (F-4 UNDER PROCEDURE CODE THAT IS POSTING AND CHECK THE PROVIDER TYPE.)
       1) FAMILY PLANNING CODES (PT 71)
       2) RURAL HEALTH CODES (PT 88)
       3) INDIAN HEALTH CODES (PT 15)
       4) MATERNITY SUPPORT CODES (PT 35)
       5) MATERNITY CASE MANAGEMENT (PT23)
       6) PSYCH SERVICE CODES (90801-90899) (PT 19 OR 20)
       7) SUBSTANCE ABUSE (PT 75)
       8) NEUROPSYCH (PT 31)
    B. CODES 99291-99294,99295-99296, 99299 - DENY
    C. BILLING - 99432 (NORMAL NEWBORN CARE OTHER THAN HOSPITAL OR BIRTHING CENTER) - DENY.
    D. CODES 00100 - 01999: PERFORMING PROVIDER IS A 48/49 OR SPECIALTY IS 5 - FORCE.
    E. ALL OTHER CODES OVERLOC TO 83.

20. PROVIDER TYPE 94 (MIDWIFE) - WORK 365 IF POSTING.

21. ALL ELSE DENY UNLESS COMMENTS ON CLAIM OR B/U REQUESTING REVIEW - O'LOC TO 83.

MEDICARE X-OVERS (O) HARD COPY CLAIMS
- OVERLOC TO 83.

MEDICARE X-OVERS (O) TAPE CLAIMS
- FORCE.

EPSDT CLAIMS (L)

1. LAB AND X-RAY - DENY
2. 99211 - DENY
3. EXCEPTION 301 ALSO POSTING, DENY THE 301 EXCEPTION, NOT THE 332.
4. PROVIDER TYPE 66,88 - DENY.
5. ALL ELSE - OVERLOC TO LOC 83.

MEDICAL VENDOR CLAIMS (P)

1. EXCEPTIONS 261, 326, 378 OR 331 FAILING ON SAME LINE - WORK THOSE EXCEPTIONS FIRST & IF DENYING THEN PA2 332 EXCEPTION.

2. SPECIAL DUTY NURSE (PT 33) (8929H AND 8931H)
   VERIFY THAT THE DATE OF SERVICE IS ONE OF THE FOLLOWING AUTHORIZED HOLIDAYS: NEW YEAR'S DAY, MARTIN LUTHER KING DAY, PRESIDENTS DAY, EASTER, MEMORIAL DAY, INDEPENDENCE DAY, LABOR DAY, THANKSGIVING, AND CHRISTMAS. IF SO, FORCE, IF NOT DENY W/EOB 180.

3. ALL ELSE - DENY.

TEXT KEY TEXT DESC
333

LOCATION 13 WORKSHEETS: (RESOLUTIONS AND ADJUSTMENTS)

1. OBTAIN CLAIM COPY, BACKUP DOCUMENT (IF AVAILABLE), AND WORKSHEET
2. REVIEW BACKUP FOR A MATCH AND APPROPRIATENESS (E.G. RECIPIENT MATCH, INGREDIENT LIST (I.E. - NDCS, QUANTITY, STRENGTH AND CHARGE) AND DATE FILLED.
   A. INGREDIENTS LIST COMPLETE, ATTACH FACESHEET AND ROUTE TO GLENICE BEDELL, MRS, M/S 45510.
   B. IF STATEMENT ON CLAIM THAT NDC'S ARE NOT AVAILABLE AND OTHER NECESSARY INFORMATION GIVEN -- SEE A ABOVE.
   C. IF INGREDIENTS LIST NOT COMPLETE - DENY W/EOB 956/281.

3. WHEN CLAIM HAS BEEN RETURNED TO OPS, ADJUDICATE PER INSTRUCTIONS ON WORKSHEET.
   A. USE 373 AS AN INFORMATIONAL EOB.
   B. DO NOT PUT A "Y" IN THE LMC INDICATOR FIELD BECAUSE THIS WILL INCORRECTLY BYPSS EXCEPTION 098 (3RD RX IN A MONTH) AUDIT.

TEXT KEY TEXT DESC
341 NDC REQUIRES APPROVED PRIOR AUTH NUMBER

--NOTE: PHARMACY CLAIMS ARE PROCESSED IN THE POS SYSTEM AS OF 3/96. THIS TEXT FILE KEPT FOR HISTORICAL PURPOSES ONLY.

1. IF PROVIDER INDICATES THAT THE DRUG IS FORMULARY OR AFTER A PREVIOUS DENIAL INSISTS THAT THE DRUG SHOULD BE FORMULARY, MANUALLY ROUTE THE CLAIM TO THE DESIGNATED DRUG UNIT PERSON FOR NECESSARY ACTION.

2. IF THE AUTHORIZATION NUMBER BEGINS WITH '85' (EXPEDITED AUTH) - OVERLOC TO 83.

3. CHECK AUTHORIZATION FILE - FORCE IF DOS IS COVERED UNDER AUTHORIZATION NUMBER. IF DATE OF SERVICE IS NOT WITHIN THE AUTHORIZED DATE SPAN - SEE 606 TEXT. IF NDC FIRST NINE DIGITS DO NOT MATCH AUTH FILE - DENY WITH EOB 251.

4. IF 2 AUTH NUMBERS ON CLAIM - DENY WITH EOB 407. DO NOT KEY ANY AUTH # ON SCREEN. SEND COPY OF CLAIM/WORKSHEET TO PRU MAILSTOP 5562 FOR PROVIDER TRAINING INDICATING PROBLEM ON PRU REFERRAL FORM.

5. IF THE DRUG IS CLOZARIL (PROVIDED ONLY BY CAREMARK PHARMACY) AND AUTHORIZATION IS FOR CLOZARIL - FORCE. DO NOT BE CONCERNED WITH

EXACT MATCH OF NDC'S.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
343 MEDICAL NECESSITY FOR THIS DIAGNOSES CODE MUST BE DOCUMENTED & APPROVED

---ALL CLAIM TYPES---

1. LOC 55 - MANAGED MEDICARE - WORK PER 988 TEXT.

2. DX CODE IS POSTING, BUT CLAIM/DOCUMENTATION INDICATES HEMORRHAGING, EXCRUCIATING PAIN, COMA, MVA (MOTOR VEHICLE ACCIDENT), ETC - FORCE. --IF IN DOUBT SEE YOUR TRAINER/SUPERVISOR.

3. IF PRIOR AUTH NUMBER IS ON THE CLAIM & DX THAT IS POSTING EXC 343 IS NOT FORCIBLE PER THIS TEXT.
   A. EE: O'LOC TO 23.
   B. RES: REVIEW AUTH NUMBER TO DETERMINE IF DX CODE IS LISTED ON THE AUTH FILE OR IF THE NOTES/COMMENTS ON THE AUTH FILE JUSTIFY FORCING THE CLAIM----IF IN DOUBT SEE YOUR TRAINER/SUPERVISOR.

--"L" - EPSDT
IF NOT ADDRESSED IN THIS TEXT UNDER SPECIFIC DX - O'LOC TO 83 FOR REVIEW.
--"M,R,S" - HOSPITAL CLAIM TYPES.
1. S CLAIMS - IF BILLING ONLY FOR ANCILLARY CHARGES FOR SWING BEDS - FORCE.
2. S & R CLAIMS - IF ADMITTING DX DOES NOT HAVE A CONTROL INDICATOR "1" - FORCE. (SEE EXCEPTION BELOW)
3. M,R,& S CLAIMS:
   A. IF AUTH # BEGINNING WITH "64" - O'LOC TO 72. *SH
   B. IF EXC 343 IS NOT POSTING ON THE PRIMARY DX CODE (NO CONTROL INDICATOR "1") AND 2ND-9TH DX IS POSTING EXC 343 - FORCE. (SEE EXCEPTION BELOW)
   C. IF EXCEPTION 345 IS ALSO POSTING - O'LOC TO 18.

EXCEPTION: IF DX CODES V42.0, V59.4, V70.1, OR V70.2 ARE IN ANY POSITION - WORK PER THIS TEXT. IF DX CODE V25.2 IS IN ANY POSITION- O'LOC TO 18.

-- "J" PHYSICIAN CLAIM TYPE:
1. IF PT 43 W/SPEC 61 (GENETIC COUNSELING) - FORCE. @
2. DDD PHYSICAL (0310M) - CHANGE DX CODE TO V93.0 & FORCE LAB, X-RAY, & IMMUNIZATIONS ON THE SAME DAY. EFFECTIVE W/DOS 8/1/03 - DENY.
3. ANESTHESIA SERVICES:
EE: IF AUTH ON CLAIM - O'LOC TO 23:
RES LOC 23:
   A. IF THE DX ON THE AUTH FILE IS THE SAME AS EITHER DX ON THE CLAIM - FORCE.
   B. IF IN DOUBT & BEFORE YOU DENY SEE MMIS.
4. IF EXC 345 IS ALSO POSTING & THE FOLLOWING CODE(S) ARE ON THE CLM - O'LOC TO 18: 00846, 00851, 00869, 01962, 01963, 01969,51925, 54690, 55250, 55450, 56301, 56302, 56308, 56318, 58150-58285, 58600-58615, 58670, 58671, 58982, 58983, 59135, 59525, 5911M-5914M OR 9802M.

5. (TEMPORARILY UNTIL CSR IS COMPLETE, APPLY THE FOLLOWING)
IF THERE ARE 2 DX PRESENT ON DETAIL LINE, F4 UNDER 1ST DX &:
1. IF "0" PRESENT IN CONTROL FIELD - FORCE.
2. IF "1" PRESENT IN CONTROL FIELD - APPLY THE FOLLOWING TEXT.
6. IF YOU ARE TOTALLY DENYING ALL SERVICES FOR THE SAME DOS PER THIS TEXT & THERE IS ALSO AN ENCOUNTER CODE FOR THE SAME DOS - DENY THE ENCOUNTER CODE W/EOB 837. IF YOU ARE PAYING ONE OR MORE OF THE SERVICES - FORCE THE 343 EXCEPTION FOR THE ENCOUNTER CODE.

---IMPORTANT NOTE - ALL CLAIM TYPES---

THE FOLLOWING DIAGNOSES CODES ARE NOT COVERED & SHOULD BE DENIED UNLESS OTHERWISE INSTRUCTED. WHEN A DIAGNOSES CODE POSTS, BUT IS NOT REFERENCED IN THIS TEXT, THERE ARE NO EXCEPTIONS & IT SHOULD BE DENIED.

111.9, 117.9 (MYCOSIS)
1. IF BILLED BY A PODIATRIST (PT 32) FOR THE FOOT - DENY W/EOB 325.
2. ALL ELSE - FORCE.

259.0- 259.1, 259.4 (OTHER ENDOCRINE DISORDERS)
1. IF A CHILD IS 8 YEARS OR YOUNGER WITH SEXUAL PRECOCITY, THIS WOULD NOT BE NORMAL FOR THIS AGE & THE CHILD SHOULD BE CHECKED TO SEE IF THERE IS AN ORGANIC CAUSE. WE WOULD PAY IN THIS INSTANCE - FORCE.
2. IF YOU HAVE ANY OTHER JUSTIFICATION THAT MIGHT WARRANT PAYING THIS DIAGNOSIS, CHECK WITH YOUR TRAINER/SUPERVISOR. OTHERWISE - DENY.

278.0-278.01 (OBESITY)
1. IF 97802-97804 (NUTRITIONAL THRPY SERVICES FOR CHILDREN) - FORCE.@
2. IF 97802-97803 (AGE OF CLIENT IS 21-60) & DX IS 278.01 - FORCE.
3. IF PROCEDURE CODES 5941M, 5953M, 5954M, 5955M, 5959M (HIGH RISK PREGNANCY OR DELIVERY) OR MOD TG W/ A DELIVERY CODE - FORCE.
4. BARIATRIC SURGERY (36415,36416,80000-89999,90801,96100,99201-99215) IF STATEMENT ON CLAIM OR COMMENTS "BARIATRIC SURG EVAL-1" - FORCE. ANY OTHER CODES W/THIS STATEMENT -RT CLAIM & BACKUP TO SANDY A/MMIS/MS 45564.
5. IF AUTH # ON CLAIM & ANY OTHER SERVICE IS FAILING:
EE: O'LOC TO 23.
RES LOC 23:
A. IF PROCEDURE CODES 43842-43848 (GASTRIC BY-PASS) AND CLAIM HAS AN AUTH NUMBER FOR SERVICES BILLED - FORCE.
B. IF PROCEDURE CODE 43659 AND CLAIM HAS AN AUTH NUMBER FOR SERVICE BILLED AND AUTH NOTES STATE "LAPAROSCOPIC GASTRIC BYPASS" - FORCE.
C. IF DX ON AUTH IS RELATED TO MAJOR SURGERY - FORCE.
D. ANY QUESTIONS SEE YOUR SUPERVISOR/TRAINER.
6. "L" EPSDT CLAIMS - IF SCREENING CODES (99381-99385, 99391-99395) ARE ON THE CLAIM - FORCE.
7. "M" OUTPATIENT CLAIMS - IF PROVIDER IS 3306909 (PROVIDENCE WEIGHT LOSS) & REV CODE IS 948 AND/OR 949 - FORCE.

302 - 302.9 (SEXUAL DEVIATION AND DISORDERS)
1. SERVICES RENDERED BY A PSYCHIATRIST (90801-90899, 9083M, 9084M) - FORCE. @
2. SERVICES RENDERED IN A COMMUNITY MENTAL HEALTH CENTER (PT 73) - FORCE. @

3. HOSPITALS - IF RSN AUTHORIZATION (AUTH NUMBER BEGINS W/88) - FORCE.
   OTHERWISE - DENY.

303 - 303.93 (ALCOHOL DEPENDENCE)
1. HOSPITAL ITA CLAIMS - SEE EXC 190 TEXT.
2. PHYSICIAN ITA CLAIMS - FORCE. @
3. IF COMMUNITY MENTAL HEALTH (PT 73) - DENY W/EOB 315.
4. FORCE THE FOLLOWING:
   A. NEWBORN
   B. AGE 16 OR UNDER. @
   C. SERVICES RENDERED IN A NURSING HOME (POS 6,7,8,24,54,31,32)-FORCE.
5. PHYSICIAN CLAIMS FOR HOSPITALIZATION AND COUPON STATES "3 OR 5 DAY DETOX" OR STATEMENT ON CLAIM OF "DETOX", SEE BELOW:
   A. IF PROCEDURE CODES 0025M & 0026M HAVE NOT BEEN USED - DENYW/EOB 340.
   B. IF PROCEDURE CODES 0025M & 0026M ARE USED, BUT THERE IS NO MENTION OF DETOX - DENY W/EOB 301.
   C. IF DETOX COUPON IS ATTACHED OR THERE IS A STATEMENT ON THE CLAIM OF DETOX & PROCEDURE CODES 0025M & 0026M HAVE BEEN BILLED - FORCE.
6. PHYSICIAN CLAIMS IN THE OFFICE:
   A. CLAIM/BACKUP INDICATES PHYSICAL OR ANY SERVICE FOR ANTABUSE THERAPY - FORCE.
   B. CLAIM IS SOBRIETY MAINTENANCE FOR ANTABUSE THERAPY - FORCE.
   C. CLAIM IS FOR JUST PLAIN ALCOHOLISM - DENY
7. PHYSICIAN ER SERVICES: POS "5" OR "23"
   A. IF CLAIM STATES ALCOHOLISM ONLY - DENY
   B. IF CLAIM INDICATES A MEDICAL NEED - FORCE.
8. OUTPATIENT HOSPITAL CLAIMS (M) - PRIMARY DX IS ALCOHOLISM:
   A. IF REVENUE CODE 450 (ER SERVICES) IS ON THE CLAIM - FORCE.
   B. IF CLAIM IS SOBRIETY MAINTENANCE FOR ANTABUSE TREATMENT - FORCE.
   C. ALL ELSE - DENY
9. INPATIENT HOSPITAL CLAIMS (S) OR DRG (R):
   A. IF CUP CLAIM (REV CD 168) - FORCE. IF CLAIM INDICATES CUP SERVICES BUT PROVIDER IS NOT BILLING REV CODE 129 OR 168 - DENY W/EOB 756.
   B. ALCOHOL ABUSE - IF FOR DETOX & PROV # BEGINS WITH 36 - FORCE IF 3 DAYS OR LESS. IF MORE THAN 3 DAYS - DENY W/EOB 258.
   C. DRUG ABUSE - IF FOR DETOX & PROV # BEGINS W/36 - FORCE IF 5 DAYS OR LESS. IF MORE THAN 5 DAYS - DENY W/EOB 258.
   D. IF NO MENTION OF DETOX OR IF PROVIDER NUMBER DOES NOT BEGIN WITH "36" - DENY W/EOB 301.
   E. IF CLAIM INDICATES DETOX AND PROVIDER NUMBER DOES NOT BEGIN WITH "36" - DENY W/EOB 983.

304 - 304.93 (DRUG DEPENDENCE)
1. FORCE THE FOLLOWING:
   A. NEWBORN
   B. IF CUP CLAIM (REV CODE 129 OR 168) - FORCE. IF CLAIM INDICATES CUP SERVICES, BUT PROVIDER IS NOT BILLING REV CODE 129 OR 168 - DENY W/EOB 756.
   D. OUTPATIENT HOSP & REV CODE 450 (ER SVS) IS ON THE CLAIM - FORCE.
   E. PROCEDURE CODES 99281-99285 & ALL OTHER SERVICES FOR SAME DOS. @
   F. IF DELIVERY CODE (VAGINAL/C-SECTION) OR HIGH RISK DELIVERY ADD ON CODE (5941M/5959M) OR DELIVERY CODE (W/TG MOD) - FORCE.
   G. IF BILLING CODES 99221-99223, 99231-99239 - DENY W/EOB 301/302.

H. PROV NUMBER 7060825 FOR DRUG SCREENS (80100-80103) - FORCE. @
I. PROV NUMBER 7115405 (NEW DASA CONTRACT LAB) FOR DRUG SCREENS:
1. 0037M, 0038M, 0039M &/OR 0065M BEFORE 10/15/03 - FORCE
2. 80100-80101 W/MODIFIER HG OR HD AFTER 10/01/03 - FORCE
2. HOSPITAL ITA CLAIMS - SEE EXC 190 TEXT.
3. PHYSICIAN ITA CLAIMS - FORCE.
4. PROCEDURE CODES 99201 - 99215 W/DX (304.00-304.02) & THERE IS A STATEMENT ON CLAIM/COMMENTS (CERT. BUPREN. PROV.) OR SOMETHING SIMILIAR - FORCE.
5. ALL ELSE - DENY.

305 - 305.03 (ALCOHOL ABUSE)
1. IF PROCEDURE CODE IS 5941M OR 5959M OR DELIVERY CODE W/MOD TG - FORCE.
2. AGE 16 AND UNDER - FORCE. @
3. IF OUTPATIENT HOSP & REV CODE 450 (ER SVS) IS ON THE CLAIM - FORCE.
4. PROCEDURE CODES 99281-99285 & ALL OTHER PROCEDURE CODES FOR SAME DOS- FORCE.
5. ALL ELSE - SEE 303.

317 - 319 (MENTAL RETARDATION)
1. SERVICE RENDERED IN A NURSING HOME (POS 6,7,8,24,54,31,32)-FORCE.
2. PROCEDURE CODES FOR PHYSICAL, SPEECH, OR OCCUPATIONAL THERAPY - FORCE

520.1-520.6, 521.0-521.6, 5236, 523.9-524.5, 524.7-525.9(DENTAL RELATED)
1. PROVIDER TYPE 27 ON CLAIM TYPE "J":
A. IF DIAGNOSIS CODE 520.5, 521.6, 524.0-524.5, 524.7-524.9 - FORCE.
B. OTHER DIAGNOSIS CODES DENY WITH EOB 325.
2. PHYSICIANS/EPSDT:
A. IF PRIOR AUTH NUMBER/NOTES AREA OR CONSULTANT SIGNATURE APPROVES THE SERVICE - FORCE.
B. OFFICE OR EMERGENCY ROOM VISIT AT NIGHT, WEEKEND OR HOLIDAY OR PROCEDURE CODES (99050, 99052, 99054) - FORCE. @ ALSO FORCE ALL RELATED SERVICES ON THE SAME DATE OF SERVICE.
C. 0122D, D1203 (FLUORIDE VARNISH) - FORCE. @
D. PHYSICIAN BILLING CODES 99201-99205, 99211-99215, 99381-99385, 99391-99395 & CLAIM INDICATES HX & PHYSICAL FOR ADMIT TO SHORT STAY UNIT, PHYSICAL EXAM OR PRE-OP, LAB OR X-RAY IN OFFICE PRIOR TO SURGERY- FORCE.
E. ANESTHESIA - FORCE. (IE: 0100M @, 00170 @, 00172 @, OR ANY SURGICAL PROC W/AN ANESTHESIA MODIFIER (ID: AA,QZ,QX,AB,AC,AD,QJ, QO,QQ,QK). THIS INCLUDES ANY RELATED SURGICAL SERVICES ON THE SAME DOS W OR W/O A MODIFIER.
F. 4401D, 4402D - FACILITY CHARGE - FORCE. @
G. 9820M, 9821M - FACILITY CHARGE - FORCE. @
H. INDIAN HEALTH CLINICS (5999M) - FORCE. @
I. CLAIM IS FOR HOSPITAL ADMIT & CLIENT IS DDD, INDICATED BY EXC 498 POSTING, OR CERTIFICATE OF ELIGIBILITY ATTACHED - FORCE.
J. AMBULATORY SURGERY CENTERS (PT 22) - FORCE. @
K. LAB (PT 43) - FORCE. @
L. NOT ADDRESSED ABOVE AND/OR ALL ELSE FOR PHYSICIANS DENTAL RELATED DX - DENY W/EOB 351.
3. OUTPATIENT CLAIMS (M):
A. FORCE THE FOLLOWING HOSPITALS:

1) CHILDREN'S ORTHOPEDIC HOSPITAL (3306206/3300068)
2) MARY BRIDGE HOSPITAL (3110806/3300340)
3) HARBORVIEW HOSPITAL (3100062/3018298/3018280)
4) UNIVERSITY HOSPITAL (3348802, 3017902)

B. FOR SHORT STAY SURGERY (CLAIM INCLUDES A REVENUE CODE SUCH AS 360-OPERATING ROOM, 490-SHORT STAY, 710-RECOVERY ROOM, 760-TREATMENT/OBSERVATION ROOM, ETC) - FORCE.
C. FORCE IF EMERGENCY AT NIGHT, ON WEEKENDS OR HOLIDAYS IF INDICATED.
D. FORCE IF PRIOR AUTH NUMBER/NOTES AREA APPROVES THE SERVICE.
E. ALL ELSE - DENY WITH EOB 351.

700 (CORNS AND CALLOSITIES) - FORCE ONLY IF OTHER MEDICAL NEED IS INDICATED ON CLAIM,BACKUP OR OTHER DX, SUCH AS ULCERATIONS, DIABETES, INFECTIONS, ETC. YOU MAY ASK TRAINER/MMIS IF UNSURE.

709-709.2 (TATTOO, SCAR CONDITIONS AND FIBROSIS OF THE SKIN)
1. TATTOO REMOVAL, ETC., IS NOT COVERED - DENY.
2. SCARS, DISFIGUREMENT, ETC., IS NOT COVERED IF THE SERVICE IS BEING DONE FOR COSMETIC REASONS - DENY.

783.6 (POLYPHAGIA - EXCESSIVE EATING)
1. PHYSICIANS- IF CLAIM STATES HYPERALIMENTATION - FORCE.
2. HOSPITALS - DENY.

798.9 (UNATTENDED DEATH) - EMERGENCY ROOM CALL FOR DOA - FORCE.

996.8 (COMPLICATIONS OF TRANSPLANTED ORGAN)
1. KIDNEY (RENAL) TRANSPLANT (SURGERIES, OFFICE CALLS, HOSP CALLS, ETC) DENY W/EOB 916 AT HEADER LEVEL.
--EXCEPTION: IF PROV SPEC IS 85 OR MDCR BACKUP OR COMMENTS ON CLAIM INDICATING "NO PART B" - FORCE & SEND A COPY OF THE CLAIM WITH ATTACHMENTS TO: AUDREY FINNIGAN M/S 45570.
--EXCEPTION: IF MEDICAL ELIGIBILITY CODE IS "0" ON RECIPIENT FILE FOR DATES OF SERVICE ON CLAIM - FORCE AND DO NOT OVER CODE.
2. OTHER ORGAN TRANSPLANTS:
A. IF REPORT OR PRIOR AUTH #:
EE: O'LOC TO 23. OTHERWISE - DENY.
RES: IF APPROVED ON PA# OR IF MEDICAL NEED IS ESTABLISHED IN THE REPORT - FORCE. OTHERWISE - DENY.
B. R,S CLAIM TYPES - SEE EXC 620 IF POSTING. OTHERWISE DENY.

NOTE: "M" OUTPATIENT CLAIM TYPE - IF THE PRIMARY DX CODE BEGINS WITH "V" & NONE OF THE "V' CODES LISTED BELOW - CHECK THE SECONDARY DX CODE & IF CONTROL INDICATOR IS "0" - FORCE. IF CONTROL INDICATOR IS "1" DENY. IF NO SECONDARY DX CODE - DENY.

V11.3 (ALCOHOLISM) - SEE 303.0
V19.8 (FAMILY HISTORY OF OTHER CONDITIONS)
1. IF BILLED BY PROV TYPE 40/SPEC 61 - FORCE.
2. EPSDT (L CLAIMS) - FORCE.

V20.0 - V20.1,V21.0
1. (HEALTHY CARE) EPSDT (L CLAIMS) - FORCE.
2. V20.1 - BILLED WITH PROCEDURE CODE T1017 W/MOD HD BY PT 35 - FORCE.@

3. V20.1 - BILLED WITH PROCEDURE CODE T1015 BY PT 35/SPEC. 90 - FORCE.@

V25.2 (STERILIZATIONS)
1. PHYSICIANS:
   A. 9802M - 9804M (FACILITY CHARGES) - O'LOC TO 18.
   B. ANESTHESIA:
      1) 00100 - 01999 - DOS PRIOR TO 12/31/01 - DENY W/EOB 302.
      2) DOS 01/01/02 AND AFTER - 00851,00869,00921 - O'LOC TO 18,
         ALL ELSE - DENY W/EOB 302. *S
   C. IF EXCEPTION 345 IS POSTING ON ANY LINE AND CODES ARE
      HYSTERECTOMIES (00846, 01962, 01963, 01969, 51925, 56308, 58150,
      58152, 58180, 58200, 58210, 58240, 58260-58270, 58275-58280, 58285
      58550, 58550, 59135, 59525, 5913M) OR VASECTOMIES (00869, 52347,
      54690, 55250, 55450, 56318, 5911M) OR STERILIZATIONS (00851,
      56301-56302, 58600, 58605, 58611, 58615, 58670, 58671, 9802M,
      5912M) - O'LOC TO 18.
   D. ALL OTHER PROCEDURES - FORCE.
2. HOSPITALS (M,R,S) - EXAM ENTRY AND RESOLUTIONS:
   A. IF ONLY LAB SERVICES ON THE CLAIM - FORCE.
   B. IF TOTALLY DENYING CLAIM & CONSENT FORM IS NOT ATTACHED - KEY 327
      IN THE SECOND EOB FIELD. IF CONSENT FORM IS ATTACHED - KEY 577 IN
      THE SECOND EOB FIELD.
   C. WORK ALL OTHER EXCEPTIONS - THEN OVERLOC TO 18 (WITH OR WITHOUT
      THE CONSENT FORM).
   D. LOCATION 18 - REFER TO 345 TEXT.

V40.0 (PROBLEMS WITH LEARNING) - IF PSYCHOLOGIST (PT 31) - FORCE

V42.0 (KIDNEY TRANSPLANT)
1. IF REVENUE CODE 250 & CLAIM STATES "DIALYSIS DRUGS" - FORCE.
2. IF MEDICARE EOMB SHOWING PART B PAYMENT - FORCE.
3. IF MEDICARE DENIAL ATTACHED INDICATING NO PART B COVERAGE AT TIME OF
   SERVICE - ENTER 111 IN THE OVERCODE AND FORCE.
4. IF NO MEDICARE DENIAL ATTACHED:
   A. IF THE RECIPIENTS MEDICAL ELIGIBILITY CODE IS "0" - FORCE.
   B. IF THE RECIPIENTS MEDICAL ELIGIBILITY CODE IS ANYTHING OTHER THAN
      "0" - ENTER 111 IN THE OVERCODE AND FORCE.

V42.1 (HEART TRANSPLANT_ - IF DONE IN OTHER THAN U OR W - FORCE.
   --CURRENTLY ONLY U OF W IS MEDICARE APPROVED & PAYABLE BY MEDICARE.

V42.4 (BONE MARROW TRANSPLANT) - IS COVERED BY MEDICARE - DENY W/EOB 916
   --IF MDCR DENIAL ATTACHED, OR STATEMENT INDICATING "NO PART B" -
     FORCE & OVERCODE 111 ON DETAIL/HEADER (AUDREY FINNIGAN).

V42.7 (LIVER TRANSPLANT)
1. IF PATIENT IS OVER 18 & NOT END-STAGE LIVER DISEASE - FORCE.
2. IF PATIENT IS UNDER AGE 18 & END-STAGE LIVER DISEASE - DENY W/EOB 061

V50.2 (ROUTINE CIRCUMCISION) - DENY W/ EOB 331.

V57.21, V57.4, V57.8, V57.81, V57.89, V57.9 (REHABILIATION)
NOTE: IF PCCM CLIENT W/REFERRING PROV # ON CLM - FORCE. (TO DETERMINE:
PF-4 UNDER PIC, PF-6, & A "P" IN PCOP TYPE ON SCREEN FOR DOS ON CLAIM)

1. HOSPITAL CLAIMS (M, R,& S):
   A. PT 44 (HOME HEALTH) - FORCE DX V57.21 & V57.89.
   B. PM&R LEVEL B (REV CODE 101) - OVERLOC TO 72.
   C. PM&R LEVEL A (TO IDENTIFY LOOK FOR 1 OR MORE OF THE FOLLOWING:
      AUTH # BEGINS WITH 57/REVENUE CODE 128/PRIMARY DX V57.X/PROVIDER
      # BEGINS WITH 32).
      EE: IF NO AUTH # - DENY W/EOB 023.
          IF AUTH # - OVERLOC TO 23.
      RES: IF CLAIM MEETS ALL OF THE FOLLOWING CRITERIA - FORCE:
          1. AUTH # BEGINS WITH "57" & COVERS ALL DOS ON THE CLAIM.
             --EACH LINE ON AUTH # MUST HAVE AN "A" STATUS.
          2. REV CODE 128 IS THE ONLY ROOM CODE ON THE AUTH NUMBER FOR
             THE DATES OF SERVICE ON THE CLAIM...AND...IS THE ONLY ROOM
             CODE BILLED ON THE CLAIM. EXCEPTION: ALSO ALLOW REVENUE
             CODE 180.
          3. PROVIDER # BEGINS WITH "32" - IF NOT DENY W/EOB 711.
          4. IF CLM DOESN'T MEET ALL OF THE CRITERIA - OVERLOC TO 72.
          --NOTE: IF FORCING 343 ALSO FORCE EXC'S 109 AND 377 ON REV
            CODES 43X & 91X.
    D. ALL OTHER (NON PM&R) CLMS - IF NOT ADDRESSED ELSEWHERE IN THIS
       TEXT - DENY.
2. ALL ELSE:
   EE: IF AUTH # ON CLAIM - OVERLOC TO 23.
       IF NO AUTH & CLAIM IS PHYSICIAN: SPECIALTY OF PROV/PERF IS 25
       (PHYSIATRIST) - DENY W/EOB 023. SPECIALTY OF PROV/PERF IS OTHER-
       DENY W/EOB 325.
   RES: IF AUTH # IF FOR PM&R/REHAB SERVICES & DX OR NOTES ON PAGE 2
        INDICATE PM&R - CHECK STATUS ON LINE & DOS:
        1. STATUS IS "A"
           A. DOS ARE LISTED - FORCE.
           B. DOS ARE NOT LISTED - DENY W/EOB 245.
        2. STATUS IS "D" - DENY W/EOB 242.
        3. STATUS IS ANYTHING ELSE - SEE SUP OR TRAINER.

V59.02 (STEM CELL DONOR) *S
1. HOSPITAL (R,S,M) CLAIMS - OVERLOC TO 72.
2. PHYSICIAN (J) CLAIMS: IF THE CENTER OF EXCELLENCE (SEE LIST BELOW)
   IS NOTED IN THE COMMENTS FIELD OR BOX 32 OF THE HCFA (CMS) CLAIM FORM
   - FORCE.
  *CHILDRENS HOSP & REGIONAL MED CENTR/SEATTLE
  *FRED HUTCH CANCER RES CENTR
  *GOOD SAM HOSP MED/PUALLUP
  *INLAND NW BLOOD CENTR
  *LEGACEY GOOD SAM/PORTLAND OR NW MARROW TRAANSPLANT PROG
  *OHSU/ORE/PORTLAND OR PSCT@ NW MARROW TRANSPLANT PROG
   (DOERNBACHER CHILDRENS HOSP)
  *PROV ST PETERS HOSP/OLY
  *SEATTLE CANCER CARE ALLIANCE/SEATTLE
  *ST JOE'S HOSP/TACOMA
  *SWEDISH/SEATTLE
  *U OF W MED CENTR/SEATTLE
  *VIRGINIA MASON HOSP

V59.3 (BONE MARROW DONOR) - HOSPITAL (M,R,S) CLAIMS - O'LOC TO 72.

V59.4 (KIDNEY DONOR) - DENY W/EOB 916, EXCEPT IF MEDICARE DENIAL ATTACHED INDICATING NO PART B COVERAGE, - FORCE WITH OVERCODE 111 ON DETAIL/HEADER (AUDREY FINNIGAN).

V61.2 (PARENT-CHILD PROBLEMS) - IF FOR CHILD ABUSE: CHANGE DX CODE TO 995.5.

V65.19 (OTHER PERSON CONSULTING ON BEHALF OF ANOTHER PERSON) -

1. INTERPRETER SERVICES - AMERICAN SIGN LANGUAGE (ASL) ONLY - PT 40 WITH SPEC. 60 OR 63:
   A. PRIOR TO 10/01/03 - 0997M AND/OR 0998M - FORCE
   B. 10/01/03 AND AFTER - T1013 AND/OR S0215 - FORCE.
2. ALL ELSE - DENY.

V65.5 (PERSON W/FEARED COMPLAINT IN WHOM NO DIAGNOSIS WAS MADE) CLAIM IS FOR A CHILD AND IT CLEARLY INDICATES THAT THE CHILD WAS BROUGHT IN BECAUSE OF AN ANXIOUS MOTHER - FORCE.

V70.0,V70.3,V70.4,V70.8 (GENERAL MEDICAL EXAM)
1. PHYSICAL EXAM FOR ADOPTION SUPPORT - FORCE.
2. HEALTHY ADULT OVER 65 RECEIVING IMMUNIZATIONS - FORCE IMMUNIZATION ONLY. ALL ELSE - DENY.
3. YEARLY PAP SMEAR (88141-88155, 88164-88167) - FORCE.
4. BIRTH CONTROL PILLS - FORCE.
5. PROCEDURE CODE 0310M & ALL PROCEDURES ON SAME DAY - FORCE.
6. E&M CODE W/EXCEPTION 498 POSTING (DDD CLIENT PHYSICAL) - DENY W/EOB 302. ALL OTHER PROCEDURES ON THE SAME DOS - DENY.
7. PHYSICAL EXAM FOR REFUGEES, OR IF IMIGRATION OR NATURALIZATION ON THE CLAIM - FORCE.
8. EPSDT "L" CLAIMS - FORCE.

V70.1 & V70.2 (GENERAL PSYCH EXAM) - IF THERE IS ANOTHER DX FOR THE SAME DOS WHICH DOES NOT REQUIRE APPROVAL OR DOES NOT SUSPEND THIS EXCEPTION - FORCE EVEN IF DX IS PRIMARY.

V70.5 (HEALTHY EXAM-GROUP SURVEY) - EPSDT "L" CLAIMS - FORCE.

V72.2 (DENTAL EXAM)-INDIAN HEALTH CLINICS (5999M) - FORCE. @
1. INDIAN HEALTH CLINICS (5999M) - FORCE.
2. ALL ELSE - SEE DX 520.1

V79.1 (ALCOHOLISM) - SEE 303.0

V79.2 (MENTAL RETARDATION) - IF SERVICE IS RENDERED IN A NURSING HOME (P.O.S. 6,7,8,24,31,32,54) - FORCE. @

V96.0 (EPSDT/HEALTH KIDS)
1. PRIOR TO 03/01/03 DOS - FORCE. @
2. AFTER 03/01/03 DOS - DENY.

TEXT KEY TEXT DESC

345 PROCEDURE CODE OR DIAGNOSIS INDICATES STERILIZATION (PAGES 1-9) OR HYSTERECTOMY (PAGES 10-16). A CONSENT FORM IS REQUIRED.

NOTE: *SH
HOSPITAL CLAIMS ONLY: IF HOSPITAL IS BILLING DX CODE V25.2 AND THERE IS NO STERILIZATION SURGICAL PROCEDURE CODE ON THE CLAIM (EXC 345 IS NOT POSTING): INPATIENT (R & S) CLAIMS - DENY EXCEPTION 343 WITH EOB 843, OUTPATIENT (M) CLAIMS - OVERLOC TO 72.

THE FOLLOWING APPLIES TO BOTH PHYSICIAN AND HOSPITAL CLAIMS:

NOTE: ADJUSTMENTS ONLY, IF THE FOLLOWING CRITERIA FOR THE CONSENT HAS NOT BEEN MET, CONTACT THE ORIGINATOR OF THE CLAIM FOR FINAL DISPOSITION.

NOTE: IF YOU HAVE A 42# THAT HAS PURGED, YOU MUST GO TO FILE/COPY ROOM IN DUS AND COPY YOUR 42# AND REBUILD THE NUMBER IN CLAIMS PROCESSING. IF YOU HAVE ANY OTHER AUTH # THAT PURGED, ROUTE TO QUALITY SUPPORT, NCC, 5506 AND ASK NCC TO REBUILD THE PURGED # INCLUDING THE NOTES.

NOTE: PROC CODES 52347, 52601, 52647, 52648, 58720 (PHYSICIAN STERILIZATIONS) OR AN ICD.9.CM EQUIVALENT IE. 65.51, 65.52, 65.53, 65.54, 65.61, 65.62, 65.63, 65.64, 66.52. IF IN DOUBT SEE YOUR TRAINER OR MMIS SERVICES.
EE: O'LOC TO 18
LOC 18:
1. V25.2 ANYWHERE ON CLAIM - FOLLOW TEXT FOR CONSENT REQUIREMENTS.
2. NO V25.2 ON CLAIM:
   A. CONSENT ATTACHED:
      1. MEETS CONSENT REQUIREMENTS - PROCESS PER TEXT.
      2. DOES NOT MEET CONSENT REQUIREMENTS - AND THERE IS A STATEMENT ON CLAIM (IE NOT STERILIZED, NO STERILIZATION DONE, NO VASECTOMY/TUBAL DONE, NOT DONE PRIMARILY FOR THE PURPOSE OF STERILIZATION) OR A REPORT TO BACKUP OR JUSTIFY ANY OF THE ABOVE STATEMENTS - BUILD A 42# INDICATING IN THE NOTES (NO V25.2 DX, JUSTIFICATION TO WAIVE CONSENT ON CLAIM/BACKUP PER DMM/MO). FORCE THE 345 EXCEPTION.
   B. NO CONSENT ATTACHED - FOLLOW 2.A.2 ABOVE.
   C. NO CONSENT ATTACHED AND NO STATEMENT - PROCESS PER TEXT.
REASONING: PER MEDICAL STAFF RATIONALE, NEVER DONE JUST FOR THE PURPOSE OF STERILIZING, TO PREVENT SURGICAL COMPLICATIONS, OR RETROGRADE INFECTION, OR IN SOME CASES, STERILIZING WAS NOT PART OF THE PROCEDURE.

STERILIZATIONS:
1. A VALID PROPERLY COMPLETED CONSENT FORM MUST BE ON FILE IN THE OFFICE PRIOR TO PAYMENT OF STERILIZATIONS AND RELATED PROCEDURES/CHARGES. ALL PROVIDERS ARE RESPONSIBLE FOR ATTACHING A COMPLETED CONSENT FORM TO THEIR CLAIMS.

NOTE: IF SYSTEM /RECORDS INDICATE PREVIOUS TUBAL, SECOND TUBAL REQUIRES A VALID AND COMPLETED CONSENT FORM. IF NOT - DENY W/EOB(S) 582/589. NOTE: AN EXCEPTION TO POLICY OR A REQUEST FOR AN EXCEPTION TO POLICY MAY BE PRESENT, IF SO, SEND TO MEDICAL CONSULTANT OFFICE FOR REVIEW BY DR/NCC. IF ALLOWED AN AUTH # SHOULD BE ADDRESSED. IF DENIED, USE EOB 582/373.

2. STERILIZATION CONSENT REQUIREMENTS:

NOTE: IF CONSENT DOES NOT MEET FEDERAL REQUIREMENTS & NO SPECIFIC DIRECTION ADDRESSED BELOW - DENY W/EOB 306.

A. ALL BLANKS MUST BE COMPLETED EXCEPT RACE, ETHNICITY, INTERPRETERS STATEMENT AREAS, BOX 24 (PRINTED NAME), AND ADDRESS OR ZIP IN SOME CASES: EXCEPTION: IF IN THE SECTION OF THE (PERSON OBTAINING CONSENT, LINES 14-17) THERE IS A SIGNATURE & DATE PRESENT, ONLY 1 OF EITHER FACILITY (INITIALS ARE ACCEPTABLE ON LINE #16 IF YOU CAN IDENTIFY THE CLINIC, EG: F.P.A.OF C. "FAMILY PLANNING ASSOCIATES OF CHELAN") OR ADDRESS NEED BE PRESENT. ZIP CODE IS NOT NECESSARY TO PROCESS THE CLAIM.
ALL BLANKS THAT INDICATE SIGNATURE REQUIRED MUST BE SIGNED, NOT TYPED. PRINTED IS ACCEPTABLE AS LONG AS IT IS ACCOMPANIED BY BY THE SIGNATURE.
EXCEPTION: IF AN INTERPRETER IS INVOLVED, AN "X" IS ACCEPTABLE BY THE PATIENT.

B. PATIENT MUST BE 18 OR OVER ON DATE THE CONSENT IS SIGNED.
NOTE: DOB ON CONSENT FORM AND DOB ON THE CLAIM SHOULD MATCH, HOWEVER, IF THEY DONT MATCH, IT IS ACCEPTABLE IF IT DOES NOT AFFECT THE LEGAL AGE (18).
NOTE: IF CLIENT IS UNDER AGE 21, THE 3 AREAS ON THE CONSENT FORM REFERRING TO AGE MUST BE MODIFIED TO REFLECT THE CORRECT AGE.

C. CONSENT SIGNATURE OF THE PATIENT EXPIRES 180 DAYS FROM THE DATE IT IS SIGNED.

D. THE FORM MUST BE SIGNED BY THE PATIENT AT LEAST 30 DAYS PRIOR TO SURGERY (DO NOT COUNT THE DATE SIGNED, START YOUR COUNT THE DAY FOLLOWING THE SIGNING AND COUNT 30 DAYS, THE SURGERY MAY BE PERFORMED ON THE 30TH DAY).

E. THE CONSENT MUST BE SIGNED BY THE DR OR PHYSICIAN AND THE SIGNATURE & DATE CAN BE EITHER BEFORE OR AFTER THE DATE OF THE SURGERY DATE INDICATED ON LINE 19.

F. EXCEPTIONS TO 30 DAY WAITING PERIOD:
1) IF PREMATURE DELIVERY BOX IS CHECKED - EDC MUST BE PRESENT ON CONSENT FORM. PATIENT SIGNATURE AND DATE MUST BE AT LEAST 30 DAYS PRIOR TO EDC AND AT LEAST 72 HOURS MUST HAVE PASSED FROM PATIENTS SIGNATURE AND DATE TO ACTUAL DATE OF STERILAZATION.
2) IF EMERGENCY ABDOMINAL SURGERY BOX IS CHECKED:
A) AND NO INDICATION OF C-SECTION - AT LEAST 72 HOURS MUST HAVE PASSED FROM PATIENTS SIGNATURE AND DATE TO ACTUAL DATE OF STERILIZATION.
B) IF INDICATION OF C-SECTION IS PRESENT EDC DATE MUST BE PRESENT ON CONSENT FORM. PATIENT SIGNATURE & DATE MUST BE AT LEAST 30 DAYS PRIOR TO EDC & AT LEAST 72 HOURS MUST HAVE PASSED FROM PATIENT SIGNATURE AND DATE TO ACTUAL DATE OF STERILIZATION.

G. IF THE MEDICAL ID CARD SHOWS DELAYED OR RETROACTIVE CERTIFICATION, ALL OF THE ABOVE CRITERIA MUST STILL BE MET.
H. IF NO CONSENT OBTAINABLE OR CONSENT CANNOT MEET REQUIREMENTS (I.E. UNDER 18, RETROCERT, INCOMPETENT) A LETTER OF EXCEPTION FROM THE MEDICAL DIRECTORS OFFICE MUST BE ATTACHED.
I. DATE OF STERILIZATION ON CONSENT MUST MATCH DATE OF SERVICE ON CLAIM.
J. THE PHYSICIAN IDENTIFIED IN THE CONSENT TO STERILIZATION SECTION ON LINE #5 & THE PHYSICIAN WHO COMPLETES THE PHYSICIANS STATEMENT ON LINE #22, & PERFORMS THE STERILIZATION DO NOT HAVE TO BE THE SAME PHYSICIAN, AND MAA WILL ACCEPT A GROUP NAME, CLINIC NAME, STATEMENT OF PHYSICIAN ON CALL AT (IE GROUP HEALTH) OR A PHYSICIANS NAME ON LINE #5 & IF LINE #5 HAS A GROUP OR CLINIC NAME, DO NOT BE CONCERNED ABOUT THE PHYSICIAN NAME ON LINE #22.
K. LINE #19 & #23 DO NOT NEED TO BE THE SAME DATE, HOWEVER, LINE #8 & #19 MUST STILL BE AT LEAST 30 DAYS APART.

EXCEPTION: "TO 30 DAY WAITING PERIOD" - EFFECTIVE 1/1/95, THE 30 DAY WAITING PERIOD FROM THE DATE OF CONSENT MAY BE WAIVED IN CERTAIN CASES FOR MEDICAL ASSISTANCE CLIENTS REQUESTING STERILIZATIONS. THE FOLLOWING CASES MEET THE WAIVER REQUIREMENT: NOTE: THE STATEMENT MUST BE THE SAME AS STATED IN MEMO (#94-71). WHEN WAIVING THE "30 DAY WAITING PERIOD" A COMPLETED COMPLIANT STERILIZATION CONSENT FORM IS REQUIRED FOR ALL OTHER REQUIREMENTS OTHER THAN THE "30 DAY WAITING PERIOD". BUILD THE 42# ADDRESSING IN THE NOTES "STATE FUNDS" AND THE REASON FROM THE CLAIM THAT MATCH THE WORDING BELOW. KEY A "W" IN THE ITA FIELD TO PROCESS THE CLAIM.

- WOMEN WHO BECOME ELIGIBLE FOR MEDICAL ASSISTANCE DURING THE LAST MO OF DELIVERY; (NOT ELIGIBLE 30 DAYS BEFORE DELIVERY).
- WOMEN WHO DO NOT OBTAIN MEDICAL CARE UNTIL THE LAST MO OF PREGNANCY OR AT DELIVERY AND WANT TO BE STERILIZED AT THE TIME OF DELIVERY; (NO MEDICAL CARE 30 DAYS BEFORE DELIVERY)
- WOMEN WHO HAVE BEEN SUBSTANCE ABUSERS DURING PREGNANCY, BUT WHO ARE NOT USING ALCOHOL OR ILLEGAL DRUGS AT THE TIME OF DELIVERY AND WANT TO BE STERILIZED AT THE TIME OF DELIVERY; (NO SUBSTANCE ABUSE AT TIME OF DELIVERY)

NOTE: THE ABOVE STATEMENTS MUST BE IN BOX 19 OR ANYWHERE ON THE CLAIM, IN THE COMMENTS, BACKUP OR ATTACHMENTS.

3. RESEARCH FOR 42#
A. CHECK AUTHORIZATION FILE BY PIC CODE FOR 42# OR ANY AUTH # THAT COVERS THE DOS. NOTE: AUTH # BEGINNING WITH "08" OR "80" ARE CONSIDERED EXCEPTION TO POLICY.
B. IF 42# FOUND, GO INTO FILE TO VERIFY THAT SERVICES IN FILE COVER SERVICES BILLED. IF SO PUT 42# ON CLAIM IN PRIOR-AUTH FIELD AND FORCE 345/343 EXCEPTION(S).

NOTE: IF DATE OF SURG ON 42# IS DIFFERENT THAN CLAIM, RESEARCH & REVIEW, IF BILLING INCORRECT DOS - DENY W/EOB 833.
NOTE: IF SERVICES DON'T MATCH, RESEARCH & REVIEW.

NOTE: IF SPECIFIC DATE OF SURGERY NOT INDICATED EITHER BY LINE ON PG 1 OR BY STATEMENT IN NOTES, THAT INFORMATION NEEDS

TO BE ADDED TO 42#. ALWAYS REFERENCE DATE, USER # AND INFO THAT HAS BEEN ADDED TO 42#.

C. IF NO 42# FOUND BUT AUTH # FOUND FOR DATE OF SERVICE, GO INTO FILE TO CHECK IF # IS FOR EXCEPTION TO POLICY. IF SO, PUT AUTH # ON CLAIM. IF ALL SERVICES ON CLAIM ARE FOR SAME DOS, PUT A "W" IN THE ITA FIELD. IF OTHER DOS ON CLAIM, CHECK CLIENT ELIGIBILTIY FILE TO SEE IF CLIENT IS ON A STATE FUNDED PROGRAM (SEE CHART AT END OF TEXT FOR STATE FUNDED PROGRAMS). IF SO, FORCE 345/343 EXCEPTION(S). IF CLIENT IS ON A FEDERALLY FUNDED PROGRAM FOR OTHER DOS, LEAVE STERILIZATION AND SERVICES FOR THAT DOS ON CLAIM, DENY OTHER DOS W/EOB 333/387 AND CREATE A NEW CLAIM. EXCEPTION: IF CLIENT IS UNDER 21, JUST FORCE 345/343 EXCEPTIONS). EXCEPTION:(HOSPITAL CLAIMS)-KEY A "W" REGARDLESS OF THE DOS ON THE CLAIM. DO NOT SEND TO MMIS.

D. IF NO 42# NOR AUTH # IS FOUND FOR EXCEPTION TO POLICY, REVIEW SCANNED CLAIMS/HARD COPY/ELECTRONIC BACKUP W/EXCEPTION 197 INDICATIONG BACK-UP SENT (BY AN "X" OR STATEMENT). IF 197 IS POSTING AND NO "X" OR COMMENT INDICATING BACK UP SENT, DENY EXCEPTION 345 AND DENY ALL OTHER SERVICES BILLED ON THE SAME DAY W/EOB 327. NO 197 EXCEPTION POSTING, DENY 345 EXCEPTION AND MANUALLY DENY ALL OTHER SERVICES BILLED ON THE SAME DAY W/EOB 327.

4. AFTER REVIEWING CLAIM/BACKUP & NO CONSENT ATTACHED:

A. IF STATEMENT ON CLAIM INDICATING PROV DID NOT KNOW PATIENT WAS ON WELFARE, SO NO DSHS CONSENT WAS OBTAINED, DENY ALL SERVICES ON THE SAME DAY W/EOB 306.

B. IF CLAIM, HISTORY, BACKUP OR AUTH # INDICATE THAT THE CLIENT WAS PREVIOUSLY STERILIZED BY ANOTHER METHOD & THERE IS NO DX V25.2 ON CURRENT CLAIM, BUILD A 42# INDICATING ALREADY STERILE, INDICATE THE REFERENCE ICN & PAY YOUR CLAIM. ANY QUESTIONS OR DOUBT - SEE SANDY A/MMIS.

5. AFTER REVIEWING CLAIM/BACKUP & CONSENT IS ATTACHED:
RECHECK AUTH FILE & STILL NO NUMBER ON FILE - REVIEW CONSENT FOLLOWING REQUIREMENTS LISTED IN 2. STERILIZATION CONSENT REQUIREMENTS:

A. CONSENT MEETS ALL RQUIREMENTS - BUILD A 42# (INSTRUCTIONS LISTED UNDER 6. - ASSIGNING A 42#).

B. CONSENT IS COMPLETE BUT 30 DAY WAITING PERIOD HAS NOT BEEN MET & 72 HOURS HAVE PASSED SINCE PATIENTS SIGNATURE. IF NO INDICATION OF PREMATURE DELIVERY/EMERGENCY ABDOMINAL SURGERY - DENY W/EOB 306. EXCEPTION: IF YOU SEE THAT A PROVIDER IS NOT UNDERSTANDING OUR DENIALS OR CLAIMS INDICATES REBILL, ETC - YOU MAY DENY W/EOB 969 & R/UNDER SEPARATE COVER EXPLAINING/REQUESTING INFO.

C. MORE THAN 180 DAYS BETWEEN DATE PATIENT SIGNED & DATED STERILIZATION WAS PERFORMED - DENY WITH EOB 306.

D. CONSENT FORM IS INCOMPLETE (ALL REQUIRED BLANKS NOT FILLED IN) DENY EXCEPTION 345 AND DENY ALL OTHER SERVICES ON THE SAME DAY WITH EOB 327. EXCEPT: IF DOS ON CONSENT IS MISSING - DENY W/EOB 833.

E. PATIENT IS UNDER 18 - DENY WITH EOB 306 (WITH NO EXC. TO POLICY).

F. PHYSICIAN ON THE CONSENT FORM LINE #22 SHOULD BE THE SAME PHYSICIAN WHO PERFORMED THE SURGERY (SURGEONS CLAIM), HOWEVER IF THE SIGNATURE IN LINE #22 IS NOT LEGIBLE & NO PRINTED NAME NAME IN LINE #24 TO VERIFY, DO NOT DENY.

PHYSICIAN CLAIMS: (SURGEON ONLY)
1) NO 42 # ON FILE, BUT CONSENT IS ATTACHED - SURGEON ON CONSENT DOES NOT MATCH CLAIM - DENY W/EOB 533 IF BOTH ARE LEGIBLE.
2) 42 # ALREADY ON FILE:
A) DR'S NAME ON 42 # DOES NOT MATCH CURRENT SURGEON CLAIM - DENY W/EOB 533/306 IF LEGIBLE.
B) NO NAME ON 42 #:
1. CONSENT ATTACHED ON CURRENT CLAIM & SURGEON MATCHES - ADD SURGEONS NAME TO 42 #.
2. CONSENT ATTACHED ON CURRENT/HISTORY CLAIM & SURGEON DOES NOT MATCH DR'S NAME ON CONSENT - DENY CURRENT CLAIM W/ EOB'S 533/306 IF LEGIBLE.
NOTE IN 42 # - SURGEON DENIED EOB 533, REFERENCE NEW ICN UPON REBILL OF SURGEONS CLAIM.
HOSPITAL CLAIMS: PROCESS ACCORDING TO ALL OTHER GUIDELINES IF THE SURGEONS BILL HAS NOT BEEN BILLED.
(REASONING: WE CANNOT HOLD THE COMPONENT BILLERS RESPONSIBLE IF THE SURGEONS BILL AND CONSENT AREN'T COMPLETED CORRECTLY, THE SURGEON IS RESPONSIBLE FOR OBTAINING THE CONSENT AND IT SHOULD MATCH THE CLAIM).
I. DOS ON CONSENT DOES NOT MATCH DOS CLAIM - DENY W/EOB 833.

6. ASSIGNING A 42#:
A. PAGE ONE - KEY IN ALL NECESSARY INFORMATION.
1) PA-CATEGORY IS 91.
2) NON-INSTITUTIONS-ENTER DATE OF SURGERY FROM THE CLAIM & CONSENT FORM.
INSTITUTIONS-ENTER APPROPRIATE SPAN OF DATES TO COVER SERVICES BILLED.
3) NON-INSTITUTIONS-USE DIAGNOSIS FROM CLAIM.
INSTITUTIONS-ENTER XXX, YYY OR ZZZ DEPENDING ON THE CLAIM TYPE.
B. PAGE TWO- NOTES KEY IN ALL NECESSARY INFORMATION.
1) DATE SCREEN BUILT.
2) USERS NUMBER.
3) DATE CONSENT SIGNED. (ORIGINAL DATE SIGNED & AMENDED DATE SIGNED).
4) REFERENCE ICN THAT VALID CONSENT IS ATTACHED TO.
5) IF PREMATURE DELIVERY, EDC DATE ALSO NEEDS TO BE IN NOTES.
6) IF EMERGENCY ABDOMINAL SURGERY, THAT INFORMATION NEEDS TO BE ADDRESSED.
7) INSTITUTIONS- ADD DATE OF SURGERY TO NOTES.

7. OTHER INFORMATION:
A. WHEN PROVIDER SPECIFICALLY ASKS FOR AN EXCEPTION TO POLICY BY A LETTER EXPLAINING CIRCUMSTANCES- SEND TO QFFS/CONNIE CHASE/ MAILSTOP 5506. ASK NCC TO REVIEW FOR POSSIBLE EXCEPTION TO POLICY AND IF APPROVED, TO PLEASE HAVE AN AUTHORIZATION NUMBER ASSIGNED WITH THE EXCEPTION TO POLICY STATED IN NOTES. WHEN CLAIM IS RETURNED, ADJUDICATE PER DR'S DECISION. IF DISAPPROVED, DENY WITH EOB'S 306 & 373. IF APPROVED -
(HOSPITALS) - USE ASSIGNED AUTH# AND KEY A "W" IN THE ITA FIELD REGARDLESS OF THE DATES ON THE CLAIM. DO NOT SEND TO MMIS.
(PHYSICIANS) USE ASSIGNED AUTH # AND IF ALL SERVICES ON THE CLAIM

ARE FOR THE SAME DATE, PUT A "W" IN THE ITA FIELD. IF THERE ARE OTHER DATES OF SERVICE ON THE CLAIM, CHECK CLIENT ELIGIBILITY FILE TO SEE IF CLIENT IS ON A STATE FUNDED PROGRAM (SEE CHART AT END OF TEXT). IF CLIENT IS ON A STATE FUNDED PROGRAM OR UNDER AGE 21, FORCE 345/343 EXCEPTIONS. IF CLIENT IS ON A FEDERALLY FUNDED PROGRAM, ROUTE CLAIM TO MMIS, STERILIZATION DESK TO HAVE A 1-DAY SEGEMENT BUILT FOR DATE OF STERILIZATION.

B. REBILLS WHERE SERVICES STILL AREN'T PAYABLE OR DONT MEET REQUIREMENTS - DENY STERILIZATION AS SUCH, EITHER 327 OR 306 EOB. OTHER SERVICES ON SAME DAY THAT WERE PREVIOUSLY DENIED BECAUSE OF CONSENT FORM OR DIDN'T MEET REQUIREMENTS, DENY WITH EOB 072.

C. ACCEPTABLE CONSENT FORMS: ARE DSHS 13-364 OR OMB APPROVED FORMS & ALL OTHER CONSENT FORMS THAT HAVE THE EXACT WORDING AS THE DSHS 13-364 OR OMB FORM (THIS INCLUDES OUT OF STATE CONSENT FORMS & SPANISH CONSENT FORMS), OTHERWISE DENY W/EOB"S 327/281.

D. AMENDED CONSENT IS ATTACHED: (PHYS IDENTIFIED IN "CONSENT TO STERILIZATION" & "PHYS STATEMENT" SECTION ARE NOT THE SAME) OR; THE NAME OF THE SURGEON HAS BEEN CHANGED.
   1. AN AMMENDED CONSENT CONTAINING ONLY THE ABOVE INFO SHOULD BE ATTACHED TO ORIGINAL CONSENT & CLAIM FORM.
   2. ALL POLICY SUCH AS DATE CLIENT INITIALLY SIGNED THE CONSENT, TO ESTABLISH 30/180 DAY REQUIREMENTS MUST BE TAKEN FROM THE ORIGINAL CONSENT.
   3. THE CLIENT SIGNATURE DATE ON THE AMMENDED CONSENT MAY REFLECT THE ACTUAL DATE OF SURGERY OR THE CURRENT DATE SHE SIGNED(DO NOT ACCEPT A COPY OF ORIGINAL W/ORIGINAL CONSENT DATE AS THE DATE CLIENT SIGNED ACKNOWLEDGING THAT A DIFFERENT PHYSICIAN WILL PERFORM THE SURGERY).
   4. IF ANY OF THE REQUIREMENTS ARE NOT MET - DENY W/EOB 306. (NOTE: IF YOU HAVE QUESTIONS REGARDING POLICY, OTHER ACCEPTABLE INFO OR UPDATED TEXTFILES - SEE MMIS SECTION)

E. CLIENT STATEMENT FORM IS ATTACHED: (PHYS IDENTIFIED IN "CONSENT TO STERILIZATION" & "PHYS STATEMENT" SECTION ARE NOT THE SAME)
   1. EFF 3/03 PER MEMO # 02-92, THE CLIENT STATEMENT FORM MAY BE ATTACHED THE ORIGINAL CONSENT & CLAIM FORM.
   2. ALL POLICY SUCH AS DATE CLIENT INITIALLY SIGNED THE CONSENT, TO ESTABLISH 30/180 DAY REQUIREMENTS MUST BE TAKEN FROM THE ORIGINAL CONSENT.
   3. CLIENT STATEMENT FORM MUST BE FILLED OUT BY THE CLIENT & MUST CONTAIN INDIVIDUAL TO BE STERILIZED, ACKNOWLEDGE THE PHYS WHO WILL PERFORM THE SURGERY, SPECIFIY TYPE OF SURGERY (OPTIONAL, ONLY NECESSARY IF SURGERY CHANGES), CLIENT SIGNATURE & DATE ACKNOWLEMENT OF NEW PHYS.
   4. THE CLIENT SIGNATURE DATE ON THE CLIENT STATEMENT FORM MAY REFLECT THE ACTUAL DATE OF SURGERY OR THE CURRENT DATE SHE SIGNED. *S
   5. IF ANY OF THE REQUIREMENTS ARE NOT MET - DENY W/EOB 306. (NOTE: IF YOU HAVE QUESTIONS REGARDING POLICY, OTHER ACCEPTABLE INFO OR UPDATED TEXTFILES - SEE MMIS SECTION)

F. DATE OF STERILIZATION MUST BE THE SAME ON ALL CLAIMS. IF CONFLICT, REVIEW ALL DOCUMENTS TO DETERMINE WHICH IS CORRECT AND ADJUDICATE

ALL PAID AND/OR UNPAID CLAIMS APPROPRIATELY.
EXCEPTION: IF THE 42# IS BUILT FROM THE SURGEONS CLAIM & CONSENT & THE SURGERY DATE ON CONSENT MATCH HIS SURGERY DATE ON HIS CLAIM & THE HOSP CLAIM SURGERY DATE DOES NOT MATCH, YOU MAY ADD THE 42# TO THE HOSP CLAIM FOR PAYMENT IF THE PHYSICIAN SURGERY DATE IS WITHIN THE HOSP CLAIM DOS, (IE SURGEON DOS IS 2/15/04 & HOSP DOS IS 2/14/04-2/19/04, HOWEVER IF THE 42# IS BUILT AROUND THE HOSP CLAIM & IT PAID & THE SURGEON CLAIM DOS FALLS WITHIN THE HOSPITAL SPAN DOS ENTERED ON THE 42#, PROCESS THE SURGEONS CLAIM. IF THE SURGEONS CLAIM DOS FALLS OUTSIDE OF THE HOSPITAL SPAN, VERIFY THE CONSENT SURGERY DATE & EITHER RECOUP & DENY THE HOSPITAL CLAIM OR DENY THE SURGEONS CLAIM. *S

G. IF THE CLIENT IS NOTED AS MENTALLY INCOMPETENT, THE LEGAL GUARDIAN HAS SIGNED, THE CONSENT IS APPROPRIATELY COMPLETED, & THERE IS A COURT ORDER ATTACHED, THE CLAIM SHOULD BE ROUTED TO QFFS/MED CONSULT/MS 5506 FOR AN EXCEPTION TO POLICY. UPON RETURN, PUT A "W" IN THE ITA AND PROCESS UNDER STATE FUNDS. FFR DOES NOT APPROVE STERILIZATIONS FOR MENTALLY INCOMPETENT INDIVIDUALS.

H. ANYTHING NOT ADDRESSED IN THIS TEXT OR ANY QUESTIONS, SEE YOUR SUPERVISOR, OR LEAD EXAMINER FOR LOC 18.

NOTE: READ NOTES AT BEGINNING OF TEXT BEFORE DENYING.

---------- THIS IS THE END OF DIRECTION FOR STERILIZATIONS ----------

HYSTERECTOMIES:

NOTE: IF YOU HAVE A HYSTERECTOMY W/DX (V25.2), CHECK CLAIM FOR OTHER MEDICAL DIAGNOSIS ON THE SAME DAY,IF ANOTHER DIAGNOSIS IS FOUND, ENTER THAT DIAGNOSIS ON THE LINE. IF NONE OTHER FOUND - DENY W/EOB 325.

NOTE: IF CPT ANESTHESIA CODE (00846) IS BILLED: (REMOVE 7/1/03)
1. PRIOR TO 1/1/02 - DENY W/EOB 302.
2. 1/1/02 AND AFTER - APPLY 345 CRITERIA.

NOTE: IF CPT ANESTHESIA CODE 01962 BILLED: (REMOVE 7/1/03
1. PRIOR TO 1/1/02 - FORCE. (NOT A HYSTERECTOMY)
2. 1/1/02 AND AFTER - APPLY 345 CRITERIA.

NOTE: PER DR COYNE ON 3/19/04, MAA WILL ACCEPT RETRO OR DELAYED CERTS IF THE CLIENT IS COVERED DURING THE TIME PERIOD IN WHICH THE HYSTERECTOMY TOOK PLACE AND A COPY OF THE PROPERLY COMPLETED CONSENT FORM IS ATTACHED.

1. A CONSENT FORM IS REQUIRED. ALL PROVIDERS ARE RESPONSIBLE FOR ATTACHING A COMPLETED CONSENT FORM TO THEIR CLAIMS.

2. CONSENT REQUIREMENTS: ANY CONSENT MAY USED, BUT IT MUST STATE HYSTERCTOMY ON THE CONSENT & CONTAIN THE FOLLOWING:
   A. PHYSICIAN'S SIGNATURE. (MUST BE PRESENT SOMEWHERE ON THE CONSENT UNLESS B.2 APPLIES & THEN IT IS SPECIFIC TO THAT SECTION ONLY)
   B. CLIENT'S SIGNATURE, THE CLIENT SIGNATURE MUST BE PRIOR TO SURGERY

DATE UNLESS, ACKNOWLEDGEMENT WAS NOT REQUIRED BECAUSE OF 1 OF
1. THE INDIVIDUAL WAS STERILE AT TIME OF SURGERY (BOX MUST BE MARKED & PHYS MUST STATE REASON & SIGN AND DATE).
2. THE INDIVIDUAL REQUIRED A HYSTO ON AN EMERGENT/LIFE THREATENING CIRCUMSTANCE (BOX MUST BE MARKED & PHYS MUST SIGN & DATE.

C. REASON FOR HYSTERECTOMY
D. NAME OF PERSON OBTAINING CONSENT, ALTHOUGH IT IS PREFERABLE TO BE THE DR. SIGNATURE IN THE BOX "SIGNATURE OF PERSON OBTAINING SURGICAL CONSENT", AND RN OR OTHER STAFF IS ACCEPTABLE.

3. REASONS TO WAIVE A PROPERLY COMPLETED CONSENT FORM:
A. PATIENT STERILE AT TIME OF PROCEDURE (I.E. PREVIOUS TUBAL, PREVIOUS BTL, STERILE, POST-MENOPAUSE, LONG STANDING INFERTILITY IN COMBINATION W/NEVER BEEN PREGNANT), OR PATIENT IS AGE 6O OR OLDER. INFO MAY BE FOUND IN AUTH #, CONSENT FORM, OP REPORT, DX, PHYSLETTER OR CLAIM.

B. PROCEDURE DONE ON EMERGENCY BASIS - LIFE THREATENING CIRCUMSTANCE PER PHYSICIAN'S STATEMENT & SIGNATURE ON CONSENT. INFO MAY ALSO BE FOUND IN AUTH #, OP REPORT, OR PHYSICIANS LETTER.
C. PROVIDER BILLED WITH AN EMERGENT DX. TO CHECK, GO TO PDD FILE AND LOOK UP BILLING DX ON HYSTERECTOMY. IF PA INDICATOR HAS AN (E), THEN DX IS CONSIDERED EMERGENT. HOSPITALS - USE ANY DX ON THE CLAIM THAT IS EMERGENT EXCEPT NORMAL/VAGINAL DELIVERY DX.

NOTE: IF ANY OF THE ABOVE APPLY & YOU ARE WAIVING CONSENT THEN THIS INFORMATION NEEDS TO BE ADDED TO AUTH FILE, IF NOT ALREADY THERE, OR A 42# NEEDS TO BE BUILT, REFERENCING WHY CONSENT IS WAIVED AND ICN WHERE INFO CAME FROM. NOTE: NEVER UPDATE AN "87" AUTH #, BUT DO X-REFERENCE THE "87" AUTH # IN NOTES PG OF 42#.

4. PRESORTING WORKSHEETS:
A. CHECK AUTHORIZATION FILE BY PIC CODE FOR AUTH # OR 42 #.
B. IF AUTH # IS FOUND, CHECK NOTES. THINGS TO LOOK FOR IN NOTES ARE;
1) REASONS TO WAIVE CONSENT.
2) CONSENT ATTACHED TO ICN.....
IF ANY OF THE LISTED INFORMATION IS FOUND IN THE NOTES, PUT AUTH # ON CLAIM AND FORCE 345 EXCEPTION. IF INFORMATION LISTED IS NOT FOUND - PUT IN FOR STAGING. EXCEPTION: IF ELECTRONIC MEDIA CLAIM AND NO BACK-UP IS INDICATED, DENY 345 EXCEPTION.
C. IF NO AUTH # IS FOUND BUT 42# IS FOUND, CHECK FILE TO VERIFY THAT SERVICES IN FILE COVER SERVICES BILLED. IF SO, PUT 42 # ON CLAIM AND FORCE 345 EXCEPTION.

D. IF BOTH AUTH # AND 42 # ARE FOUND FOR HYSTERECTOMY, CROSS-REFERENCE INFORMATION INTO BOTH FILES. IF THIS HAS ALREADY BEEN DONE, THEN PUT THE AUTH # ON THE CLAIM AND FORCE THE 345 EXCEPTION. NOTE: NEVER UPDATE AN "87" AUTH #, BUT IT MAY BE NECESSARY TO X-REFERENCE THE "87" # IN THE 42 #.

E. IF NO AUTH # OR 42 # ARE FOUND, ALL HARD COPY WORKSHEETS PUT IN FOR STAGING. ELECTRONIC MEDIA CLAIMS - IF BACK-UP IS INDICATED, PUT IN FOR STAGING. IF NO BACK-UP IS INDICATED, CHECK DIAGNOSIS ON CLAIM IN PDD FILE FOR EMERGENT DIAG (E IN PA-INDICATOR FIELD).

IF EMERGENT, GIVE TO LOC 20 LEADWORKER TO BUILD 42 #. IF NON-EMERGENT (N OR Y IN PA-INDICATOR FIELD), DENY 345 EXCEPTION.

5. AFTER STAGING - NO CONSENT FORM ATTACHED:
   A. RECHECK AUTH FILE - FOLLOW INSTRUCTIONS UNDER D. PRESORTING WORK-SHEETS 1-4.
   B. AFTER RECHECKING AUTH FILE, IF AUTH # FOUND, BUT THERE IS NO

      ON FILE, DENY 345 EXCEPTION.
   C. AFTER RECHECKING AUTH FILE AND NO NUMBER FOUND, DENY 345 EXCEP.

6. AFTER STAGING - CONSENT FORM ATTACHED:
   A. RECHECK AUTH FILE - FOLLOW INSTRUCTIONS UNDER D. PRESORTING WORK-SHEETS 1-4.
   B. AFTER RECHECKING AUTH FILE, IF AUTH # FOUND BUT THERE IS NO REF-ERENCE TO WAIVING CONSENT OR CONSENT IS ON FILE, REVIEW BACK-UP. IF VALID CONSENT IS ATTACHED, ADD INFORMATION INTO AUTH #. IF CONSENT LACKS ALL NECESSARY REQUIREMENTS - DENY W/EOB 969 AND RETURN UNDER SEPARATE COVER OR DENY W/EOB 327, WHICHEVER IS THE MOST APPROPRIATE. NOTE: NEVER UPDATE AN "87" AUTH #.

7. ADDING INFORMATION TO AUTH SCREEN:
   THE ONLY INFORMATION LOC 20 SHOULD ADD TO AN AUTH SCREEN IS INFORMATION REGARDING THE CONSENT. IF CONSENT IS ATTACHED, PUT IN NOTES DATE, USER # AND REFERENCE THE ICN THAT THE CONSENT IS ATT-ACHED TO. OR IF WAIVING A CONSENT FOR ANY REASON, PUT IN NOTES DATE, USER # AND SPECIFY REASON CONSENT IS BEING WAIVED. ALWAYS, REFERENCE WHERE THE INFORMATION CAME FROM. NOTE: NEVER UPDATE AN "87" AUTH #, BUT IT MAY BE NECESSARY TO X-REFERENCE THE "87" # IN THE 42 #.

8. ASSIGNING A 42 #:
   A. PAGE ONE - KEY IN ALL NECESSARY INFORMATION
      1. PA - CATEGORY IS 91.
      2. DATES:
       - NON-INSTITUTIONS - ENTER DATE OF SURGERY FROM CLAIM.
       - INSTITUTIONS - ENTER SPAN OF DATES FOR HOSPITAL STAY. *S
      3. DIAGNOSIS:
       - NON-INSTITUTIONS - PUT DX FROM CLAIM FORM IN DX FIELD.
       - INSTITUTIONS - ENTER XXX,YYY OR ZZZ DEPENDING ON THE CLAIM TYPE.
      4. NON-INSTITUTIONS - APPROVAL SHOULD ALWAYS BE ADDRESSED. IF NOT NEEDED PER DX THAT DOESN'T REQUIRE APPROVAL, ADD THAT TO NOTES REFERENCING ICD-9 DX CODE AND ICN INFO CAME FROM. IF DX DOES REQUIRE APPROVAL AND YOU HAVE NO AUTH # TO REFERENCE-ADD THIS INFO TO NOTES.(EFFECTIVE 10/01/96 - APPROVAL MAY NOT BE BE AN ISSUE, HOWEVER IF 353 IS POSTING, ADDRESS IT).
      NOTE:NEVER UPDATE A "87" #, BUT IT MAY BE NECESSARY TO X-REFERENCE AN "87"# IN THE 42#.
   B. PAGE TWO - KEY IN ALL NECESSARY INFORMATION:
      1. DATE SCREEN BUILT.
      2. USER NUMBER.
      3. INDICATE HYSTERECTOMY CONSENT ATTACHED OR CONSENT WAIVED FOR - STATE REASON AND REFERENCE ICN WHERE INFORMATION CAME FROM.

4. INSTITUTIONS - ADD SPAN OF DATES FROM CLAIM, WHICH INCLUDES THE SURGERY DATE. *S

9. OTHER INFORMATION:
   A. AUTHORIZATION #'S FOR HYSTERECTOMIES THAT STATE IN NOTES: EXCEPTION TO POLICY FOR MI PROGRAM. EXCEPTION TO POLICY ACUTE & EMERGENT PROGRAM, ETC ARE NOT EXCEPTION TO WAIVE CONSENT. THE EXCEPTION IS FOR THE MEDICAL NECESSITY FOR THE PROCEDURE WHICH WOULDN'T NORMALLY BE COVERED UNDER THE PROGRAM THAT THE PATIENT IS ON. A VALID CONSENT FORM IS STILL REQUIRED UNLESS THE PATIENT IS STERILE.
   B. REMEMBER - EXCEPTION 345 FOR HYSTERECTOMIES IS FOR CONSENT NOT APPROVAL. APPROVAL ISSUES ARE A SEPERATE ISSUE AND WILL BE HANDLED ACCORDINGLY.
   C. NEVER UPDATE AN "87" AUTH #. IT MAY BE NECESSARY TO CREATE A 42#, ADDRESS 87# IN NOTES AND ENTER 42# ON CLAIM. IF "ETP" IS THE ISSUE, THERE WILL ALWAYS BE SEPARATE APPROVAL FROM THE 87#.
   D. ANYTHING NOT ADDRESSED IN THIS TEXT OR ANY QUESTION, SEE YOUR SUPERVISOR OR LOC 17 LEAD EXAMINER.

   E. FFR WILL PAY FOR HYSTERECTOMIES OF A MENTALLY INCOMPETENT INDIVIDUAL, HOWEVER, THE CONSENT FORM MUST MEET ALL FFR REQUIREMENTS AND BE SIGNED BY THE LEGAL GUARDIAN AND THE HYSTO MUST HAVE A MEDICAL DX. EXPEDITED AUTH MAY BE REQUIRED DEPENDING UPON THE DX.

THE FOLLOWING MAY NOT BE A COMPLETE LIST. AS NEW STATE PROGRAMS ARE DEVELOPED, THEY CAN BE ADDED TO THIS LIST. IF YOU HAVE AN EXCEPTION TO POLICY TO PAY OUT OF STATE FUNDS AND YOU ARE UNSURE OF THE CLIENTS PROGRAM, YOU CAN ALWAYS SEND TO MMIS / CATHIE OTT MAILSTOP 5564. SHE WILL LOAD FOR PAYMENT IF NECESSARY.

100% STATE FUNDED PROGRAMS

PROGRAM CODE	MATCH CODE
M (MI)	G,P
Q (ITA)	U
R (REFUGEE)	U
S	U
U (GAU)	ANY
V	F,Z
W (ADATSA)	U,R
X MEDICAID EXPEDITED DISABILITY	U

PROCEDURE TO FOLLOW WHEN DENYING A CLAIM W/EOB 969:

1. FILL OUT ALL AREAS AT TOP OF RETURN FORM.
   A. RETURN REASON:
   B. CLAIM #:
   C. RETURN DATE:
   D. PIC:
2. IF PRE-PRINTED REASON ON FORM, X THE ONE THAT APPLIES TO YOUR RETURN.

3. IF NOT, X THE LINE INDICATING (OTHER) AND ADDRESS THE PROBLEM.
4. HARD COPY CLAIMS:
   ADD ICN TO BOX 19.
   ADD (R 969) TO UPPER RIGHT CORNER OF HARD COPY CLAIM.
   ADD YOUR (USER #) TO UPPER LEFT CORNER OF HARD COPY CLAIM.
   LINE THROUGH CURRENT ICN ON HARD COPY CLAIM.
5. ADDRESS ENVELOPE.
6. PUT RETURN FORM, CONSENT AND CLAIM (IF HARD COPY) IN ENVELOPE.
7. PUT ENVELOPE IN OUT GOING MAIL BOX OR SLOT.

---------- NOTE ----------

DO NOT FORGET TO DENY THE CLAIM

TEXT KEY TEXT DESC

348 SUSPEND OVER MAX - CODE INDICATED ON THE PDD WHICH SUSPENDS IF THE BILLED AMOUNT IS GREATER THAN THE SUSPEND MAX FEE.

MED VENDOR (P) --- SEE PAGE 014 (RES ONLY)
DENTAL (K) --------SEE PAGE 017

PHYSICIAN CLAIMS (J) HEALTHY KIDS (L) OUTPATIENT (M PT 62 ONLY)
THESE SUSPEND IF THE BILLED AMOUNT IS GREATER THAN THE SUSPEND MAX.

NOTE:
(EE) IF THIS TEXT INDICATES TO PRICE A DRUG/CONTRAST MATERIAL AT AT INVOICE PRICE AND PDDD DESCRIPTION DOES NOT LIST A DOSAGE (IE,5 MG) & NO INDICATION OF DRUG/CONTRAST MATERIAL, NAME, STRENGTH &/OR QUANTITY IS PRESENT-DENY W/EOB 436/196. PROV MUST LIST DRUG/CONTRAST MATERIAL NAME, STRENGTH AND/OR DOSAGE USED ON CLAIM OR BACKUP.

NOTE:
(EE) IF THIS TEXT INDICATES TO PAY AT INVOICE PRICE - O'LOC TO 14 FOR PRICING, UNLESS INVOICE DOES NOT MATCH, THEN DENY W/EOB'S 459/196.
NOTE:
(EE) IF AUTH # - O'LOC TO 14
(LOC 14) IF AUTH # - REVIEW AUTH NOTES BEFORE PRICING.

MISCELLANEOUS
1. A4250 - A4572 (SUPPLIES)
(EE) IF NO INVOICE ATTACHED - DENY W/EOB 196.
(LOC 14) IF INVOICE ATTACHED - PAY AT INVOICE PRICE.

2. A4600 - A9700 (CONTRAST/RADIOPHARMACEUTICAL MATERIALS/AGENTS)
Q3000 - Q3012 (RADIOPHARMACEUTICAL IMAGING AGENTS)
(EE) 1: IF NO INVOICE ATTACHED - DENY W/EOB 196.
2: IF INVOICE ATTACHED - O'LOC TO 14.
(RES)LOC 14 - IF INVOICE ATTACHED - PAY AT INVOICE PRICE.

3. L8600 (BREAST IMPLANT)
(EE) IF INVOICE ATTACHED, PAY AT INVOICE PRICE.
IF NO INVOICE ATTACHED, PRICE @ $650.00.

4. L8605/1949M (BREAST TISSUE EXPANDER)
(EE) IF INVOICE ATTACHED, PAY AT INVOICE PRICE.
IF NO INVOICE ATTACHED, PRICE @ $950.00.

3. Q0105-Q0107 (LOCM)
(EE) IF NO INVOICE ATTACHED - DENY W/EOB 196.
IF INVOICE ATTACHED, PAY AT INVOICE PRICE, IF PROV INDICATES AN ADDITIONAL 15% ON HIS INVOICE, PAY INVOICE PRICE + 15%.

4. 9019M (SPECIAL MAILING/PROVIDER #1049477 INLAND NW GENETICS CLINIC)
(EE) IF NO INVOICE ATTACHED - DENY W/EOB 196.

IF INVOICE ATTACHED, PAY AT INVOICE PRICE.

5. 90749 (UNLISTED IMMUNIZATION)
(EE) DENY W/EOB 248.

6. 9908M (INLAND IMAGING HEART CATHETER)
(EE) IF NO INVOICE ATTACHED, PAY UP TO $300.00.
IF INVOICE ATTACHED, PAY AT INVOICE PRICE UP TO $300.00.

7. 9909M (INLAND IMAGING SUPPLES)
(EE) IF NOT INVOICE ATTACHED, DENY W/EOB 196.
IF INVOICE ATTACHED, PAY AT INVOICE.

8. 1603L (PREFABRICATED ORTHOTIC)
(EE) IF NO INVOICE, DENY W/EOB 196.
IF INVOICE ATTACHED, PAY AT INVOICE.

9. Q4050 - Q4051 (CAST SUPPLIES/SPLINT SUPPLIES)
(EE) IF NOT INVOICE, ADENY W/EOB 196.
IF INVOICE ATTACHED, PAY AT INVOICE.

SURGERIES (10000-69999)
(LOC 14)
A. 37799 (IF FOR HICKMAN/BROVIAC CATH, PORTA CATHETER OR IF FOR GROSHONG CATH), PAY AT $225.16 (4.2). IF FOR REMOVAL OF ABOVE CATHETERS, OVERLOC TO 14.
B. ALL ELSE
1) IF NO REPORT OR NO COMMENT INDICATING ABOVE - DENY W/EOB 190.
2) IF REPORT ATTACHED OR AN X IN COMMENTS, OVERLOC TO 14.
- RT CLAIM/BACKUP/FORM TO OMD/LAURA PIERPOINT/MS 45506 FOR PRICING. FILL OUT THE FORM INDICATING WHAT YOU WANT THE MED CONSULT/NCC TO DO. UPON RETURN, CLAIMS SHOULD BE PRICED BY CP PER INFO ON FORM USING INFO EOB 373. ALL OTHER POLICY/PROCEDURE (053/345/ETC) IS APPLICABLE.
- PRIOR TO FINALIZING THE CLAIM - IF THE MC/NCC HAS INDICATED A DECISION BASED ON ANOTHER PROCEDURE - ENTER THE PROCEDURE IN THE ONLINE COMMENT SCREEN. ANY QUEST- SEE TRAINER/MMIS.

J1565 (INTRAVENOUS RESPIRATORY SYNCTIAL VIRUS)
(EE) IF CLAIM OR BACKUP INDICATES SYNAGIS - DENY W/EOB 302.
(LOC 14) RESPIGAM & ALL ELSE - MANUAL PRICE AT BILLED AMT.

J3490 (UNCLASSIFIED DRUGS)
(EE):
A. SYNVISC/HYALGAN PER STATEMENT/COMMENTS - DENY W/EOB 302.
B. ALL ELSE:
1. BILLED AMT IS OVER $1100:
A. INVOICE IS ATTACHED & NDC AND DOSAGE IS ON CLAIM/COMMENTS - O'LOC TO 14.
B. IF ANY OF THE ABOVE ARE MISSING - DENY W/EOB'S 196/405.
2. BILLED AMT IS UNDER $1100:
A. DOSAGE, & NDC IS ON CLAIM/COMMENTS - O'LOC TO 14.
B. IF ANY OF THE ABOVE ARE MISSING - DENY W/EOB 405.

RES/ADJ (LOC 14)

A. BILLED AMT IS OVER $1100: PRICE PER INVOICE.
B. BILLED AMT IS UNDER $1100: PRICE PER POS SYSTEM.
EXCEPT PT 71: RT WRKSHT/CLAIM/BACKUP TO PRS/LOU M/MS 45510
W/NOTATION INDICATING (FAMILY PLANNING, J3490 OVER $100)
PLEASE PRICE.

PRICING PER POS SYTEM, USE NDC AWP ALLOWANCE X UNITS BILLED X ABOVE ALLOWED % FOR DOS = ALLOWED AMT. SEE EXAMPLE BELOW:

.26 (POS AWP) X 10 (UNITS BILLED) X 89% = $2.31 (ALLOWED AMT)

ALLOWABLE % PER DOS:
CLAIMS W/DOS THRU 6/30/03 = 89% OF AWP.
CLAIMS W/DOS 7/1/03 & AFTER = 86% OF AWP.

NOTE: ANY QUESTIONS SEE MMIS/SANDY ASBACH.

NOTE: ALL CLAIMS CUT TO 1 UNIT PER 177 W/EOB 431, REVIEW ON-LINE COMMENTS FOR ORIGINAL UNITS BILLED FOR PRICING PER NDC.

J7315/J7316/J7317 (HYALGAN)
(LOC 14)

NOTE: HYALGAN MAY BE BILLED UNDER
1. J7315 - (HYALGAN 20 MG) DOS 7/1/99 THRU 03/31/02
2. J7316 - (HYALGAN 5 MG) DOS 1/1/02 - 02/28/03
3. J7317 - (HYALGAN 20-25 MG) DOS 1/1/03 & AFTER
-NOTE: SYNVISC/HYALGAN ARE NOT ALLOWED IN COMBINATION. IF BILLED IN COMBO - SEE YOUR LOC 14 TRAINER/MMIS.

-NOTE: J7315/J7316/J7317 BILLED IN COMBO - O'LOC TO 83.

HYALGAN SERVICES ARE ONLY ALLOWED FOR:

1. REQUIREMENTS:
A. SPECIFIC TO SPECIALTY FOR PROVIDER/PERFORMING PROVIDER#:
1) ORTHOPEDIC SURGEONS (SPECIALTY 20)
2) INTERNIST/RHEUMOTOLOGISTS (SPECIALTY 41)
3) SPECIFIC APPROVED PERFORMING PROVIDER #'S:
A) 1687201 (DR SNOOK)
B) 8197378 (DR ARTZIS)
C) 8274003 (DR SHANNON)
D) 8646200 (DR LIND)

NOTE: IF A CLINIC BILLING, (20/70) PF-4 UNDER PERFORMING PROVIDER # TO CHECK SPECIALTY.
B. J7315/J7316/J7317 (HYALGAN) MUST BE BILLED W/PROCEDURE CODE 20610 IN ORDER TO RECEIVE PAYMENT.

2. IF BOTH REQUIREMENTS NOT MET - DENY J7315/J7316/J7317 W/EOBS 325/373.

NOTE: IF 20610 BILLED ON SAME DOS AND NOT ABOVE LISTED SPECIALTY OR SPECIFIC PROVIDER NUMBER AND DENYING J7315/J7316/J7317,

DENY 20610 W/EOBS 325/373 ALSO.

3. IF BOTH REQUIREMENTS ARE MET: MANUAL PRICE (J7315/J7316/J7317) W/INFO EOB 373.

PRICING

A. 7/1/99 - 04/30/02 - $661 FOR THE SERIES OF 5 INJECTIONS.
B. 05/01/02 - 06/30/02 - $640.80 FOR THE SERIES OF 5 INJECTIONS.
C. 07/01/02 - 12/31/02 - $522.40 FOR THE SERIES OF 5 INJECTIONS
D. 01/01/03 - 06/30/03 - $666.40 FOR THE SERIES OF 5 INJECTIONS.
E. 07/01/03 & AFTER - $643.95 FOR THE SERIES OF 5 INJECTIONS.

NOTE: J7315 (20 MG) = 1 UNIT OR 1 INJECTION OF DRUG & ALLOWS $132.20 A MAX OF 5 UNITS ARE ALLOWED ($661.00). 1 UNIT PER DOS, PER KNEE. 20610 CAN BE BILLED UP TO 5 TIMES (1 FOR EA INJECTION OF THE DRUG), PER KNEE. LT OR RT MUST BE INDICATED.

NOTE: J7316 (5 MG) = 1 UNIT. 4 UNITS = 1 INJECTION OF THE DRUG. EA UNIT IS ALLOWED A MAX OF $33.05 THRU DOS 4/30/02, $34.02 FOR DOS 5/1/02 - 6/30/02 & $26.12 FOR DOS 7/1/02 -12/31/02. A MAX OF 20 UNITS ARE ALLOWED ($661) THRU DOS 4/30/02, ($640.80) FOR DOS 5/1/02 -6/30/02 & (522.40) FOR DOS 7/1/02 - 12/31/02. UNITS PER KNEE. 20610 CAN BE BILLED UP TO 5 TIMES (1 FOR EACH 4 UNITS OF THE DRUG), PER KNEE. LT OR RT MUST BE INDICATED.

NOTE: J7317 (20-25 MG) = 1 UNIT OR 1 INJECTION OF DRUG & ALLOWS $133.28 FOR DOS 01/01/03 THRU 06/30/03, $128.79 FOR DOS 07/01/03 & AFTER. A MAX OF 5 UNITS ARE ALLOWED ($666.40) FOR DOS 01/01/03 THRU 06/30/03, ($643.95) FOR DOS 07/01/03 & AFTER. 1 UNIT PER DOS, PER KNEE, 20610 CAN BE BILLED UP TO 5 TIMES (1 FOR EA INJECTION OF THE DRUG), PER KNEE. LT OR RT MUST BE INDICATED.

NOTE: THE INJECTION PROCEDURE (20610) SHOULD BE BILLED ON SEPARATE LINES. IF MULTI UNITS ON 1 LINE - DENY W/EOB 538.

ANY QUESTIONS SEE SANDY IN MMIS OR ROUTE TO MMIS/SANDY/45564

J7320 (SYNVISC)
(LOC 14)

NOTE: SYNVISC/HYALGAN ARE NOT ALLOWED IN COMBINATION. IF BILLED IN COMBO - SEE YOUR LOC 14 TRAINER.

SYNVISC SERVICES ONLY ALLOWED FOR:
1. REQUIREMENTS -
   A. SPECIFIC TO SPECIALTY OR PROVIDER/PERFORMING PROVIDER #:
      1) ORTHOPEDIC SURGEONS (SPECIALTY 20)
      2) INTERNIST.RHEUMOTOLOGISTS (SPECIALTY 41)
      3) PERFORMING PROVIDER #'S:
         A) 1687201 (DR SNOOK)
         B) 8197378 (DR ARTZIS)
         C) 8274003 (DR SHANNON)
         D) 8646200 (DR LIND)

NOTE: IF A CLINIC BILLING, (20/70) PF-4 UNDER THE PERFORMING PROVIDER # TO CHECK SPECIALTY.

B. J7320 MUST BE BILLED W/PROCEDURE CODE 20610 IN ORDER TO RECEIVE PAYMENT.

2. IF BOTH REQUIREMENTS NOT MET - DENY J7320 W/EOBS 325/373.
NOTE: IF 20610 BILLED ON SAME DOS AND NOT ABOVE LISTED SPECIALTY OR SPECIFIC PROVIDER NUMBER AND DENYING J7320 DENY 20610 W/EOBS 325/373 ALSO.

3. IF BOTH REQUIREMENTS MET - MANUAL PRICE SYNVISC (J7320) W/INFO EOB 373.

PRICING
A. PRIOR TO 6/30/99 DOS - $496 FOR SERIES OF 3 INJECTIONS.
B. 7/1/99 - 04/30/02 - $646.95 FOR THE SERIES OF 3 INJECTIONS.
C. 05/01/02 - 06/30/03 - $627.45 FOR THE SERIES OF 3 INJECTIONS.
D. 04/01/03 - 06/30/03 - $655.26 FOR THE SERIES OF 3 INJECTIONS.
E. 07/01/03 DOS & AFTER - $633.15 FOR THE SERIES OF 3 INJECTIONS.

NOTE: J7320 (16 MG) = 1 UNIT OR 1 INJECTION OF DRUG. EACH UNIT ALLOWS A MAX OF $215.65 THRU DOS 04/30/02, $209.15 FOR DOS 05/01/02 THRU DOS 03/31/03, $218.42 FOR DOS 04/01/03 THRU 6/30/03 & $211.05 FOR DOS 07/01/03 AND AFTER. A MAX OF 3 UNITS ARE ALLOWED, ($646.95) THRU 04/30/02 DOS, ($627.25) FOR 5/1/02 DOS THRU 3/31/03, ($655.26) FOR 4/1/03 DOS THRU 6/30/03, & ($633.15) FOR 07/01/03 DOS & AFTER. 1 UNIT PER DOS, PER KNEE. 20610 CAN BE BILLED UP TO 3 TIMES (1 FOR EACH INJECTION OF THE DRUG), PER KNEE. LT OR RT MUST BE INDICATED.

NOTE: THE INJECTION PROCEDURE (20610) SHOULD BE BILLED ON SEPARATE LINES. IF MULTI UNITS ON 1 LINE - DENY W/EOB 538.

ANY QUESTIONS SEE SANDY IN MMIS OR ROUTE TO MMIS/SANDY/45564.

J9999: UNLISTED CODE (CLAIM MUST INDICATE ONE OF THE FOLLOWING)
(EE)
A. LEVONORGESTREL OR IRINOTECAN - DENY W/EOB 302.
B. HERCEPTIN - IF DOS IS 1/1/00 & AFTER - DENY W/EOB 302.
(IF ONLY 1 UNIT IS BILLED ON ANY OF THE ABOVE - ADD EOB 452)
C. ALL ELSE:
1. BILLED AMT IS OVER $1100:
A. INOVICE IS ATTACHED & NDC & DOSAGE IS ON CLAIM/COMMENTS - O'LOC TO 14.
B. IF ANY OF THE ABOVE ARE MISSING - DENY W/EOB"S 196/405.
2. BILLED AMT IS UNDER $1100:
A. DOSAGE & NDC IS ON CLAIM/COMMENTS - O'LOC TO 14.
B. ANY OF THE ABOVE ARE MISSING - DENY W/EOB 405.

(LOC 14)
A. BILLED AMT IS OVER $1100: PERICE PER INVOICE.

B. BILLED AMT IS UNDER $1100: PRICE PER POS SYSTEM.

CLAIMS W/DOS THRU 06/30/03 = 89% OF AWP
07/01/03 DOS & AFTER = 86% OF AWP.

PRICING PER POS SYSTEM USE NDC AWP ALLOWANCE X UNITS BILLED X ABOVE ALLOWED % FOR DOS = ALLOWED AMT. SEE EXAMPLE BELOW:

.26 (POS AWP) X 10 (UNITS BILLED) X 89% = $2.31 (ALLOWED AMT)

ANY QUESTIONS SEE MMIS/SANDY A

95199 (UNLISTED ALLERGY/IMMUNOLOGIC SERVICE OR PROCEDURE)
(EE)
A. IF INVOICE ATTACHED, PAY INVOICE PRICE, UNLESS INVOICE DOES NOT MATCH - DENY W/EOB'S 459/196.
B. IF NO INVOICE ATTACHED - DENY W/EOB 196.

MEDICAL VENDOR CLAIMS (P)
1. 0001A - ADVANCED LIFE SUPPORT (ALS)
A. DATES OF SERVICES 12/1/94 AND AFTER NO LONGER REQUIRE WRITTEN JUSTIFICATION - 0001A MAY BE BILLED ALONE. SYSTEM WILL PRICE SERVICE. NO EXAMINER INTERVENTION REQUIRED.

B. DATES OF SERVICE PRIOR TO 12/1/94 - FOLLOW INSTRUCTIONS BELOW:

ALS MUST BE JUSTIFIED BY ONE OF THE FOLLOWING -
(JUSTIFICATION MAY BE ON CLAIM, BACKUP REPORT, PREVIOUS CLAIM OR NEXT CLAIM FOLLOWING)
1) 0020A - HEART MONITORING
A) HEART MONITORING BY ITSELF DOES NOT JUSTIFY ALS
B) HEART MONITORING MUST BE PERFORMED BY A PARAMEDIC OR R.N. OR PHYSICIAN -AND- A CAPABILITY MUST EXIST FOR DEFIBRILLATION.
2) 0033A - AIRWAY MANAGEMENT
3) 0044A - ADMINISTRATION, MONITORING OR DISCONTINUANCE OF IV
NOTE: IF THE CLAIM INDICATES IV ADMINISTRATION AS JUSTIFICATION FOR ALS-PAY ALS RATE.
4) ADMINISTRATION OF DRUGS BY IV. NOTE: THE DRUG IS NOT PAYABLE, HOWEVER THE ADMINISTRATION OF A DRUG BY IV MAY BE USED AS JUSTIFICATION FOR ALS-ADVANCED LIFE SUPPORT TRANSPORT.
5) 0022A NEONATAL TRANSPORT
6) CPR/RESUSCITATION

NOTATION OF ANY OF THE ABOVE (A-F) ON THE CLAIM OR BACKUP IS ACCEPTED AS JUSTIFICATION FOR PAYMENT OF THE ALS BASE RATE.

C. IF THE SERVICE IS ALS RATE JUSTIFIED, MANUALLY PRICE AT
1) EFF. 1/1/93 - 101.12
2) EFF. 7/1/92 - 96.30
3) EFF. 1/1/90 - 94.46
NOTE: WHEN JUSTIFICATION ON BACKUP, PREVIOUS OR NEXT CLAIM - OVERCODE - 014.
D. IF THE SERVICE IS NOT JUSTIFIED, FORCE EXCEPTION 348 WITH

EOB 373.

2. 0129V - OVERLOC TO LOC 83.

3. PRESCRIPTION DRUG ITEMS - DENY WITH EOB 508.

4. ANY OTHER PROCEDURE CODE SUSPENDING OVER THE S MAX, PAY AS BILLED UNLESS
   A. BILLED AMOUNT IS 5-6 TIMES OVER THE S MAX - OVERLOC TO LOC 83.
   B. LOCATION 83 - WHEN PRICING AND NOTATIONS ARE RETURNED, WRITE THE DECISIONS ON THE CLAIM IN RED WITH EOB 373, DENY CURRENT WORKSHEET WITH EOB 333, AND RE-ICN THE CLAIM AND BACKUP IN A SPECIAL HANDLING BATCH.

DENTAL (K) - 09630/D9630 MATERIALS & PHARMACEUTICALS FOR ANESTHESIA
EXAM ENTRY - IF LIST OF MATERIALS OR INVOICE ATTACHED PA-2.
IF NO INVOICE ATTACHED - FORCE.

TEXT KEY TEXT DESC
351 VARIANCE - BILLED CHARGE EXCEEDS

PHYSICIANS
1. MULTIPLE SERVICES
   A. MULTIPLE HOSPITAL,CHEMOTHERAPY & OFFICE VISITS MAY BE BILLED ON 1 LINE IF THE DATES OF SERVICE ARE CONSECUTIVE & THE PROVIDER IS NOT BILLING MORE THAN ONE CALL A DAY. HOWEVER, IF THERE IS MORE THAN ONE DATE INVOLVED AND THE DATES OF SERVICE ARE CONSECUTIVE ENTER THE ENDING DATE AND THE APPROPRIATE UNITS.
   B. IF YOU ARE UNABLE TO DETERMINE IF THE CALLS ARE CONSECUTIVE (I.E. NUMBER OF DAYS WON'T DIVIDE EVENLY INTO BILLED AMOUNT, NO ENDING DATE, DATES NOT ITEMIZED, ETC.) OR IF THE BREAKDOWN OF SERVICE INDICATES THE DATES ARE NOT CONSECUTIVE OR THE PROVIDER IS BILLING TWO CALLS A DAY AND THEY ARE NOT ON SEPARATE LINES
      1. DENY WITH EOB 187.
      2. IF MULTIPLE SERVICES ARE INDICATED ON THE SAME DAY, BUT THE NUMBER OF UNITS ARE WRITTEN SOMEWHERE ON THE CLAIM OTHER THAN UNIT BOX, KEY IN 1 UNIT & FORCE.
   C. MULTIPLE LAB CHARGES, X-RAY CHARGES CAN BE BILLED ON ONE LINE NOT IN CONSECUTIVE ORDER AS LONG AS THE UNITS & "TO" DATE ARE ENTERED
      1) IF THE "TO" DATE HAS NOT BEEN ENTERED, ROUTE A COPY OF THE CLAIM TO PRU SO THE PROVIDER CAN BE CONTACTED.
      2) ENTER THE CORRECT UNITS AND "TO" DATE IF AVAILABLE.
      3) IF MULTIPLE SERVICES CANNOT BE DETERMINED - PA2 FOR REVIEW AND DETERMINATION BY RESOLUTION EXAMINER.
   D. CALL SERVICES OTHER THAN CONSECUTIVE OFFICE, IP OR SUBSTANCE ABUSE (0016M) CALLS SHOULD NOT BE BILLED MORE THAN 1 DATE PER LINE.
      1) IF YOU HAVE A PROVIDER BILLING MORE THAN 1 CALL PER LINE (OTHER THAN INPATIENT SERVICES OR CONSECUTIVE SUBSTANCE ABUSE 0016M CALLS) - ROUTE A COPY OF THE CLAIM TO PRU.
      2) DENY WITH EOB 187.
   E. 90285 - DO NOT ENTER MORE THAN ONE UNIT PER LINE. IF MORE THAN ONE UNIT HAS BEEN BILLED ON CLAIM, ROUTE COPY OF CLAIM TO PRU.

2. ALLERGY TESTING (95000-95051, 95080-95082) AND NERVE CONDUCTION CODES (95900-95904) ARE PAID ON A PER TEST BASIS. CHECK THE CLAIM TO SEE IF THE NUMBER OF TESTS IS INDICATED.
   A. IF INDICATED , ENTER THE UNITS.
   B. IF NOT INDICATED IN THE UNIT BOX (24-F),TAKE A COPY OF THE CLAIM AND ROUTE TO PROVIDER RELATIONS. DENY CLAIM WITH EOB 452.
3. ALLERGY IMMUNOTHERAPY (95125 & 95150) - PAY ON A PER VIAL BASIS - CHECK TO SEE IF THE NUMBER OF VIALS WERE INDICATED, ENTER THE UNITS OR DENY WITH EOB 452.
4. ANESTHESIA (MODIFIER 30)
   A. CHECK THE CLAIM TO SEE IF THERE IS TIME UNITS PRESENT.
      1) IF SO, ENTER THE TIME UNITS.
      2) IF NOT, AND TIME IS STATED CALCULATE UNITS:
         A) EACH 12 MINUTES IF TO BE CONSIDERED ONE UNIT OF TIME.
         B) ANY FRACTIONAL TIME UNITS OVER 12 ARE TO BE ROUNDED OFF TO THE NEXT HIGHEST UNIT (I.E. 20 UNITS = 2 UNITS)

C) ENTER THE TIME UNITS
D) TAKE A COPY OF THE CLAIM AND ROUTE TO VENDOR CONSULTANT.
3) IF NOT & NO TIME IS STATED ENTER ONE UNIT & SEND COPY TO PRU.
B. CAUDAL ANESTHESIA (9920M - 9939M) - FEE HAS BEEN ESTABLISHED FOR EACH CODE. NUMBER OF UNITS SHOULD NOT EXCEED ONE.

5. MODIFIERS - CHECK THE CLAIM TO SEE IF IT IS FOR AN ASSISTANT SUGERY OR ANESTHESIA. IF SO, ENTER APPROPRIATE MOD (ASSIST-80, ANESTH-30).
6. PRE-NATAL CARE - IF A PROVIDER BILLS A DELIVERY CODE OR C-SECTION & THE DESCRIPTION OF SERVICE INDICATES THE SERVICE IS BEING RENDERED IS PRENATAL CARE - DENY 340.
7. DRUGS - 90782, 90784, 90788
A. IF INVOICE ATTACHED, PAY AT INVOICE PRICE
B. IF THE DRUG IS CHEMOTHERAPY LISTED ON EXCEPTION 348, CHANGE THE CODE TO 90797 USING EOB 359 (BEFORE 7/1/84), 96545 (AFTER 7/1/84).
C. IF THE DRUG IS FOR OTHER THAN CHEMOTHERAPY LISTED ON 348 - FORCE.
8. CHECK TO SEE THAT THE PROCEDURE IS PRICING PROPERLY - IF NOT, SHOW YOUR SUPERVISOR.
9. 90748 - HEPATITIS B - FORCE.
10. NONE OF THE ABOVE APPLIES - FORCE.

EPSDT
1. 09995 - ALLOW MULTIPLE UNITS ON THE SAME DAY.
2. 0244M, 9074M - ALLOW ONLY ONE UNIT.

MEDICAL VENDOR
1. FREIGHT CHARGES (0930E) - FORCE.
2. CHIROPRACTOR CLAIMS (PT 30) - IF BILLING MULTIPLE DAYS ON ONE LINE THAT ARE NOT CONSECUTIVE - DENY WITH EOB 187.

OUTPATIENT HOSPITAL - CHECK TO BE SURE EVERTHING HAS BEEN KEYED PROPERLY. IF SO, FORCE

ALL OTHER CLAIMS TYPES - CHECK TO BE SURE EVERYTHING HAS BEEN KEYED PROPERLY AND IF APPROPRIATE THE PROCEDURE HAS PRICED PROPERLY. IF SO, FORCE.

THE END

TEXT KEY TEXT DESC
352 VARIANCE - ALLOWED CHARGE EXCEEDS.

NOTE: EFFECTIVE 9/12/98, VARIANCE WILL NO LONGER POST ON PHYSICIAN & OUTPATIENT CLAIMS FOR LABORATORY SERVICES.

PHYSICIAN CLAIMS

1. MULTIPLE SERVICES
   A. MULTIPLE VISITS (I.E. HOSPITAL VISITS INCLUDES INPATIENT PSYCHIATRIC CALLS) MAY BE BILLED ON ONE LINE IF THE DATES OF SERVICE ARE CONSECUTIVE AND THE PROVIDER IS NOT BILLING MORE THAN ONE CALL A DAY. HOWEVER, IF THERE IS MORE THAN ONE DATE OF SERVICE INVOLVED AND THE DATES OF SERVICE ARE CONSECUTIVE ENTER THE ENDING DATE AND THE APPROPRIATE NUMBER OF UNITS.
   B. IF YOU ARE UNABLE TO DETERMINE IF THE CALLS ARE CONSECUTIVE (I.E. NUMBER OF DAYS WON'T DIVIDE EVENLY INTO BILLED AMOUNT, NO ENDING DATE, DATES NOT ITEMIZED, ETC.) OR IF THE BREAKDOWN OF SERVICE INDICATES THE DATES ARE NOT CONSECUTIVE OR THE PROVIDER IS BILLING 2 CALLS A DAY & THEY ARE NOT ON SEPARATE LINES - DENY 187.
   C. MULTIPLE LAB, X-RAY CHARGES CAN BE BILLED ON ONE LINE IF THE DATES ARE IN CONSECUTIVE ORDER, UNITS ENTERED, AND "TO" DATES ARE ENTERED.
      1) ENTER THE CORRECT UNITS AND "TO" DATE IF AVAILABLE.
      2) IF MULTIPLE SERVICES CANNOT BE DETERMINED - PA2 FOR RESOLUTION EXAMINER TO REVIEW AND MAKE DETERMINATION.
      3) CALL SERVICES OTHER THAN CONSECUTIVE OFFICE, INPATIENT, SUBSTANCE ABUSE SHOULD NOT BE BILLID MORE THAN 1 DATE PER LINE.
         A) IF YOU HAVE A PROVIDER BILLING MORE THAN 1 CALL PER LINE (OTHER THAN CONSECUTIVE OFFICE, INPATIENT, SUBSTANCE ABUSE) ROUTE A COPY OF THE CLAIM TO PRU.
         B) DENY WITH EOB 187.
   D. 90285 (NEWBORN BABY CARE) DO NOT ENTER MORE THAN 1 UNIT PER LINE. IF MORE THAN ONE UNIT HAS BEEN BILLED ON CLAIM, ROUTE COPY OF CLAIM TO PROVIDER RELATIONS UNIT.
   E. 99070 (SUPPLY CODE)
      1) IF BILLED FOR INJECTABLE DRUG/ANTIGEN - DENY 302.
         EXCEPTIONS - VITAMIN B-12 - IF OTHER THAN PERNICIOUS, MEGALOBLAST, FISH TAPE WORM, MACROCYTIC OR PLASTIC ANEMIA, BY DX OR DESCRIPTION - DENY W/325.
         DEPO PROVERA - IF OTHER THAN CANCER DX - DENY W/EOB 325.
      2) IF BILLED IN CONJUNCTION W/NERVE BLOCK CODES (64400-64530) OR INJECTION PROCEDURES (36000-36299, 64400-64530) - DENY 324.
2. ALLERGY TESTING AND NERVE CONDUCTION CODES (95900 & 95904) ARE PAID ON A PER TEST BASIS. CHECK THE CLAIM TO SEE IF THE NUMBER OF TESTS IS INDICATED.
   A. IF INDICATED, ENTER THE UNITS.
   B. IF NOT INDICATED IN BOX (24-F) ON THE CLAIM, ROUTE A COPY OF CLAIM TO PRU AND DENY WITH EOB 452.
3. ANESTHESIA - CHECK THE CLAIM TO SEE IF THERE ARE TIME UNITS PRESENT.
   A. IF SO, ENTER THE APPROPRIATE TIME UNITS.
   B. IF NOT, AND TIME IS STATED CALCULATE UNITS:
      1) EACH 12 MINUTES IS CONSIDERED ONE UNIT OF TIME

2) ANY FRACTIONAL TIME UNITS OVER 12 ARE TO BE ROUNDED OFF TO THE NEXT HIGHEST UNIT (I.E. 13 MINUTES=2 UNITS, ETC.)
3) ENTER TIME UNITS W/EOB 101.

C. IF NOT & NO TIME IS STATED - DENY WITH EOB 230.

4. MODIFIERS - CHECK THE CLAIM TO SEE IF IT IS FOR ASSISTANT SURGERY OR ANESTHESIA & IF THEY ARE NOT USING A MODIFIER - DENY WITH EOB 036. EXCEPTION: IF THE CLAIM STATES ASSIST AT SURGERY - ENTER MOD 80.
5. PRE-NATAL CARE
   A. IF A PROVIDER BILLS A DELIVERY CODE OR C-SECTION CODE AND THE DESCRIPTION OF SERVICE INDICATES THE SERVICE BEING RENDERED IS PRENATAL CARE. DENY 340.
   B. TRIMESTER CARE AND TOTAL OB CARE ARE ALL INCLUSIVE- ALLOW 1 UNIT.
6. DRUGS - 90782, 90784, 90788
   A. IF THE DRUG IS FOR CHEMOTHERAPY LISTED ON EXCEPTION 348, CHANGE THE CODE TO 90797 USING EOB 359 (BEFORE 7/1/84), 96545 (AFTER 7/1/84).
   B. IF THE DRUG IS FOR OTHER THAN CHEMOTHERAPY LISTED ON EXCEPTION 348 TEXT FILE - FORCE.
   EXCEPTION - VITAMIN B-12, IF OTHER THAN PERNICIOUS, MEGALOBLAST, FISH TAPE WORM OR MACROCYTIC ANEMIAS - DENY W/EOB 325.
   DEPO PROVERA, IF OTHER THAN CANCER DX - DENY W/EOB 325.
7. CHECK TO BE SURE THE PROCEDURE CODE IS PRICING PROPERLY. IF NOT, LET YOUR SUPERVISOR KNOW.
8. NONE OF THE ABOVE APPLY - FORCE.

DENTAL
1. 03310-03330 IF CLAIM STATES OPEN & IRRIGATE OR WORDING TO THAT EFFECT - DENY 324.
2. ALL ELSE - FORCE.

MEDICAL VENDOR - MAX ALLOWED CHARGE EXCEEDS BILLED CHARGE BY MORE THAN THE ALLOWED PERCENTAGE.

NOTE: IF 177 IS POSTING - WORK THE 177 EXC FIRST.

1. ADULT DAY HEALTH (CODES 9801H- 9804H) - IF BILLING NON-CONSECUTIVE DAYS ON 1 LINE AND THEY HAVE LISTED THE ACTUAL DAYS OF THE MONTH SEEN - FORCE.

2. HOME HEALTH - IF ACTUAL DATES OF SERVICE NOT LISTED ON CLAIM - DENY W/EOB 177. IF DATES AND UNITS DO NOT MATCH - DENY W/EOB 305.

3. OXYGEN - CPAP'S AND VENTILATORS ONLY
   CPAP'S: E0601 & K0532
   VENTILATOR'S: E0450, K0533, E0460 & 6894E
   IF PROVIDER IS BILLING TOS 9 WITH MS MODIFIER, CHANGE TO TOS R.
   PROVIDERS ARE INSTRUCTED TO USE MODIFIER MS AND TOS R WHEN CLAIMING A 6 MONTH MAINTENANCE CHECK.
   E0600-OXYGEN SUCTION PUMP-LIMIT OF 2 IN 5 YRS. CUT BACK UNITS TO 2 W/EOB 101. IF UNITS APPEAR EXCESSIVE IE..30 UNITS DENY W/EOB 452.

4. NURSE DELEGATION (9800N-8903N) - FORCE.

5. "L" CODES (P&O) - OVERLOC TO 75.
   MMIS - FORCE CLAIM AND SEND "DEAD" FLATCHEETS TO DEBBIE COVERDELL

DHSQS, QRS, MS4-5506.

6. PT 26 OR 39 - CATHETERS, FORCE.
   BANDAGES, DRESSING & TAPES - FORCE.

7. A5112 - DENY.

8. NOT ADDRESSED ABOVE - PA2 TO RES.

RESOLUTIONS:
EMC - REFER TO EXAM ENTRY SECTION ABOVE FIRST.

1. FORCE ANYTHING THAT APPEARS TO BE APPROPRIATE BILLING.
2. DENY W/EOB 036 IF RENTAL CODE BEING BILLED AS PURCHASE.
3. DENY IF UNITS APPEAR EXCESSIVE.
4. DENY W/EOB 302 IF IT APPEARS PROVIDER IS BILLING WITH THE WRONG
   PRROCEDURE CODE FOR AMOUNT BILLED.
5. DENY W/EOB 340 IF DESCRIPTION OF SERVICE ON CLAIM DOES NOT MATCH
   PROCEDURE CODE.

NOTE: SEE TRAINER/SUPERVISOR/MMIS IF UNSURE.

EXAMPLES & GUIDELINES:
NOTE: SOMETIMES THE REASON FOR 352 POSTING MAY BE THE SUPPLY IS
"PER ROLL" AND THE PROVIDER IS BILLING "YDS".
SUPPLY IS "PER 8 OUNCES" AND THE PROVIDER IS BILLING 16 (OUNCES)
INSTEAD OF '2'.
SUPPLY MAY BE "PER BOX" AND PROVIDER IS BILLING, INAPPROPRIATELY,
"EACH" AS IN SWABS.

MEDICAL NUTRITION FORMULAS: PF4 UNDER PROCEDURE CODE TO
INDICATE UNIT MEASURE.
SOME CODES MUST BE BILLED BY CONVERTING CALORIES TO UNITS,
1 UNIT = 100 CALORIES. DENY IF CALORIES AREN'T
CONVERTED CORRECTLY OR IF PROVIDER APPEARS TO BE BILLING
"CANS" OR "OUNCES" OR "CASE". (23,000 CALORIES = 230 UNITS.)

NOTE: IF YOU FEEL THERE NEEDS TO BE SOME "TRAINING" INTERVENTION
OR MORE INFORMATION IS NECESSARY TO ADJUDICATE THE CLAIM(S),
YOU MAY WANT TO SEND THE CLAIM OR EXAMPLES DOWN TO PRU WITH A "PURPLE
SHEET.

HOSPITALS, OUTPATIENT (M) - IF UNITS EXCESSIVE DENY WITH EOB 452,
OTHERWISE - FORCE. IF IN DOUBT, SEE YOUR SUPERVISOR.

ALL OTHER CLAIM TYPES - CHECK TO BE SURE THAT EVERYTHING HAS BEEN KEYED
PROPERLY AND IF APPROPRIATE THAT THE PROCEDURE CODE HAS PRICED
CORRECTLY. IF SO, FORCE.

TEXT KEY TEXT DESC
353 PROCEDURE REQUIRES PRIOR APPROVAL

NOTE: IF DENYING THE CLAIM FOR MEDICARE OR MANAGED CARE EXCEPTIONS, DO NOT WORK THIS EXCEPTION.

RES: IF SERVICE ON AUTH SCREEN HAS BEEN DENIED - DENY W/EOB 242.

CLAIM TYPE (J AND P):

MULTIPLE AUTH #'S ON CLAIM AT HEADER LEVEL (BOX 23) - DENY W/EOB 407
DO NOT KEY EITHER AUTH #, SEND COPY OF CLAIM/WORKSHEET TO PRU, MS 5562
FOR PROVIDER TRAINING. INDICATE THE PROBLEM ON THE PRU REFERRAL FORM.

MULTIPLE AUTH #'S ON DETAIL LINE (BOX 24-K) KEY AS BILLED
MULTIPLE AUTH#'S IN BOX 19: IF LINE # PRESENT - KEY AS BILLED.
(J TEXT CONTINUES ON P 8, P TEXT CONTINUES ON P 21)

IF THERE IS NO PRIOR AUTH NUMBER AND THE CLAIM HAS BEEN MANUALLY APPROVED BY QUALITY SUPPORT. ENTER A "Y" IN THE LMC FIELD WITH EOB 373 AND FORCE 353. (DOES NOT APPLY TO MED VENDORS.)
NOTE: PRIOR APPROVAL IS WAIVED ON CLAIMS SUBMITTED WITH A MEDICARE DENIAL, BUT APPROVAL AFTER THE FACT IS REQUIRED. EXAM ENTRY:
A. IF PRIOR AUTH # IS PRESENT - O'LOC TO 23.
B. IF WRITTEN APPROVAL IS ON THE CLAIM - FORCE
C. IF NO PRIOR AUTH # OR WRITTEN APPROVAL AND NOTHING IN THE FOLLOWING TEXT ALLOWS YOU TO FORCE THE 353 - DENY.

-READ ALL NOTES ABOVE BEFORE PROCEEDING TO THE PAGE FOR YOUR CLAIM TYPE-
K - P. 6
J - P. 8
P - P. 21
RESOLUTIONS - P. 23
ADJUSTMENTS - P. 25

HOSPITAL OUTPATIENT (M):

1. MRI'S:
--EXAM ENTRY:
A. IF NO AUTH # - DENY.
B. IF AUTH # PRESENT - O'LOC TO 23.
--RESOLUTIONS:
A. IF PROC ON AUTH # DOES NOT MATCH PROC BILLED - DENY W/EOB 251.
B. IF DATES OF SERVICE ON AUTH # DO NOT MATCH - DENY W/EOB 245.
C. IF DATES OF SERVICE & PROC CODE MATCH - FORCE.

2. PET SCANS:
A. G0125,G0210-G0218,G0220-G0234,G0253-G0254):
1) IF NO AUTH # - DENY W/EOB 828.
2) IF AUTH # - EE: OVERLOC TO 023.
B. 78810,G0030-G0047:
1) IF NO AUTH # - DENY W/EOB 023.

2) IF CLAIM HAS AUTH # THAT BEGINS W/87...DENY W/EOB'S 023/251. IF ANY OTHER AUTH # - OVERLOC TO 23

---LOCATION 23---
1) IF PROC ON AUTH # DOES NOT MATCH PROC BILLED - DENY W/EOB 251.
2) IF DATES OF SERVICE ON AUTH # DO NOT MATCH - DENY W/EOB 245.
3) IF DATES OF SERVICE & PROC CODE MATCH - FORCE.

3. SLEEP STUDIES (95805,95807-95811) - CLAIM MUST MEET "ALL" OF THE FOLLOWING CRITERIA:

- DIAGNOSES CODE 347, 780.51, 780.53, OR 780.57....AND
- ICD-9-CM PROCEDURE CODE 89.17 OR 89.18.....AND
- BE ONE OF THE PROVIDERS LISTED BELOW.

A. IF CLAIM MEETS "ALL" OF THE CRITERIA LISTED ABOVE - FORCE.
B. IF CLAIM DOES NOT MEET "ALL" OF THE CRITERIA LISTED ABOVE - DENY WITH EOB 456.

3100062 - HARBORVIEW MEDICAL CENTER
3149101 - AUBURN REGIONAL MEDICAL CENTER
3300126 - HOLY FAMILY HOSPITAL - DENY DOS PRIOR TO 01/12/04. *SH
3300258 - ST CLARE HOSPITAL
3300332 - TACOMA GENERAL HOSPITAL
3300340 - MARY BRIDGE CHILDREN'S HOSPITAL
3302601 - ST PETER HOSPITAL/PROVIDENCE
3303104 - ST MARY MEDICAL CENTER
3303500 - HARRISON MEMORIAL HOSPITAL - DENY DOS PRIOR TO 01/01/03.
3304201 - SACRED HEART MEDICAL CENTER/SPOKANE
3306206 - CHILDREN'S HOSPITAL & MEDICAL CENTER - DENY DOS 09/01/04 AND AFTER. *SH
3307402 - PROVIDENCE YAKIMA MEDICAL CENTER - DENY DOS 02/01/04 AND AFTER.
3308707 - GOOD SAMARITAN HOSPITAL/PUYALLUP - DENY DOS 10/01/02 AND AFTER.
3309200 - SWEDISH HOSPITAL MEDICAL CENTER
3309507 - SWEDISH MEDICAL CENTER/PROVIDENCE
3309606 - PROVIDENCE GENERAL MEDICAL CENTER (SEATTLE/EVERETT) - DENY DOS 02/01/04 AND AFTER.
3312204 - VALLEY MEDICAL CENTER/RENTON - DENY DOS 02/01/04 & AFTER
3315009 - VIRGINIA MASON HOSPITAL
3319506 - HIGHLINE COMMUNITY HOSPITAL
3340809 - OVERLAKE HOSPITAL (EASTSIDE SLEEP DISORDERS CENTER) - DENY DOS PRIOR TO 03/01/03.
3343407 - ST JOSEPH HOSPITAL/IDAHO
3347606 - MID-COLUMBIA MEDICAL CENTER/OREGON
3361102 - GOOD SAMARITAN HOSPITAL/PORTLAND

4. ALL ELSE:
---EXAM ENTRY:
A. IF NO AUTH PRESENT - DENY.
B. IF AUTH PRESENT - OVERLOC TO 23.
---LOC 23 (RES):
A. IF PROC ON AUTH DOESN'T MATCH PROC BILLED - DENY W/EOB 251.

B. IF DOS ON AUTH DON'T MATCH DOS BILLED - DENY W/EOB 245.
C. IF PROC AND DOS MATCH AUTH - FORCE.

DENTAL (K)

1. IF CLAIM IS INCOMPLETE AND APPEARS TO BE A REQUEST FOR APPROVAL (E.G. NO DATES OF SERVICE) - DENY AT HEADER LEVEL WITH EOB 155. INDICATE D-155/QUS ON CLAIM AND BATCH COVER, THEN PLACE CLAIM IN QUS ROUTING SLOT IN EXAM ENTRY UNIT AREA.

2. CLAIMS BEING DENIED BY QUS OR RETURNED TO ADJUSTMENTS TO DENY FOR X-RAYS OR JUSTIFICATION, DENY WITH EOB 242.

3. GAU/W CODES (0075D) - IF INFORMATION (COUPON, AWARD LETTER ETC.) INDICATES THAT THE CLIENT IS NOT GAU, OR W

FOR THE DOS, AND THIS CODE IS BILLED, DENY WITH EOB 282. IF AUTH # PRESENT - PA-2, OTHERWISE IF NO AUTH # OR CONSULTANT SIGNATURE ON CLAIM - DENY WITH EOB 418.

4. PROCEDURE CODES 0806D, 0836D, 0840D, 0843D, 0866D - 0869D (ORTHO CLEFT PALATE PATIENTS) FORCE IF PROVIDER NUMBER 5006556, 5009048, 5011424, 5019617, 5021324, 5022777, 5028113, 5030242, 5030291, 5087002, 5094206, 5357504, OR 5528500.

5. D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5860 (DENTURES AND PARTIALS) - IF AGE 19 OR 20 - FORCE.

6. D7241 (REMOVAL OF IMPACTED TOOTH) - IF AGE 19 OR 20 - FORCE.

7. IF OTHER THAN THE ABOVE -
A. EE - IF NO AUTH # OR CONSULTANT SIGNATURE IS PRESENT ON CLAIM, DENY. OTHERWISE ENTER AUTH# IN PA FIELD & O'LOC TO 23 OR IF APPROVED BY QUALITY SUPPORT, ENTER Y IN THE LMC FIELD, GIVE INFO EOB 373 AND FORCE 353.
B. RESOLUTIONS -
1) NO AUTH # ON CLAIM OR "Y" IN THE LMC FIELD - DENY.
2) AUTH # INFO AND CLAIM INFO ARE RELATED OR CLOSE - OVERLOC TO 25. IF NOT DENY.

PHYSICIANS (J)

(LOC 23/27) UNLESS TEXT DIRECTS YOU OTHERWISE, DO AS FOLLOWS:
1. PROC ON AUTH # DOES NOT MATCH PROC BILLED - DENY W/EOB 251.
2. DATES OF SERVICE ON AUTH # DO NOT MATCH - DENY W/EOB 245.
3. DATES OF SERVICE & PROC CODE MATCH - FORCE.

1. ADMITS (99221-99223)
NOTE: BABY ON PARENTS PIC - FORCE.
NOTE: IF CLIENT IS UNDER AGE 7 - FORCE.
A. IF PA# - O'LOC TO 23.
B. IF ADMIT BILLED IN COMBINATION W/STERILIZATIONS (55250,55450, 58600-58605,58611,58615,58982,58983,59101,59106) - OVEROC TO 18.
C. IF ADMIT BILLED WITH HYSTERECTOMIES (51925,56308,58150-58285,58290

-58294,58550-58554,59135,59525) AGE 45 & UNDER - O'LOC TO 18.
(LOC 18 - IF APPROVAL CANNOT BE OBTAINED - DENY W/EOB 828).

D. ALL ELSE:
EXAM ENTRY: PA-2
RES LOC 23:
NOTE: EFF AS OF 12/25/03 THE SYSTEM LOOKS AT BOTH DX FIELDS TO DETERMINE IF 1 OF THE DX THAT REQUIRES APPROVAL IS PRESENT. IF ONE OF THOSE DX IS IN 1ST OR 1ST & 2ND POSITION, THE SYSTEM WILL POST. IF DX THAT DOES NOT REQUIRE APPROVAL IS IN 1ST OR 1ST & 2ND, THE SYSTEM WILL NOT POST.

1. EXCEPTION 055 IS NOT POSTING:
   A. ADMIT IS THE ONLY PROCEDURE FOR THE INPATIENT STAY - DENY W/EOB 828.
   B. THERE ARE OTHER SERVICES ON THE CLAIM FOR THE INPATIENT STAY;AND
      1. THERE IS A MAJOR SURGERY W/090 FU DAYS;
         A. THE SURGERY REQUIRES APPROVAL - DENY THE ADMIT & ALL INPATIENT SERVICES W/EOB 828.
         B. THE SURGERY DOES NOT REQUIRE APPROVAL ON ADMIT - FORCE 353 & PAY ALL SERVICES.
      2. OTHERWISE, DENY THE ADMIT & ALL INPATIENT SERVICES W/EOB 828.
2. EXCEPTION 055 IS POSTING: SEE 055
   A. IF FORCEABLE PER 055 - SEE B ABOVE.
   B. IF NOT FORCEABLE PER 055 - FOLLOW 055 INSTRUCTIONS FOR DENIAL & EOB'S. IF EITHER PROCEDURE/SURGERY OR ADMIT ARE PAYABLE PER 353, PAY ALL OTHER SERVICES FOR INPATIENT STAY.

2. MRI/MRA (70336,70540-70549,70551-70553,70557-70559,71550-71552, 71555,72141-72159,72195-72198,73218-73223,73225,73718-73723,73725,74181-74183,74185,75552-75556,76093,76094, 76394,76400,76498,G0296). *S

A. EE: IF AUTH # - O'LOC TO 23.
RES: LOC 23: (IF 1M MOD, REMOVE TO CHECK AUTH, BUT BE SURE TO RE-KEY MOD)
1) IF MRI DOES NOT MATCH AUTH # - DENY W/EOB 251.
2) IF DOS AREN'T COVERED - DENY W/EOB 245.
3) IF NO AVAILABLE UNITS - DENY W/EOB 246.
4) OTHERWISE, PAY PER AUTH (IF SPECIAL AGREEMENT, PAY PER SA)
B. IF NO AUTH - DENY MRI/MRA & ALL SERVICES RELATED SOLEY TO THE MRI/MRA ON SAME DAY, SAME TIME OR SAME POS W/EOB 828.

3. PM&R - (0030M-0035M)
A. EE - NO AUTH # - DENY. IF AUTH # - O'LOC TO 23.
B. RES LOC 23 - CODES DO NOT MATCH AUTH SCREEN, SEND LIVE WORKSHEET TO DHSQS/QFFS/NCC, PM&R, MS 45506, ADDRESS THE PROBLEM & PROCESS UPON RETURN.

4. ELECTIVE SURGERY OUTPATIENT/INPATIENT/AMB SURGERY/PET SCANS
NOTE: IF AUTH # - O'LOC TO 23.
A. REDUCTION MAMMOPLASTY (19140,19318) - IF BILLED W/DX 611.1 OR

611.9 - DENY W/EOB 828.
IF BILLED W/ANY OTHER DX ON ANY DOS - DENY W/EOB 325.

B. GASTROPLASTY (43842,43843,43846)- IF BILLED W/DX 278.0 OR 278.01 - DENY W/EOB 325.

C. BLADDER REPAIR (51840-51845,57288-57289) - DX 625.6, 788.30 - 788.39 - DENY W/EOB 828. ANY OTHER DX - DENY.

D. HYSTERECTOMY (51925,56308,58150-58285,58290-58294,58550-58554, 59135,59525)
NOTE: EFF 12/25/03, THE SYSTEM WILL LOOK AT BOTH DX FIELDS. IF ONE OF THE BYPASSABLE DX IS IN EITHER 1ST OR 2ND POSTION, THE SYSTEM WILL NOT POST.
EE: O'LOC TO 18.
LOC 18 - IF AUTH CANNOT BE OBTAINED - DENY W/EOB 828.
NOTE: LOC 18 - CHECK THE DX INFO FOR EE ABOVE.

E. BLEPHAROPLASTY/STRABISMUS/REDUCTION PTOSIS
1) 67901-67908, 67311-67340 (BLEPHAROPLASTY/STRABISMUS)
A) AGE 17 & UNDER - FORCE.
B) AGE 18 & OVER - NO AUTH # - DENY, OTHER WISE O'LOC TO 23.
2) 67911,67913-67924, EFF 2/15/02 THESE CODES WILL NO LONGER POST FOR APPROVAL. (QFFS WITHDREW ORIGINAL REQUEST FOR APPROVAL REQUIREMENT).

F. PET SCANS (G0125,G0210-G0218,G0220-G0234,G0253-G0254)
1) NO AUTH #- DENY W/EOB 828.
2) OTHERWISE, O'LOC TO 23

G. BARIATRIC SURGERY (43842,43843,43846,43847) WITH DX 278.01 - IF AUTH # - O'LOC TO 23, IF NO AUTH - DENY.

5. SLEEP STUDIES (95805, 95807-95811)
CHECK COMMENTS LINE OR BOX 32 ON CLAIM FOR ONE OF THE CENTERS OF EXCELLENCE (COE) LOCATIONS LISTED BELOW. PARTIAL DESCRIPTION IN COMMENTS/BOX 32 IS ACCEPTABLE.

A. IF AN APPROVED COE LOCATION:
1) DX IS (780.51, 780.53, 780.57 OR 347) - FORCE.
2) DX IS OTHER THAN THE ABOVE - DENY W/EOB 325.

B. IF NOT AN APPROVED COE LOCATION - DENY W/EOB 545.

CENTER OF EXCELLENCE LOCATIONS (COE)

AUBURN REGIONAL & MEDICAL CENTER, AUBURN
CHILDRENS HOSP & MEDICAL CENTER/SLEEP CLINIC,BELLEVUE THRU 8/31/04 BS
COLUMBIA SLEEP LAB, RICHLAND - THRU DOS 01/31/04
GOOD SAM HOSP/PUYALLUP - THRU DOS 09/29/02 ONLY
HARBORVIEW MEDICAL CENTER,SEATTLE
HARRISON HOSPITAL, BREMERTON, WA - EFF DOS 1/1/03
HIGHLINE COMMUNITY HOSP, SEATTLE
HOLY FAMILY HOSP/SLEEP DISORDER CENTER,SPOKANE. EFF 1/12/04 DOS.
LEGACY GOOD SAMARITAN HOSP/MEDICAL CENTER, PORTLAND, ORE
MARY BRIDGE CHILDRENS/TACOMA GENERAL HOSPITAL,TACOMA
OVERLAKE HOSP MED CENTER(EASTSIDE SLP DIS), BELLEVUE, EFF 3/01/03
MID-COLUMBIA MEDICAL CENTER, THE DALLES, ORE
PROVIDENCE GENERAL MEDICAL CENTER, EVERETT - THRU DOS 01/31/04
PROVIDENCE MEDICAL CENTER, YAKIMA - THRU DOS 01/31/04
PROVIDENCE ST PETERS HOSP/OLYMPIA
PROVIDENCE SWEDISH MEDICAL CENTER, SEATTLE
RICHLAND SLEEP LAB/CENTER/RICHLAND; DR PAT HAMNER -THRU DOS 01/31/04

SACRED HEART MEDICAL CENTER, SPOKANE
SLEEP INST OF SPOKANE/104W.5TH SUITE 400W, SPOKANE
ST CLARE HOSP, TACOMA
ST JOSEPH REGIONAL MEDICAL, LEWISTON, ID
ST MARYS MEDICAL CENTER, WALLA WALLA
SWEDISH FIRST HILL, SEATTLE
SWEDISH MEDICAL CENTER, SEATTLE
TACOMA GEN HOSP/MARY BRIDGE CHILDRENS, TACOMA
VALLEY MEDICAL/RENTON - THRU DOS 01/31/04
VANCOUVER NEUROLOGY, VANCOUVER, WA - EFF DOS 1/1/03
VIRGINIA MASON HOSPITAL, SEATTLE

6. PAIN MANAGEMENT (0096M-0099M), OUTPATIENT EVALUATION (0088M-0095M) - AUTH IS NOT NECESSARY, HOWEVER, THE PROVIDER MUST STILL LIST THE NAME OF THE APPROVED PLACE OF SERVICE AS ST JOSEPH HOSPITAL, TACOMA, 3309309. IF IT'S THERE - FORCE. IF IT IS NOT LISTED - DENY W/EOB 545.

7. ORGAN TRANSPLANTS - THE FOLLOWING ORGAN TRANSPLANT PROCEDURES MUST HAVE THE CENTER OF EXCELLENCE (COE) WHERE SERVICES WERE PERFORMED ON THE CLAIM (EMC-SEE COMMENTS), (HC-SEE BOX 32)

A. IF AN APPROVED (COE) PERFORMING SURGERY LISTED BELOW - FORCE.

1) HEART (33945)
CHILDRENS HOSP & MED CENTER/SEATTLE
OHSU/OREGON (OREGON HEALTH SCIENCES UNIVERSITY)
SACRED HEART MEDICAL CENTER/SPOKANE
UNIVERSITY OF WA MEDICAL CENTER

2) LUNG (32851-32854)
SACRED HEART MED CENTER/SPOKANE
UNIVERSITY OF WA MED CENTER

3) HEART/LUNG (33935)
SACRED HEART MED CENTER/SPOKANE
UNIVERSITY OF WA MED CENTER/SEATTLE

4) LIVER (47135,47136)
OHSU/OREGON (OREGON HEALTH SCIENCES UNIVERSITY)
UNIVERSITY OF WA MED CENTER/SEATTLE
CHILDRENS HOSP & MED CENTER/SEATTLE

5) KIDNEY (50360,50365,50380)
OHSU/OREGON (OREGON HEALTH SCIENCES UNIVERSITY)
SACRED HEART MED CENTER/SPOKANE
SWEDISH/SEATTLE
UNIVERSITY OF WA MED CENTER/SEATTLE
VIRGINIA MASON/SEATTLE
CHILDRENS HOSP & MED CENTER, SEATTLE

6) PANCREAS (48160,48554)
UNIVERSITY OF WA MED CENTER
OHSU/OREGON HEALTH SCIENCES/PORTLAND

7) KIDNEY/PANCREAS (50360,50365 OR 50380 AND 48160 OR 48554)
VIRGINIA MASON HOSP/SEATTLE
UNIVERSITY OF WA MED CENTER/SEATTLE
OHSU/OREGON HEALTH SCIENCES/PORTLAND
8) BONE MARROW TRANSPLANT "AUTOLOGOUS" (38230,38241) ONLY
ST.JOSEPH'S HOSPITAL/TACOMA
NOTE: SEE MORE BMT COE'S BELOW

9) PERIPHERAL STEM CELL TRANSPLANT "PSC-T" (38206,38231,38241)
MARY BRIDGE CHILDRENS HOSPITAL/TACOMA (EFF 5/2/02 DOS & AFTER)
NOTE: SEE MORE PSC-T BELOW

10) BONE MARROW TRANSPLANT (38230,38240,38241,38242)
CHILDRENS HOSP & REGIONAL MED CENTER/SEATTLE
FRED HUTCHINSON CANCER RESEARCH
LEGACY GOOD SAM HOSP/PORTLAND OR NW MARROW TRANSPLANT PROG
OHSU/ORE/PORTLAND OR PSCT@ NW MARROW TRANSPLANT PROG
(DOERNBACHER CHILDRENS HOSPITAL)
SEATTLE CANCER CARE ALLIANCE/SEATTLE
UNIVERSITY OF WA MED CENTER/SEATTLE
VIRGINIA MASON HOSP/SEATTLE

11) PERIPHERAL STEM CELL TRANSPLANT (38205,38206,38231,38240,
38241,38242)
CHILDRENS HOSP & REGIONAL MED CENTER/SEATTLE
FRED HUTCHINSON CANCER RESEARCH CENTER
GOOD SAM HOSP MEDICAL/PUYALLUP
INLAND NORTHWEST BLOOD CENTER
LEGACY GOOD SAM HOSP/PORTLAND OR NW MARROW TRANSPLANT PROG
OHSU/ORE/PORTLAND OR PSCT@ NW MARROW TRANSPLANT PROG
(DOERNBACHER CHILDRENS HOSPITAL)
PROVIDENCE ST PETERS HOSP/OLYMPIA
SEATTLE CANCER CARE ALLIANCE/SEATTLE
ST JOSEPH'S HOSPITAL/TACOMA
SWEDISH/SEATTLE
UNIVERSITY OF WA MED CENTER/SEATTLE
VIRGINIA MASON HOSPITAL

B. OTHERWISE -
IF APPROVAL ON THE CLAIM - O'LOC TO 83.
IF NO APPROVAL AND NO CENTER OF EXCELLENCE - DENY W/EOB 545.

8. ALL ELSE:
A. EE:
1) AUTH # - O'LOC TO 23.
2) NO AUTH FOR BELOW - DENY.
A) PET SCANS - (G0030-G0047, 78810)
B) OSTEOINTEGRATED IMPLANTS (69714-69718)
C) COCHLEAR IMPLANT (69930) NOTE: IF 69990 FOR MICRO IS
ALSO IN AUTH NOTES, PAY PER PDDD.
D) COCHLEAR IMPLANT (A9900) EXTERNAL REPLACEMENT PART.
E) VAGUS NERVE STIMULATOR INSERT (61885,61886,64573,64585)
EXCEPTION: 61885/61886 -O'LOC TO 23 FOR REVIEW.

LOC 23: IF 61862 IS ON THE SAME CLAIM & EXCEPTION 105 IS EITHER NOT POSTING OR HAS BEEN FORCED - YOU MAY FORCE EXCEPTION 353 FOR EITHER 61885/61886, OTHERWISE - DENY IF NO AUTH.

F) VNS (61888) - FORCE.
G) CRYSOSURGICAL ABLATION OF PROSTATE (55873)
H) REMOVAL/REPL OF PENIS PROSTATE (54416-54417)
I) MICRODISSECTION (88380)
J) MAGNETOENCEPHALOGRAPHY (95965,95966,95967)
K) ENDOMETRIAL CRYOBLATION (0009T)
L) TB TEST (0010T)
M) OSTEOCHONDRAL KNEE AUTOGRAFTS (0012T,0013T)
N) INJECTIONS (J2020,J2940,J2941,J7340,S0093)
O) REDUCTION OF PTOSIS (67909)
P) TUMOR IMAGING (78810)
Q) ORTHOTICS (L3000 - L3649)
R) ABLATION (20982)
S) HYOID MYOTOMY (21685)
T) TWIST DRILL BURR HOLES (61863-61868)
U) OCULAR RECONSTRUCTION (65780-65782)
V) CORRECT LAGOPHTHALMOS (67912)
W) HARVEST CONJUNT ALLOGRAFT (68371)
X) ULTRASOUND GUIDANCE (76937)
Y) RADIOPHARMACEUTICAL THERAPY (79403)
Z) VARIOUS LAB PROCEDURES (85055,85396,88112)
Z1) MENINGOCOCCAL VACCINE (90734)
Z2) ASSISTIVE AUGMENTAION (97755)
Z3) VARIOUS SURGERY PROCEDURES (0048T,0049T,0051T,0053T-0057T, 0060T,0061T)
Z4) VARIOUS INJ (J0215,J2353,J2354,J3465,Q3031,S0107,S0136)
Z5) MANDIBLE RECONSTRUCTION(21195,21196)
Z6) GENIPLASTY/AUGMENT (21120)

B. RES LOC 23
1) IF ONE OF THE 600 EXCEPTIONS POSTING - WORK IT.
2) AFTER PRICING A NON COVERED CODE, IF 353 STILL POSTING- FORCE.
3) ANY PROBLEMS OR QUESTIONS ABOUT AUTH ON CLAIM - O'LOC TO 83.

MEDICAL VENDORS (P)

(NOTE: CODES 5008V, 5009V, V5252, V5253, V5246 & V5247 CHECK BOX 19 FOR AUTH #. IF FOUND KEY IN, IF NOT DENY.)

1. 4570B (MISC MEDICAL SUPPLIES)
A. IF DOS 7/1/00 & AFTER - O'LOC TO 47
(MMIS NOTE: CODE SET AT MANUAL PRICE 11/1/00)
B. IF PRIOR TO DOS 7/1/00 & NO PRIOR AUTH # - DENY
C. IF PRIOR AUTH # PRESENT O/L TO 23.

2. K0544, K0547-IF MANAGED MEDICARE FORCE EXCEPTION 353

3. L1000, L1110, L1120, L1200, L1300, L1310
A. IF PRIOR AUTH # PRESENT O/L TO 23.
B. IF CLIENT IS 16 YRS OR YOUNGER & NO PRIOR AUTH # - FORCE
C. IF CLIENT IS 17 YRS OR OLDER & NO PRIOR AUTH # - DENY.

L3030-IF PROVIDER BILLING WITH DIAGNOSIS CODE 736.79 OR 755.67 (PRONATION)-FORCE

4. E1399 (MISC DME)
   A. IF PRIOR AUTH # O/L TO 23.
   B. IF NO PRIOR AUTH # - O'LOC TO 83.

5. 5029V (MISC HEARING AID)
   A. IF PRIOR AUTH # OVERLOC TO 83.
   B. IF NO PRIOR AUTH # - DENY.

6. IF CLAIM IS COMPLETE AND NO PRIOR AUTH # IS PRESENT AND PROVIDER IS REQUESTING APPROVAL IN WRITING - DENY WITH EOB 155 AND ROUTE TO QUS (MS-5506).

7. IF OTHER THAN THE ABOVE:
   A. PA # PRESENT O/L TO 23.
   B. NO PA # - DENY

RESOLUTIONS:
NOTE: AUTH NUMBERS BEGINNING WITH "87" - "EXPEDITED PRIOR AUTHORIZATION" PLACED ON CLAIM BY PROVIDER AFTER MEETING CRITERIA LISTED IN THE BILLING INSTRUCTIONS.

1. PRIOR AUTH #'S BEGINNING WITH "87" (EXPEDITED AUTH) AND PROC CODE OR TOS DOES NOT MATCH AUTH FILE - DENY W/EOB 251/828.

   EXCEPTION: IF THERE IS AN 'S'(SOMETIMES) UNDER "PA REQUIRED" PDDD FILE - FORCE. CODE REQUIRING EXPEDITED PRIOR AUTH WILL OTHERWISE HAVE A "Y" (YES) IN THE "PA REQUIRED" FIELD ON THE PDDD FILE.

2. ALL OTHER PRIOR AUTH #'S:
   A. IF NOTES ON AUTH SCREEN CONFLICT WITH REQUESTED SERVICES ROUTE LIVE WORKSHEETS TO QUS - QUALITY UTILIZATION UNIT (SEE UNIT MANUAL FOR APPROPRIATE PERSON).
   (I.E. APPROVAL IS FOR RENTAL, HOWEVER, THE AUTH SCREEN HAS TOS '9' BUT SHOULD BE A TOS 'R').
   B. PROCEDURE CODE DOES NOT MATCH CODES IN AUTH FILE:
      1) IF THERE IS AN 'S'(SOMETIMES) UNDER "PA REQUIRED" ON PDDD FILE AND CODE IS NOT LISTED IN AUTH FILE AND THERE IS ANOTHER CODE ON CLAIM THE AUTH WAS FOR, FORCE 353.
      2) ALL ELSE - DENY 251.
   C. PROCEDURE IS PENDING ('M' OR 'P') - DENY W/EOB 198
   D. PROCEDURE WAS DENIED ('D') - DENY W/EOB 242
   E. PROCEDURE IS INCLUDED ('I') - DENY W/EOB 324
   F. SEE UNIT MANUAL OR TRAINER/SUPERVISOR IF QUESTIONS.

ADJUSTMENTS:
1. THE AUTH FILE IS NOT ACCESSIBLE TO THE SYSTEM IN THE ADJUSTMENT MODE, THEREFORE, ALL UPDATES TO THE AUTH FILE MUST BE DONE MANUALLY. UPDATES TO PT33 (SPECIAL DUTY NURSING) AND OXYGEN CODES MAY BE DONE BY THE UNIT, HOWEVER, NONDME, MEDICAL SUPPLY, DME AND PROSTHETIC & ORTHOTIC MUST BE DONE BY QUS. AFTER COMPLETING

ADJUSTMENT REQUEST ROUTE "DEAD WORKSHEET" WITH CLEAR INSTRUCTION
OF WHAT NEEDS UPDATING TO THE APPROPRIATE PERSON.
(SEE UNIT MANUAL FOR FURTHER INSTRUCTION).

NOTE: IF PA# WAS CURRENTLY VALID BUT NOW APPEARS INVALID, NUMBER MAY HAVE BEEN "PURGED". SEND CLAIM TO QUS OR OTHER APPROPRIATE UNIT TO "REBUILD PURGED AUTH FILE" SO CLAIM CAN BE ADJUSTED.

2. IF ANY FURTHER QUESTIONS SEE TRAINER/SUPERVISOR.

TEXT KEY TEXT DESC

354 MISSING TOOTH NUMBER, ARCH OR QUADRANT

THE FOLLOWING PROCEDURES REQUIRE AN ARCH DESIGNATION - DENY W/EOB 555.
01515/D1515 05630/D5630
05510/D5510 05899/D5899
05610/D5610

05999/D5999 - EXAM ENTRY IF AUTH PA-2. RES REVIEW AUTH, IF APPROVED - FORCE.

THE FOLLOWING PROCEDURES REQUIRE A QUADRANT DESIGNATION - DENY W/EOB 556
01510/D1510 0435D
04210/D4210 04999/D4999 - IF AUTH PA-2
04341/D4341 09951/D9951

01550/D1550 REQUIRES EITHER AN ARCH OR QUADRANT DESIGNATION - DENY.

09110/D9110-
A. DOS PRIOR TO 11-1-02 REQUIRES EITHER TOOTH # OR QUADRANT - DENY.
B. DOS 11-1-02 OR AFTER - FORCE.
ALL ELSE REQUIRES A TOOTH NUMBER - DENY W/EOB 554.

IF MULTIPLE SERVICES (ROOT PLANINGS, EXTRACTIONS, RESTORATIONS, PULP VITALITY TESTS, PALLIATIVE TREATMENT ETC) ON SAME LINE, DENY THAT LINE WITH EOB 538.

TEXT KEY	TEXT DESC
355	INVALID TOOTH NUMBER, ARCH OR QUADRANT --NOTE - IF PROVIDER USES TOOTH # 1 THRU 9 - KEY A LEAD ZERO. THE FOLLOWING PROCEDURE CODES REQUIRE AN ARCH DESIGNATION-DENY W/EOB 555 01515/D1515 05630/D5630 05510/D5510 05610/D5610 THE FOLLOWING PROCEDURE CODES REQUIRE A QUADRANT DESIGNATION - DENY WITH EOB 556 01510/D1510 0435D 04210/D4210 09951/D9951 04341/D4341 01550/D1550 REQUIRES EITHER AN ARCH OR QUADRANT DESIGNATION - DENY. 09110/D9110 REQUIRES EITHER A TOOTH OR QUADRANT DESIGNATION - DENY. ALL ELSE REQUIRES A TOOTH NUMBER-DENY WITH EOB 554. IF YOU SEE ANYTHING ELSE THAT NEEDS TO BE ADDRESSED, SEE YOUR SUPERVISOR SO THEY CAN LET MMIS SERVICES KNOW.

TEXT KEY	TEXT DESC
358	(PE) THIS IS SHOWING A VALID REVENUE CODE ON THE CHARGE FILE WITH NO "DOLLARS" INDICATED. CHECK PROVIDERS FILE FOR THE CORRECT RATE AND EFFECTIVE DATE. IF NOT FOUND CONTACT THE PROVIDER FOR THIS INFORMATION. THEN ENTER THE "DOLLAR" AMOUNT ON THE PROVIDERS CHARGE FILE AND MAKE UP PENDING DOCUMENTS TO INSURE THE PROV SUBMITS BACK-UP MATERIAL FOR OUR RECORDS

TEXT KEY TEXT DESC

361 PROCEDURE CODE NOT ON FILE.

MEDICARE X-OVER (O) HARD COPY (TOS 9 & R)
1. IF 453 EXC ALSO POSTING, WORK ONLY 453 AND PA2 361 EXC.
2. IF PROCEDURE CODE OR MODIFIER ON CLAIM DOES NOT MATCH BACKUP
   - DENY W/EOB 105.
3. "J" CODE AND PT 51 - DENY.
4. PT 34 - KEY X IN LMC & CHANGE TOS TO 3. IF LINE WILL DENY
   FOR EXCEPTION 430, REMOVE X IN LMC AND LET CLAIM DENY. OTHERWISE
   CHANGE TOS BACK TO 9 REMOVE X IN LMC AND OL 83.

   PT 19 OR 20 - CHANGE TOS 9 TO 3.

   ALL OTHER PT TYPES - CHANGE TOS 9 TO 3 - IF 361 STILL POSTS
   CHANGE BACK TO 9 & OVERLOC TO 83.

5. NOT ADDRESSED ABOVE - OVERLOC TO 83.

MEDICARE X-OVER (O) HARD COPY (TOS 3 & Z)
1. IF 453 EXC ALSO POSTING, WORK ONLY 453 AND PA2 361 EXC.
2. PROCEDURE CODE M0101 - CHANGE TO 99212.
3. VERIFY KEYING AND CORRECT IF NECESSARY.
4. IF TOS "3" ON CLAIM - KEY IT IN AND DENY SERVICE W/EOB 711 IF 361
   STILL POSTING, ANY OTHER TOS ON CLAIM - DENY W/EOB 014.
5. IF EOMB FROM MEDICARE INDICATES A DIFFERENT PROCEDURE FROM THE
   ONE BILLED ON THE CLAIM KEY X IN LMC, KEY IN THE PROCEDURE CODE
   FROM THE EOMB AND ENTER. IF 361 GOES AWAY KEY ORIGINAL BACK IN
   AND DENY THE 361, REMOVING THE X FROM LMC.

6. ALL ELSE - SEE X-OVER TAPE CLAIMS (O) PHYSICIAN (TOS 3 & Z)

MEDICARE X-OVER (O) TAPE CLAIMS (TOS 3 & Z)

1. PROCEDURES CODES BEGINNING WITH AN "ALPHA" CHARACTER - OVERLOC - 83.
   EXCEPTION:
   PT 20 AND BILLING DME CODES - DENY W/EOB 853.

2. PROCEDURE CODE 90732 AND T.O.S. V. (UNDER THIS COMBINATION, MEDICARE
   ALWAYS SENDS VACCINE FOR PNEUMOCCOCUS). CHANGE T.O.S TO 3.

3. IF CODE IS 90782 AND IS FOR PROVIDER TYPE 26, CHANGE TO CODE 0001E.

4. PROVIDER TYPE 22 (ASC)
   1. CODE 66999 - CHANGE CODE TO 69999 AND PROCESS.
   2. IF BILLING FOR OFFICE CALLS (99201-99215) - DENY W/EOB 711.
   3. ALL ELSE - DENY W/EOB 079.

5. IF PROVIDER TYPE IS 41 (BLOOD BANK) BILLING "J" CODE CHANGE TOS
   FROM 9 TO 3. ANYTHING ELSE - CHANGE TOS 3 TO 9.

6. PROCEDURE CODE 04590 - CHANGE TO A4590

7. ALL ELSE O'LOC TO 83.

MEDICARE X-OVER (O) TAPE CLAIMS (TOS 9 & R)

1. IF PROVIDER TYPE IS 41 (BLOOD BANK) BILLING "J" CODE CHANGE TOS FROM 9 TO 3.

2. IF PROVIDER TYPE 19,20,24,25,28,31,32,43,48,49, - CHANGE TO TOS 3, IF EXCEPTION 361 STILL POSTS, CHANGE BACK AND O-LOC TO 83.

3. IF PROVIDER TYPE 40 & SPECIALTY 66 - CHANGE TO TOS 3. IF EXCEPTION 361 STILL POSTS, CHANGE BACK AND O-LOC TO 83.

4. "J" CODE AND PROVIDER TYPE 51-DENY

5. ALL ELSE - OVERLOC TO 83.

MED VENDOR CLAIMS (P)

1. 6299E PROCEDURE CODE (OXYGEN & OXYGEN EQUIP)- BILLING W/ MODIFIER RR AND TOS R- CHANGE TO TOS 9 AND REMOVE MODIFIER.

2. CODES J0000-J8999 - DENY WITH EOB 947

3. HOME HEALTH (PROV TYPE 44) - IF REVENUE CODES 421,431,441,551,558, 571,580, OR 590 OVERLOC TO 67. ALL ELSE - DENY WITH EOB - 788

4. NURSE DELEGATION (PROV TYPE 33 & 44) - CODES 8900N, 8901N, 8902N, 8903N - OVERLOC TO 83.

5. VENTILATOR CODES - E0450,E0453,E0460, OR K0533
IF USING TOS 9 WITH MODIFIER 5B OR U2, CHANGE TOS TO R BUT DO NOT CHANGE 5B OR U2 MODIFIER.

6. ALL ELSE - DENY.

TEXT KEY	TEXT DESC
362	SPECIAL AGREEMENT MODIFIER

IF THE PROVIDER TEXT EXPLAINS NO MODIFIER IS NEEDED, BECAUSE THE PROCEDURE CODE WILL PRICE AUTOMATICALLY, REMOVE THE 1M MODIFIER AND USE EOB - 700

TEXT KEY TEXT DESC

365 PROCEDURE TO PLACE OF SERVICE.

MED VENDORS(P) PAGE 10

PHYSICIANS CLAIMS (J)

PROVIDER #7023328 (KITSAP RESIDENTIAL CTR) - FORCE ANY POS.

EXCEPTION 365 & 222 ARE POSTING - WORK EXCEPTION 222 FIRST.

EXCEPTION 365 & 332 ARE BOTH POSTING: (EXCEPTION PROV TYPE 94)
1. WORK 332. IF DENYING THE 332 - PA-2 365.
2. IF FORCING THE 332 - WORK 365.

EXCEPTION 365 & 353 ARE POSTING:
1. ADMITS - WORK 353 FIRST, IF PA-2ING THE 353, PA-2 THE 365.
2. ALL ELSE - WORK BOTH EXCEPTIONS.

THE FOLLOWING HAVE LIMITATIONS AS TO THE PLACE OF SERVICE.
1. 59400, 59409, 59410, 59610, 59612, 59614 (DELIVERIES)
A. PROV TYPE 94(MIDWIFE). IF POS IS 3,4,11,OR 12 - DENY. IF POS IS 9 OR 25, THE SERVICE MUST BE PERFORMED IN AN APPROVED BIRTHING CENTER. THE PROVIDER NUMBER OF THE APPROVED BIRTHING CENTER DOES NOT NEED TO BE ON THE CLAIM. SERVICES ARE BILLABLE UNDER THE MIDWIFE'S PROVIDER NUMBER IN COMBINATION WITH THE NAME OF THE APPROVED BIRTHING CENTER IN BOX 32 OF THE HCFA 1500 OR IN COMMENTS FOR ELECTRONIC CLAIMS.
OR: IF BILLED UNDER THE PROVIDER NUMBER OF AN APPROVED BIRTHING CENTER (LISTED BELOW) - FORCE.

LIST OF APPROVED BIRTHING CENTERS:

7091804 (PREVIOUS 9601303 WHICH TERMED 10/01/98)
SEATTLE HOME MATERNITY SERVICE - OR
SEATTLE HOME MATERNITY AND CHILD BIRTH CENTER
7012214 SEATTLE NATUROPATHY ACUPUNCTURE & BIRTH CENTER
7024409 VAN EATON CLINIC - TERMED AGREEMENT AS OF DOS 3/25/02
7042369 ARLINGTON BIRTH CENTER - TERMED 10/14/99
7047590 GREENBANK WOMENS CLINIC AND CHILD BIRTH CENTER
7060452 LAKESIDE BIRTH CENTER
7076524 PUGET SOUND BIRTH CENTER
7076813 WENATACHEE MIDWIFE AND CHILD BIRTH CENTER.
7088883 BEST BEGINNINGS BIRTH CENTER
7092430 OLALLA ORCHARD BIRTH CENTER
7095466 COMMUNITY BIRTH & FAMILY CENTER
7095599 WOMANCARE CLINIC & MIDWIFERY - EVERETT, WA TERM 7/18/01
7096159 COLUMBIA BIRTH CENTER - KENNEWICK, WA
7097124 EASTSIDE BIRTH CENTER - BELLEVIEW WA
7097363 WOMENCARE CLINIC - ARLINGTON, WA TERM 3/25/02
7098783 THE BIRTHING INN PLACE - TACOMA, WA
7105588 CASCADE BIRTH CENTER - EVERETT, WA

7119209 BIRTHRIGHT LLC - SPOKANE, WA

1) IF FACILITY'S NAME IS NOT ONE OF THE ABOVE - DENY EOB 320.
2) IF FACILITY'S NAME IS NOT INDICATED - DENY EOB 218.
3) IF POS 9 OR 25 & FACILITY'S NAME IS LISTED IN BOX 32 OR IN COMMENTS FOR ELECTRONIC CLAIMS - FORCE.

B. PROVIDER TYPE IS OTHER THAN 94 - FORCE.

2. 5935M - (LABOR MANGMNT) OR 7/1/03 & AFTER 99211-99215 IN COMBO WITH 99354 & POSSIBLY 99355 ALL W/MOD TH -PT 94 OR MIDWIFE PROVIDING SERVICES IN AN APPROVED BIRTHING CENTER (SEE ABOVE - SECTION A TO IDENTIFY) AND POS 3,9,11 OR 25 - FORCE.

3. PT 94 MIDWIFE - ANY CODES (OTHER THAN ABOVE) BILLED IN PLACE OF SERVICE 9 OR 25 - OVERLOC TO 83.

4. 99221 (ADMIT) BILLED W/90801 IN POS 2,3,5,11,22,23,52,71,81 - FORCE. (THEY ARE DOING A MEDICAL PHYSICAL FOR PSYCH), OTHERS - DENY.

5. 90941-90990, 90997-90999 (DIALYSIS) - IF FOR TELEPHONE CHARGES - DENY WITH EOB 325.

6. 95805-95811 (SLEEP STUDIES) IF FORCING 353 & POS IS OTHER THAN 1,2,3,11,21,22,51,52,71,81 - O'LOC TO 59 FOR REVIEW.

7. 9802M - 9804M:
A. IF BILLED BY AN EMERGENCY ROOM PHYSICIAN (PT 18) - DENY 317.
B. IF ANY OTHER PROVIDER - FORCE.

8. 99054 - SUNDAYS AND HOLIDAYS SUSPENDS IN P.O.S. 1,21,51
A. SERVICE IS BILLED ON SAME DAY AS HOSPITAL CALLS (99231-99236, 99433,99238,99239),FOLLOW UP CONSULTS (99261-99263), OR CONFIRMATORY CONSULTS (99271-99275) - DENY W/EOB 384.
B. ANYTHING ELSE - FORCE.

9. 10000-69999, 55250, 5940M-5955M, 5957M-5959M (SURGERY) - IF MODS 55 OR 56 - FORCE.
A. 11720 - 11721 - DEBRIDEMENT OF NAILS POSTS IN POS 4,6,7,8,12, 24,31,32,54
1) IF CLAIM, COMMENTS OR DX ANYWHERE ON THE CLAIM INDICATE DIABETES - FORCE.
2) IF DX IS FOR LACERATIONS, CONTUSIONS, ETC. THAT WOULD REQUIRE A PHYSICIANS CALL TO THE NH - FORCE.
3) IF DIAGNOSIS IS FOR:
A) 703.0 (INGROWN NAILS) - FORCE.
B) 703.8 (ONYCHAUXIS) - FORCE.
C) 440 & 440.2 ATHEROSCLEROSIS OBLITERANS OR BYPASS GRAFT OF EXTREMITIES - FORCE.
D) 110.1 (ONYCHOMYCOSIS & MYCOSIS) - DENY W/EOB 342. EXCEPT: IF CLAIM INDICATES DIABETES, UNABLE TO WALK, OR OTHER MED COMPLICATIONS THAT WOULD MAKE THIS DX MEDICALLY NECESSARY OR CLIENT IS DDD (EXCEPTION 498 FAILING) OR CLIENT RESIDES IN A DDD FACILITY, THEN FORCE.

4) IF NOT MENTIONED ABOVE - DENY W/EOB 342.

B. 2978M - 2987M - CASTING POSTS IN POS 1,2,5,21,22,23,51,52 AND PROVIDER SPECIFICALLY STATES THEY PROVIDED THE MATERIALS OR HAVE AN INVOICE - FORCE.

C. 50590 - POS 3 - DENY. BJS

D. 56308, 58150-58285 - OVERLOC TO 18.

E. 59320 - POS 6 & 24 - FORCE BJS

F. 5940M - 5959M (TRIMESTER CARE & HIGH RISK) - DENY.

G. 59425 OR 59426 (ANTEPARTUM CARE) - DENY, UNLESS POS 50, THEN O'LOC TO 75.

H. 59510,59514,59515,59525,59620,59622,5947M (C-SECTION) - DENY.

I. 51715 (IMPLANT PROCEDURE) IF BILLED WITH L8603/L8606 (COLLAGEN IMPLANT) - DENY, OTHERWISE - FORCE.

J. PT 22 BILLING IN POS OTHER THAN 6 OR 24 - DENY.

K. 69990 - IF BILLED W/ANOTHER SURGICAL PROCEDURE (10000-69999) IN POS 1,2,3,5,6,11,21,22,23,24,51,52,71,81 - FORCE. ALL ELSE - 0'LOC TO 36. LOC 36 - IF 69990IS BILLED ALONE & THERE ARE NO OTHER SURGERIES IN HX - DENY W/EOB 757. IF OTHER SURGERIES IF OTHER SURGERIES ON CLAIM NOT POSTING 365 - FORCE. IF SURGERIES IN HX PAID & SURGERIES ARE APPROPRIATE W/69990 - DENY W/EOB 189. (ADJ) - IF PAYING THE 69990 - FORCE THE 365.

L. SURGERIES IN POS (3,9,11,25,71,99)
EE - SURGERIES IN POS (3,11,25,71,99)- O'LOC TO 36, POS (9) - - DENY.
RES - SURGERIES IN POS (3,11,25,71,99):
A. IF 9801M-9811M ARE ON THE CLAIM - FORCE THE SURGERY.
B. ALL ELSE - O'LOC TO 75.

M. OTHER SURGERY CODES SUSPENDING - OVERLOC TO 75.

10. 7612M,7698M,R0070,R0075 (PORTABLE BEDSIDE EXAM IN HOSPITAL)
A. PLACE OF SERVICE 1,21,51:
1) NO MOD 26 - DENY W/EOB 504.
2) IF MOD 26 - DENY W/EOB 036.
B. PLACE OF SERVICE 2, OR 5 - CHECK PROVIDER TEXT FOR SPECIAL AGREEMENT:
1) IF SPECIAL AGREEMENT - FORCE.
2) NO SPECIAL AGREEMENT ON FILE - DENY 350.

11. 80000-85048, 85150-87250, 87999-88099, 89000-89080, 89105-89125, 89160-89325, 89360-89399, 8000M, 8001M
A. LAB WORK SUSPENDING IN POS 1,2,5,21,22,23,51,52 - TAKE THE FOLLOWING ACTION:
1) PROV # 7016702 - FORCE.
2) PROVIDER IS A 100 PERCENT PROVIDER- FORCE.
3) PROVIDER HAS A SPECIAL AGREEMENT TO PROVIDE 100% OF THE SERVICE FOR THESE CODES (MOD 1M) -FORCE.
4) PROVIDER IS A SPLIT BILLER WITH NO SPECIAL AGREEMENT-DENY 350.
5) (INFO ONLY) REFERENCE INDICATORS ON PROVIDER FILE.
SPLT = P 45 PER CENT
SPLT = T 55 PER CENT
SPLT = BLANK 100 PER CENT
CERTAIN PROVIDERS ARE LOADED ON PROVIDER FILE AS 100% AS THEY PROVIDE THE TECHNICAL & PROFESSIONAL COMPONENT. THERE IS WRITTEN VERIFICATION ON FILE. *C

B. PROVIDER TYPE (43) IN POS 9,25,60,99 - FORCE. THIS EXCEPTION WAS CREATED MAINLY FOR LABS BILLING URINALYSIS. EG (81003)
C. PROVIDER TYPE (43) IN POS 7,8,31,32,54 - DENY.

12. 88399 (UNLISTED SURG PATHOLOGY)
A. IF MOD TC - DENY W/EOB 340 & ROUTE TO PRU/MS 5562.
B. IF ANOTHER MOD - FORCE.

13. 99241 - 99245, 99271 - 99275 - IF POS IS 20 OR 49 - FORCE.
(THIS INFO WILL BE ADDED TO THE PDDD FILE UPON COMPLETION OF CSR).

14. 99432, S8415 (PT 94) - DENY W/EOB 968.

EXCEPTION- ONLY PAYABLE IF REVIEWED AND APPROVED IN SPECIAL BATCH FROM HOME BIRTH PROGRAM MANAGER, BEV ATTERIDGE. THEN FORCE.

15. IF SPECIAL AGREEMENT FOR ANY OTHER CODES NOT LISTED ABOVE, FOLLOW TEXT AS APPLICABLE AND FORCE 365.

16. FQHC (SPECIALTY 90) IN POS 50 - IF THE PDD FILE ALLOWS THE CODE PAYABLE IN PLACE OF SERVICE 3 - FORCE.

17. 96400 - 96549 (CHEMO ADMINS)
J9000 - J9998 (CHEMO INJECT)
POS IS 49 (INDEPENDENT CLINIC) - FORCE.

18. ALL ELSE - DENY.

MEDICAL VENDOR CLAIMS (P)

IF BILLING WITH POS 3,11,71,81 & PRV TYPE IS 26,39,40 - DENY
IF BILLING WITH POS 9,25,60,99 & PRV TYPE OTHER THAN 50,51,53,54,55 OR 45 - DENY
IF BILLING WITH POS 2,22,23,52 - DENY
IF BILLING DME W/ POS 1,21,51 SEE SECTION "8" FOR FURTHER INSTRUCTIONS.

1. 2001A, 2002A: CHIROPRACTOR HOME VISIT POSTS IN OTHER THAN POS 4,12- DENY.
2. 5001V-5005V, V5050 (HEARING AIDS):
A. ORDERING/REFERRING PROVIDER # OR NAME IS PRESENT - FORCE.
B. ORDERING/REFERRING PROVIDER # OR NAME IS NOT ON CLAIM OR WORKSHEET- DENY 009.
3. 0800E - 0899E (WHEELCHAIR PARTS): IF POS IS 1,2,3,5,9,11,22,23,25, 51,52,60,71,81,99 - DENY.
4. 0108L,0109L,0206L,0207L,4088A - FITTING FEES FOR PROSTHETICS, ORTHOTICS AND OSTOMIES ARE ONLY PAYABLE IN HOSP (POS 1,21,51)-DENY 376. FITTING FEES NO LONGER VALID WITH DOS 7/1/96 (INCLUDED IN FEE FOR PROSTHETIC/ORTHOTIC).
5. 0000B - 0160B (IV THERAPY, NON-NUTRITIONAL) - DENY 984.
6. ENTERAL THERAPY BILLED BY PROVIDER TYPE 40 AND POS 7,8,31,32,54 FOR PUMP,IV POLE,BAGS AND ACCESSORIES - FORCE.
IF BILLING FOR "ORAL" ENTERAL THERAPY - DENY

7. 97010-97799, 0001M, 0002M, M0006-M0008 -(PHYSICAL THERAPY) - DENY
EXCEPTION: PROVIDER #7277007, NELDA J. OLSON, RPT. - FORCE.

8. FOR OTHER DME CODES - DME BILLED IN POS 1,7,8,21,31,32,51,54 DENY W/ 984.
A. EXCEPTION: IF APPROVED - FORCE.(EE-OL TO 23 IF AUTH # PRESENT)
B. EXCEPTION: IF AN IMR FACILITY LISTED IN 432 TEXT-FORCE.
C. EXCEPTION: BANDAGES, TAPES, DRESSINGS SEE 9-B BELOW

9. DISPOSABLE/NON-REUSEABLE SUPPLIES BILLED & PATIENT IN NURSING HOME. (POS 7,8,31,32,54)

A. URINARY RETENTION CATHETERS, TUBES & BAGS - - FORCE IF JUSTIFICATION INDICATES A HEALTH RISK (IE. A PERMANENTLY IMPAIRED, MALFUNCTIONING BODY ORGAN OR DIAGNOSIS/COMMENTS INDICATING SEIZURES, URINE RETENTION OR RENAL FAILURE.

1) INCONTINENCE OR NEUROGENIC BLADDER ARE ONLY INDICATION - DENY

NOTE: IF CLAIM ALSO INDICATES JUSTIFICATION AS ABOVE(SEE #1) SUCH AS PERMANENTLY IMPAIRED,MALFUNCTIONING BODY ORGAN (DIAGNOSIS CODES WITH PRINTED DESCRIPTIONS OFTEN STATE INCONTINENCE) PROVIDER HAS TAKEN RESPONSIBILITY FOR CLAIM PAYMENT WITH JUSTIFICATION-FORCE.

2) IF PROVIDED IN AN IMR FACILITY LISTED IN 432 TEXT-FORCE.
3) CATHETER INSERT TRAYS - FORCE IF MEETS JUSTIFICATION REQUIREMENT IN #1.

4) TAPE & EMC COPIES DENY WITH EOB 984 UNLESS COMMENTS OR BACKUP AVAILABLE.

5) IF INDICATION OF INTERMITTENT CATHERIZATION IN POS 7,8,31,32 OR 54-FORCE.

B. BANDAGE,TAPE,DRESSING OR WOUND FILLER CODES BILLED WITH MODIFIERS X1-X9 OR A1-A9 IN POS 7,8,31,32 OR 54-FORCE

C. ALL ELSE - OVERLOC TO 83

10. OXYGEN PROCEDURE CODES- ADVANCED LIFELINE SERVICES ALLOWED TO BILL FOR SERVICES FOR TRACH/VENT CLIENTS IN P.O.S. 8-BY SPECIAL AGREEMENT PROVIDER NUMBER 9032269 & 9035239, FORCE IF POS 8,31,32 IF OTHER THAN ABOVE AND FLAGGING EXCEPTION 378, WORK THAT EXCEPTION FIRST

11. NURSE DELEGATION SERVICES (8900N-8903N) PT 33/44 - DENY.

12. ALL ELSE DENY.

TEXT KEY TEXT DESC
366 INVALID PROVIDER SPECIALTY FOR PROCEDURE

DENTAL (K)

0803D - ORTHODONTIC CONSULTATION - IF PERFORMING PROVIDER'S SPECIALTY IS 12 - FORCE.

D0470 (DIAGNOSTIC CASTS)
1. IF PROVIDER SPECIALTY IS 12:
A. IF AUTH NUMBER - PA-2. RES - IF AUTHORIZED - FORCE.
B. IF NO AUTH - DENY.

D9220, D9241,D9248 (ANESTHESIA AND IV SEDATION), AND
D9630 (OTHER DRUGS)

NOTE: IF PROVIDER IS BILLING FOR NITROUS OXIDE, PERIDEX RINSE, STERILE TRAYS, OR HOME FLUORIDE - DENY WITH EOB 325, EXCEPTION: IF BILLING NITROUS OXIDE FOR DOS 7-1-01 OR AFTER-DENY W/EOB 302.

1. IF ASTERISK AFTER THE SORT NAME OF PROVIDER OR PERFORMING PROVIDER - FORCE. (THESE ARE GENERAL DENTISTS WITH CONSCIOUS SEDATION PERMITS)
2. IF PERFORMING PROVIDER SPECIALTY IS 09 - FORCE.
3. IF PROVIDER NUMBER 5022801 (UNIVERSITY OF WA) AND PATIENT IS UNDER AGE 21 OR IS DDD (EXCEPTION 498 POSTING) - FORCE.
4. OTHER THAN THE ABOVE - DENY.

15823 TO 60281 - OVERLOC TO 83.

99201-99245 - IF PERFORMING PROVIDER SPECIALTY IS 12 - FORCE.

ALL OTHER DENTAL CODES - DENY.

TEXT KEY TEXT DESC
367 REVENUE CODE NOT ON CHARGE FILE

--NOTE TO PROVIDER ENROLLMENT: PLEASE VERIFY REVENUE CODES TO PROVIDER TYPE BEFORE LOADING.

IF BILLING DME CODES - DENY WITH EOB 909. EXCEPTION: HOME HEALTH PROVIDERS BILLING SUPPLIES MUST BILL USING THEIR DME PROVIDER # - IF USING A HOME HEALTH PROVIDER # - DENY 711.

1. HOSPITAL (M & S) CLAIMS:
   A. IF CLAIM IS FROM ONE OF THE FOLLOWING PROVIDER TYPES/SPECIALTIES, WORK PER INSTRUCTIONS ELSEWHERE IN THIS TEXT FILE. DO NOT OVERLOC TO 72.
    - PROVIDER TYPE 20 (PHYSICIAN) *SR
    - PROVIDER TYPE 44 (HOME HEALTH)
    - PROVIDER TYPE 62 W/SPECIALTY 86 (KIDNEY CENTER)
    - PROVIDER TYPE 63 (HOSPICE)
    - PROVIDER SPECIALTY 92 (DETOX) OR 93 (FREE-STANDING DETOX)
    - PROVIDER TYPE 88 W/SPECIALTY 70 OR 90(RURAL HEALTH)OR(RHC/FQHC)
   B. ALL ELSE - OVERLOC TO 72.

2. PROVIDER TYPE 20 - PHYSICIAN - (M) CLAIM TYPE - DENY W/EOB 328.

3. PROVIDER TYPE 44 - HOME HEALTH (M) CLAIM TYPE. IF REVENUE CODE IS LISTED BELOW - OVERLOC TO 67. ALL ELSE- DENY.
   421 - PHYSICAL THERAPY
   431 - OCCUPATIONAL THERAPY
   441 - SPEECH THERAPY
   551 - SKILLED NURSING INTERVENTION
   558 - SKILLED HIGH RISK OB NURSING (ENDED 7/31/03)
   571 - HOME HEALTH AIDE
   580 - BRIEF NURSING VISIT
   590 - FLU VACCINE (ENDED 7/31/03)

4. PROVIDER TYPE 62/SPECIALTY 86 - KIDNEY CENTERS (M) CLAIMS. IF REVENUE CODE IS LISTED BELOW - OVERLOC TO 67. ALL ELSE - DENY.
   250 - PHARMACY
   260 - IV THERAPY
   270 - MEDICAL/SURGICAL SUPPLIES
   303 - LAB/RENAL PATIENT (HOME)
   304 - LAB/NON-ROUTINE DIALYSIS
   634 - DRUGS/EPO < 10,000 UNITS
   635 - DRUGS/EPO > 10,000 UNITS
   636 - DRUGS REQUIRING DETAILED CODING
   730 - EKG/ECG
   821 - HEMODIALYSIS/COMPOSITE
   825 - HEMODIALYSIS/SUPPORT SERVICES (HOME)
   831 - PERTIONEAL DIALYSIS/COMPOSITE
   835 - PERTIONEAL DIALYSIS/SUPPORT SERVICES (HOME)
   841 - CAPD/COMPOSITE
   845 - CAPD/SUPPORT SERVICES (HOME)

851 - CCPD/COMPOSITE
855 - CCPD/SUPPORT SERVICES (HOME)
880 - MISC DIALYSIS/GENERAL CLASSIFICATION
881 - MISC DIALYSIS/ULTRAFILTRATION

5. PROVIDER TYPE 63 - HOSPICE (M) CLAIMS. IF REVENUE CODE IS LISTED BELOW - OVERLOC TO 67. ALL ELSE - DENY.
115 - HOSPICE ROOM & BOARD PRIVATE (REPLACES 653)
125 - HOSPICE ROOM & BOARD 2 BEDS (REPLACES 653)
135 - HOSPICE ROOM & BOARD 3-4 BEDS (REPLACES 653)
145 - ROOM & BOARD (DELUXE) HOSPICE (REPLACES 650)
650 - FREE-STANDING HOSPICE ROOM & BOARD
651 - ROUTINE HOME CARE
652 - CONTINUOUS HOME CARE
653 - NURSING FACILITY ROOM & BOARD (CODE ENDS 10/15/03)
655 - INPATIENT RESPITE CARE
656 - GENERAL INPATIENT CARE (NON-RESPITE)
659 - PALLIATIVE CARE - END OF LIFE GRANT

6. PROVIDER TYPE 88/SPECIALTY 70 OR 90 - RURAL HEALTH (M) CLAIMS. IF BILLING REVENUE CODE 521 AND THE PROVIDER NUMBER BEGINS WITH A "3" OVERLOC TO 83. ALL ELSE - DENY.

7. PROVIDER SPECIALTY 92 (DETOX) - INPATIENT (S) CLAIMS. IF REVENUE CODE IS LISTED BELOW - OVERLOC TO 72. ALL ELSE - DENY.
126 - ROOM & BOARD (DETOX)
136 - ROOM & BOARD (DETOX)
156 - ROOM & BOARD (DETOX)
250 - PHARMACY
260 - IV THERAPY
270 - MEDICAL SURGICAL SUPPLIES
300 - LABORATORY
320 - RADIOLOGY
450 - EMERGENCY ROOM
730 - EKG/ECG
740 - EEG

8. PROVIDER SPECIALTY 93 (FREE-STANDING DETOX CENTER) - INPATIENT (S) CLAIMS. IF REVENUE CODE 126 - OVERLOC TO 72. ALL ELSE - DENY.

TEXT KEY TEXT DESC
368

MODIFIER REQUIRES MANUAL PRICE
PHYSICIAN CLAIMS (J). EPSDT (L). X-OVER (O) MOD 50/53/62/66 ONLY.

1. MODIFIER 23 - UNUSUAL ANESTHESIA - DENY WITH EOB 562.

2. MODIFIER 50 (E1/E3 OR E2/E4 OR RT/LT) - BILATERAL PROCEDURES
   A. MEDICARE X-OVER (O) (EE)
      1) IF PROCEDURE INDICATES (BI-100%) IN THE DESCRIPTION ON THE PDDD FILE:
         A) PROCEDURE BILLED ONLY ON 1 LINE - REMOVE MOD 50 & ENTER 2 UNITS.
         B) PROCEDURE BILLED ON MULTIPLE LINES - REMOVE MOD 50 & ENTER 1 UNIT.
      2) IF PROCEDURE HAS A "Y" IN THE BI-SURG FIELD ON THE PDDD & DOES NOT HAVE (BI-100%) IN DESCRIPTION - PA-2 TO RES FOR REVIEW.
      3) IF PROCEDURE HAS A "N" IN THE BI-SURG FIELD ON THE PDDD
         A) SURGERIES (10000-69999) - O'LOC TO 36 TO REVIEW.
         B) OTHERWISE - REMOVE THE MOD 50 & ENTER.

   B. MEDICARE X-OVER (O) (RES)

      NOTE: AFTER DETERMINING IF BI SURG PROCEDURE, TAKE A LOOK AT THE CLAIM, IF 2 LINES OF SAME SURGERY AND MOD 50 ON ONE OF THE LINES, & MDCR HAS PAID ON BOTH LINES, DETERMINE IF ONE OF THE LINES MDCR PD ABOUT 1/3 OF THE OTHER LINE. IF SO, LOOK AT THE PROCEDURE & DETERMINE IF ITS A PROCEDURE THAT COULD BE BILLED ONCE BI-LATERALLY & AGAIN FOR ONLY 1 SIDE. IF SO, PAY ON BOTH IF APPROPRIATE, IF NOT PAY ON ONLY THE PROCE-DURE W/MOD 50 IF APPROPRIATE & USE INFO EOB 001. DENY THE OTHER LINE W/EOB 324.

      1) PF-4 UNDER CODE TO SEE OUR MAX ALLOWABLE FOR DOS.
         NOTE: IF (6) NON-COVERED - REMOVE MOD 50.

      2) IF (BI SURG) INDICATOR = Y:
         NOTE: MDCR PAYS ONLY ON THE LINE W/MOD 50, UP TO THE BILLED AMT. IF MULTI LINES & 1 DENIED, APPLY PRICING TO LINE W/MOD 50.
         A) MULTIPLY MAX ALLOWED X 150% = OUR NEW MAX ALLOWED FOR BILATERAL.
         B) COMPARE OUR NEW MAX ALLOWED TO MDCRS ALLOWED & USE THE LESSER OF THE TWO TO CALCULATE (E) BELOW.
         C) COMPARE THE LESSER TO MDCRS PAID AMT.
            1. IF MDCRS PD AMT IS MORE THAN OUR NEW MAX ALLOWED - FORCE 368 & LET EXCEPTION 430 AUTO DENY.
            2. MDCRS PD AMT IS LESS THAN OUR NEW MAX ALLOWED - SUBTRACT MDCRS PD AMT FROM OUR NEW MAX ALLOWED = PAYMENT DUE.

NOTE: MANUAL PRICE THE LINE W/PAYMENT DUE & FORCE EXCEPTION 430.

IF EXCEPTION 576 POSTS - FORCE IT AS WELL.

3) IF (BI-SURG) INDICATOR = N:
A) 2 LINES BILLED - KEY LT ON LINE 1 & RT ON LINE 2 & ENTER.
B) 1 LINE BILLED - REVIEW W/SUP/TRAINER FOR REMOVAL OF MOD 50 & THE USE OF 1 OR 2 UNITS. (MAY BE NECESSARY TO CONTACT MMIS).

PHYSICIANS (J)

C. IF IN THE 9---- SERIES, SEE BELOW:

1) IF PROCEDURE INDICATES (BI-100%) IN THE DESCRIPTION ON THE PDDD FILE:
A) IF PROCEDURE BILLED ON 1 LINE W/MOD 50 - MANUAL PRICE AT 2 TIMES THE MAX ALLOWED OR BILLED AMOUNT, WHICHEVER IS LESS.
B) IF PROCEDURE BILLED ON 2 SEPARATE LINES - PAY BOTH LINES AT 100% OF SYSTEM ALLOWED.
2) ALL ELSE, IF A (Y) IN THE (BI-SURG) FIELD ON THE PDDD:
EE; PA-2. RES; IF PROCEDURE BILLED ON 2 SEPARATE LINES- MANUAL PRICE 1 LINE W/MOD 50 AT 50% OF THE ALLOWED AMT PER PDDD & REMOVE THE MOD 50 FROM THE OTHER LINE. IF PROCEDURE BILLED ON 1 LINE W/MOD 50-MANUAL PRICE AT 150% OF THE MAX ALLOWED OR BILLED AMT, WHICHEVER IS LESS.
3) IF NO (Y) IN THE (BI-SURG) FIELD ON THE PDDD - DENY W/EOB 866.
SEE NOTES BELOW:
NOTES:
-PLACE OF SERVICE IS 1,2 OR 5 & MOD 26/TC ALSO PRESENT: 2 LINES OF SAME PROCEDURE - KEY MOD 26OR TC ON 1 LINE & MOD 50 ON OTHER LINE. PROCEDURE BILLED ON 1 LINE ONLY - KEY MOD 26 OR TC & O'CODE W/818.
-IF BY REPORT PROCEDURE - ONLY APPLY % LISTED ON PDDD.

D. IF IN THE SURG SECTION (10000-69999, 2978M-2987M) EXCEPT 36415 LEAVE MOD & OVERLOC TO 36 - WORK OTHER EDITS & INSTRUCTIONS FIRST.

NOTE: TPR IS POSTING & INSTRUCTIONS ARE TO PA-2, O'LOC TO 29.

NOTE: PT 22, EE - O'LOC TO 36.

NOTE: STERILIZATIONS (56301-56302, 58600, 58605, 58611, 58615, 58670, 58671) OR VASECTOMY (52347, 54690, 55250, 55450, 56318) - O'LOC TO 18. HYSTERECTOMY (56308, 58150, 58152, 58180, 58200, 58210, 58240, 58260-58270, 58275-58280, 58285, 58550, 59135, 59525) - O'LOC TO 18.

NOTE: REVIEW FOR POSSIBLE AUTH REQUIREMENT PER EXCEPTION 353, ANY QUESTIONS - SEE LEAD/SUP/TRAINER.

(1602L) EE - PRICE PER MAX ON PDD FILE FOR DOS
NOTE: IF 1 LINE ON CLAIM - DENY W/EOB 538/036.
NOTE: IF MULTI LINES - PAY 2, DENY ADDITIONAL LINES W/EOB 339.
(1600L) EE - IF 2 1600L'S - DENY BOTH W/EOB 302, SHOULD BE

BILLING 1601L FOR THE PAIR.

E. IF 5941M-5947M OR 5957M-5959M - DENY W/EOB 036.

F. PT 22 - EXAM ENTRY OVERLOC TO 36.
RES:
1) PROCEDURE ALLOWS BILATERAL SURGERY PER PDD FILE FOR TOS "3" - DENY W/EOB'S 538/700.
2) PROCEDURE DOES NOT ALLOW BILATERAL SURGERY PER PDD FILE FOR TOS "3" - DENY W/EOB 700.

G. IF MODIFIER 50 USED WITH A RADIOLOGY PROCEDURE AND;
NOTE: IF PLACE OF SERVICE IS 1,2,5,21,22,23,51,52 & PROCEDURE APPEARS TO BE FOR A TECHNICAL/PROFFESSIONAL COMPONENT - SEE EXCEPTION 222.
NOTE: IF A "BY REPORT" PROCEDURE - ONLY APPLY % LISTED ON PDDD.
1) IF PROCEDURE INDICATES (BI-100%) IN THE DESCRIPTION ON THE PDDD FILE:
A) IF PROCEDURE BILLED ON 1 LINE W/MOD 50 - MANUAL PRICE AT 2 TIMES THE MAX ALLOWED OR BILLED AMOUNT, WHICHEVER IS LESS.
B) IF PROCEDURE BILLED ON 2 SEPARATE LINES - PAY BOTH LINES AT 100% OF SYSTEM ALLOWED.
2) ALL ELSE, IF A (Y) IN THE (BI-SURG) FIELD ON THE PDDD:
EE: PA-2.
RES: IF PROCEDURE BILLED ON 2 SEPARATE LINES - MANUAL PRICE 1 LINE W/MOD 50 AT 50% OF THE ALLOWED AMOUNT PER PDDD W/O'CODE 818 & IF MOD 50 ON OTHER LINE - REMOVE IT. IF PROCEDURE BILLED ON 1 LINE W/MOD 50 - MANUAL PRICE AT 150% OF THE MAX ALLOWED OR BILLED AMOUNT, WHICHEVER IS LESS & USE O'CODE 818.
3) IF NO (Y) IN THE (BI-SURG) FIELD ON THE PDDD - DENY W/EOB 866.

H. IF MODIFIER 50 IS USED WITH LAB CODES - DENY EXCEPTION CODE 169.

I. IF PROVIDER HAS BILLED MOD 50 INCORRECTLY - DENY W/EOB 866.
(SEE SUPERVISOR IF YOU HAVE QUESTIONS)

4. MODIFIER 53 (TERMINATED PROCEDURE) WHEN BILLED W/PROCEDURES 45378, G0105, G0121:
PHYSICIAN CLAIMS: POS- (F=1,2,5,6,7,8,21,22,23,24,25) AND (NF = 3,4,9,11,20)
DOS 7/1/99 - 6/30/00 - PAY AT $48.90.
DOS 7/1/00 - 6/30/01 - PAY AT $32.88 FOR FACILITY (F)
DOS 7/1/00 - 6/30/01 - PAY AT $52.57 FOR NON-FACILITY (NF)
DOS 7/1/01 - 6/30/02 - PAY AT $30.70 FOR FACILITY (F)
DOS 7/1/01 - 6/30/02 - PAY AT $57.82 FOR NON-FACILITY (NF)
DOS 7/1/02 - 6/30/03 - PAY AT $34.58 FOR FACILITY (F)
DOS 7/1/02 - 6/30/03 - PAY AT $66.66 FOR NON-FACILITY (NF)
DOS 7/1/03 - 6/30/04 - PAY AT $34.35 FOR FACILITY (F)
DOS 7/1/03 - 6/30/04 - PAY AT $64.38 FOR NON-FACILITY (NF)

ALL OTHER PROCEDURES/PROVIDERS:
A. IF EXCEPTION 169 POSTING - WORK IT FIRST.

B. OTHERWISE - REMOVE MOD 53 & O'CODE W/809

EXCEPT: PT 22 - IF A 1 LINE CLAIM, REMOVE MOD 53. IF MULTI LINE CLAIM & MOD 53 IS THE ONLY MOD ON CLAIM - DENY THE ENTIRE CLAIM W/EOB 822.

NOTE: IF TPR POSTING & INSTRUCTIONS ARE TO PA-2, O'LOC TO 29.

NOTE: IF STERILIZATIONS (56301, 56302, 58600, 58605, 58611, 58615, 58670M 58671), VASECTOMY (52347, 54690, 55250, 55450, 56318) - O'LOC TO 18. HYSTERECTOMY (56308,58150,58152,58180,58200, 58210,58240,58260-58270,58275-58280,58285,58550,59135,59525) - O'LOC TO 18. ALL ELSE - O'LOC TO 09.
NOTE: REVIEW FOR AUTH REQUIRED PER EXCEPTION 353, ANY QUESTIONS - SEE LEAD/SUP/TRAINER.

X-OVER CLAIMS: (MOD 53 ONLY)
A. EE:
1) SURGERIES (10000-69999,92975-92984,92986-92998,93501-93545, 0001T-0002T,0005T-0009T,0012T-0014T,0016T-0017T)
A) 45378 - O'LOC TO 36.
B) ALL OTHER SURGERIES (10000-69999,92975-92984,92986-92998, 93501-93533,0001T-0002T,0005T-0009T,0012T-0014T,0016T-0017T) - MOVE MOD 53 FROM THE 1ST MOD SLOT TO 2ND-4TH SLOT, UNLESS NO ROOM THEN REMOVE MOD 53 AND OVCD 609.
2) ALL ELSE - REMOVE THE MODIFIER.
B. RES:
1) COMPARE MDCRS ALLOWED TO OUR MAX ALLOWED FOR 45378 ABOVE IN PHYS SECTION
2) WHICHEVER ALLOWED IS LESSER, MDCR'S OR OURS:
A) SUBTRACT MDCR PD FROM LESSER ALLOWED AMOUNT,
B) MANUAL PRICE LINE W/PAYMENT DUE & FORCE 430 IF POSTING
3) IF MDCR PD MORE THAN WE ALLOW DENY 368 EXC - W/EOB 030.

5. MODIFIER 62 (CO-SURGEON) OR 66 (SURGICAL TEAM)
EXAM ENTRY:
A. X-OVER CLAIMS - PA-2 (WILL GO TO 09 FOR PRICING)
B. PHYSICIAN CLAIMS: REMOVE MOD IF NOT A SURG (10000-69999,92975-92984,92986-92998,93501-93545,0001T-0002T,0005T-0009T,0012T-0014T, 0016T-0017T).
- ALL ELSE,
1) HYSTERECTOMIES - (56308,58150,58152,58180,58200,58210,58240, 58260-58270,58275-58280,58285,58550,59135,59525) -O'LOC TO 18
2) STERILIZATIONS/VASECTOMIES - (52347,56301-56302,58600,58605, 58611,58615,58670-58671/54690,55250,55450,56318) -O'LOC TO 18.
3) IF A NON COVERED CODE FOR DOS -
1. NO AUTH # PRESENT ON THE CLAIM- DENY W/EOB 325.
2. AUTH # IS PRESENT ON THE CLAIM - OVERLOC TO 36.
4) IF THE PROCEDURE IS BY REPORT OR UNLISTED AND PAYS AT A PERCENT OF CHARGES (TYPE 4 ON PDDD) AND THE BILLED AMT IS OVER $1100.00 - IF THERE IS NO REPORT ATTACHED - DENY W/EOB 190. IF THERE IS A REPORT ATTACHED - OVERLOC TO 14.
5) ALL ELSE - OVERLOC TO 36.

C. RESOLUTIONS: SEE EXCEPTION 053 FOR PRICING C-SURGEONS/TEAM
1) PHYSICIAN CLAIMS - SEE EXCEPTION 053 FOR PRICING CO-SURGEON
NOTE: LOC 36 - REVEIW PER AUTH REQUIRED PER EXCEPTION 353, ANY QUESTIONS - SEE LEAD/SUP/TRAINER.
2) X-OVER CLAIMS:
PF-4 UNDER CODE TO SEE IF (Y) IN CO-SURGEON (MOD 62)/TEAM (MOD 66) FIELD.
A) IF (Y) - LOOK AT MAX ALLOWED FOR DOS & MULTIPLY MAX ALLOWED X 62.5% = NEW MAX ALLOWED.
1. IF MDCR PD MORE THAN WE ALLOW - DENY 368 W/EOB 030.
2. IF OURS IS MORE:
A. SUBTRACT MDCR PD FROM MEDICARES ALLOWED.
B. MANUAL PRICE LINE W/PAYMENT DUE & FORCE 430 IF POSTING.

B) IF (N):
1. IF MEDICARE PAID - LOOK AT MAX ALLOWED FOR DOS & MULTIPLY MAX ALLOWED X 62.5% = NEW MAX ALLOWED.
A. IF MDCR PD MORE THAN WE ALLOW - DENY 368 W/EOB 030.
B. IF OURS IS MORE:
1) SUBTRACT MDCR PD FROM MEDICARES ALLOWED.
2) MANUAL PRICE LINE W/PAYMENT DUE & FORCE 430 IF POSTING.
2. IF MEDICARE DID NOT MAKE PAYMENT - DENY 368 W/EOB 095.

6. MODIFIER 1M - SPECIAL AGREEMENT - (MOD VALID THRU 10/15/03 DOS)
CHECK PROVIDER TEXT AND FOLLOW THOSE INSTRUCTIONS. IF NO SPECIAL AGREEMENT TEXT - DENY WITH 350. ANY QUESTIONS - OL TO 83 WITH NOTE IN F7 SCREEN.

7. MODIFIER 2R (RABIES) - MANUAL PRICE EACH UNIT AT $134.17. IF THE BILLED AMT IS LESS THAN OUR ALLOWABLE - MANUAL PRICE AT THE BILLED AMT. (EA 2 ML VIAL USED IS 1 UNIT).
NOTE: EFFECTIVE W/DOS 4/1/99 - DENY W/EOB'S 700/302.

8. MODIFIER 99 (J AND O).

EXCEPTION: O TAPES - O'LOC TO 36.
NOTE: O TAPES LOC 36 REVIEW ALL MODIFIERS AND FOLLOW 996 TEXT AND 368 TEXT FOR ALL PRICING MODIFIERS IF APPLICABLE.
NOTE: EFFECTIVE 6/9/01, THE SYSTEM WILL DEFAULT TO MOD 99 IF MULTI MODS ARE PRESENT ON TAPE "O" CLAIMS. THE MODS WILL BE PLACED IN THE COMMENTS (F-7) FOR REVIEW.

EE: PROVIDER BILLED ONLY MOD 99 - DENY W/EOB 285.
EE: PROVIDER BILLED MOD 99 & OTHER MULITPLE MODS ON CLAIM:
A. (J) - SEE INFO 993.
B. (O) - SEE INFO 996.
C. IF NOT APPLICABLE - CONTINUE READING.

EE: EXAMINER KEYED MOD 99 BECAUSE MULTIPLE MODS WERE INDICATED - O'LOC TO 09, UNLESS EXCEPTION ADDRESSED BELOW:
A. (J) - SEE INFO 993 FOR MULTI MODS.
B. (O) - SEE 996 FOR MULTI MODS BEFORE PA-2ING.

EXCEPTION: EFFECTIVE FOR CLAIMS PROCESSED ON 4/4/02 - 6/30/03
PROCESS DATE, IF MOD 9T IS ON CLAIM, SEE INFO TEXT 993.

EXCEPTION: 2 ANESTHESIA MODS BILLED (AA,AB,AC,AD,QK,QX-QZ) - DENY
W/EOB 562.

EXCEPTION: MOD 9T/ST & 1 OF THE ABOVE ANES MODS & THE PROCEDURE
IS ANESTHESIA (00100 - 01999) - O'LOC TO 09. *S

EXCEPTION: MOD 9T/ST MAKES UP 1 OF THE MULTIPLES & PROCEDURE IS
A SURGERY (10000-69999 EXCEPT 36415)(92975-92984,92986-
92998,93501-93545,0001T-0002T,0005T-0009T,0012T-0014T,
0016T-0017T) - WORK ALL OTHER EDITS EXCEPT 222 AND IF
NOT DENYING ENTIRE LINE/CLAIM - O'LOC TO 36.

EXCEPTION: 165, 166, AND/OR 263 POSTING AND NOT DENYING ENTIRE CLAIM
- PHYSICIAN (J) CLAIM TYPE ONLY.
EE:
A. CLAIM PROCEDURE CODE IS A HYSTERECTOMY (59125, 56308, 58150,
58152, 58180, 58200, 58210, 58240, 58260-58270, 58275-58280,
58285, 58550, 59135, 59525, 5913M-5914M) - O'LOC TO 18.
B. CLAIM PROCEDURE CODE IS A STERILIZATION (52347, 56301-56302,
58600, 58605, 58611, 58615, 58670-58671, 9802M, 5912M) OR A
VASECTOMY (54690, 55250, 55450, 56318, 5911M) - O'LOC TO 18.
C. CLAIM PROCEDURE CODE IS AN MRI/MRA - O'LOC TO 23.
EE: USE PDDD DESCRIPTION TO DETERMINE - MRI/MAGNETIC RESONANCE
IMAGING OR MRA/MAGNETIC RESONANCE ANGIOGRAPHY.
D. CLAIM PROCEDURE CODE IS A SURGERY CODE (10000-69999, 92975-92984,
92986-92998, 93501-93545, 0001T-0002T, 0005T-0009T, 0012T-0014T,
0016T-0017T, EXCEPT 36415) - O'LOC TO 36.
E. ALL ELSE O'LOC TO 09.

RES:
LOC 18 - HYSTERECTOMIES, REVIEW FOR EXPEDITED AUTH PER 353 EXC AND
CONSENT PER 345 EXC.
LOC 18 - STERILIZATIONS, REVIEW FOR CONSENT PER 345 EXC.
LOC 23 - MRI'S/MRA'S REVIEW FOR AUTH REQUIRED PER 353 EXC.
NOTE: ONLY POS OTHER THAN 1 REQUIRES EXPEDITED AUTH.
LOC 36 - SURGERIES REVIEW FOR AUTH REQUIRED PER 353 EXC.

NOTE: ALL SPECIALTY LOCATIONS - ASSIGN MODIFIER TO LINE AND PRICE
PER FOLLOWING INSTRUCTIONS WHEN APPROPRIATE AFTER 353 EXC,
345 EXC AND 053 EXC REVIEW.

RES: STAGE:
A. MULTIPLE MODS ON THE CLAIM, USE THE PRIORITY MOD FROM THE CLAIM,
COMMENTS OR BACKUP.
NOTE: 9T/ST IS ALWAYS PRIORITY, EXCEPT ANES - SEE BELOW *C

B. 9T/ST IS ONE OF THE MODS:
NOTE: IF PAYING RADIOLOGY AT TRAUMA RATE, FORCE EXCEPTION 222
AFTER MANUALLY PRICING.
1) IF LAB (80000-89999) KEY THE OTHER MOD, DO NOT ALLOW PAYMENT
FOR 9T/ST.

2) IF OTHER THAN PROVIDER TYPE 18, 20, 25, 48, 49, 93 - KEY THE OTHER MOD OR PRICE AT PDDD MAX ALLOWED, DO NOT ALLOW PAYMENT FOR 9T.
3) IF ANES PROC (00100-01999) - KEY ANES MOD (AA - QZ IN 1ST MOD FIELD, ST/9T IN 2ND, ENTER, MANUAL PRICE INCL ST/9T FEE, USE EOB 428 IN 1ST HEADER EOB FIELD & ENTER CLAIM TO CHECK HX FOR OTHER ANES CLAIM. DO NOT FORCE 087 UNTIL THIS IS DONE.
4) REVIEW ALL OTHER MODS FOR APPROPRIATE PAYMENT AND:
A) 01/01/01 DOS TO 03/17/02 DOS - ALLOW 400% OF THE PDDD ALLOWED FOR POS (1, 2, 5).
B) 03/18/02 DOS FOR ALL CLAIMS PRICED UP THRU PROCESSING DATE OF 04/03/02 (NOT DOS) - ALLOW 250% FPR POS (1, 2, 5). IF ANOTHER VALID PAYMENT MOD ON DETAIL LINE, REMOVE 9T & USE INFO EOB 036.
C) DOS 03/18/02 TO 06/30/03 & NOT ADDRESSED ABOVE - DO NOT PAY TRAUMA ALLOW. REMOVE 9T MOD ADD REASON IN COMMENT PAGE. ENTER OTHER PRICE OR INFO MODS IN MOD FIELDS.
D) 07/01/03 DOS & AFTER - ALLOW 250% OF THE PDDD ALLOWED FOR POS (1,2,5,21,22,23,26)

C. 90 IS ONE OF THE MODS - KEY MOD 90 ON CLAIM & ENTER.
1) IF EXCEPTION 174 POSTS & NO PERF PROV # IN CLAIM OR COMMENTS - DENY EXCEPTION 174.
2) IF EXCEPTION 174 DOES NOT POST - KEY ANOTHER MOD.

TEXT KEY TEXT DESC
375 EXAM ENTRY - O'LOC TO 14

RES/ADJ J CLAIMS (LOC 14) - SEE BELOW

NOTE: WHEN SENDING CLAIM TO MED CONSULTANT/MMIS SERVICES - CYCLE ON SCREEN W/EOB 103 IN ORDER TO INDICATE STATUS OF CLAIM.

NOTE: IF NOT ADDRESSED IN THIS TEXT - O'LOC TO 83.

1. UNLISTED AND % PROCEDURES (OTHER THAN CODES THAT BEGIN WITH "A", "J", "Q" OR "S" & PAY AT 100%) - FOR THOSE CODES SEE PG 4,#2
   A. RES:
      1) PET SCANS (78608-78609,78459,78491-78492,78810,G0210-G0234, G0253-G0254)
         A) AUTH ON CLAIM:
            1. TECHNICAL COMPONENT (MOD TC) - MANUAL PRICE AT 45% OF BILLED AMOUNT UP TO 1850.00 MAX W/EOB 373.
            2. GLOBAL (100%) - MANUAL PRICE AT 45% OF BILLED AMOUNT UP TO 1895.00 MAX W/EOB 373.
            3. IF 600 SERIES EXCEPTION POSTING, REVIEW SCANNER/KEYING, OTHERWISE - O'LOC TO 83 WITH NOTE IN COMMENT SCREEN.
         B) NO AUTH - WORK 353 EXC OR 326, WHICHEVER IS POSTING.

NOTE: ANY QUESTIONS ASK MMIS/SANDY OR TRINA

      2) PROVISION OF RADIONUCLIDES (78990) PAY AS BILLED.
      3) ALL ELSE: NO REPORT - DENY W/EOB 190, OTHERWISE SEE BELOW.

   B. RES LOC 14:
      RT CLAIM/BACKUP TO OMD/LAURA PIERPOINT/MS 45506 FOR PRICING. UPON RETURN, CLAIMS THAT HAVE BEEN REVIEWED & PRICED BY NCC/MED CONSULTANTS SHOULD BE PD BY CLAIMS PROCESSING AS PRICED IF THE NCC/MED CONSULTANT HAS INDICATED PAYMENT IS TO BE PD AT % OF SOMETHING OR INDICATES A SPECIAL PAYMENT BECAUSE OF ANOTHER REASON (STATEMENT WILL SAY "ACTUAL FEE"). DO NOT USE MOD PLACEMENT ON THESE PROCEDURES. HOWEVER IF ANOTHER PROCEDURE ON THE CLAIM NEEDS A MOD, THIS IS ACCEPTABLE. OTHERWISE, IF NO PAYMENT AT A % OR NO SPECIAL PAYMENT INSTRUCTION, FOLLOW THE POLICY & PROCEDURE IN THE053 IF APPLICABLE.
      (MED CONSULT/NCC WILL BE PRICING AT THE 100%/COMPARABLE FEE).

      NOTE: INDICATE ON COVER LETTER THE ISSUE TO BE PRICED - SURGICAL, ANESTH, PET SCAN OR RADIOLOGY, ECT. INDICATE ON MMIS CLAIM COPY/WORKSHEET THE PROCEDURES YOU WANT PRICED & INDICATE PAID OR LIVE PROCEDURES THAT WILL PAY INDEPENDENTLY AND NEED NOT TO BE PRICED. USE INFO EOB 373. ALWAYS USE EOB 383 ON THE LINE(S) IF THE NCC/MED CONSULTANT ADJUSTS THE ORIGINAL FEE ON AN ADJUSTMENT. ATTACH A CONSULTANT PRICING FORM TO EACH CLAIM ROUTING.

NOTE: WHEN ENTERING CLAIM TO PAY ONCE RETURNED, ENTER THE MEDICAL CONSULTANT DETERMINED PROCEDURE CODE INTO THE ONLINE COMMENT SCREEN.

ANY QUESTIONS SHOULD GO THROUGH YOUR SUPERVISOR.

NOTE: (38999) FOR UNRELATED DONOR SEARCH, CONSULTATION AND COORDINATION FEE, ALLOWANCE PER NCC/MED CONSULTANT IS LOCATED IN THE ROLADEX FILE.
NOTE: EFFECTIVE 6/20/98, MAA WILL NO LONGER PAY FOR DONOR SEARCH IN ORDER TO BE CONSISTENT WITH POLICY OF NOT PAYING FOR ORGAN DONOR TRANSPLANTS.
UPDATE: EVEN THOUGH MAA NOW PAYS FOR TRANSPLANTS FOR COE, ETR TEAM DECISION IS TO CONTINUE NOT TO PAY - DENY W/EOB'S 325/373.

NOTE: APPLY ALL OF THE 053 AUDIT POLICY, STERILIZATION/HYSTERECTOMY POLICY, AUTHORIZATION POLICY, NON-COVERED SERVICE POLICY, AND AGE/GENDER POLICY FOR ALL UNLISTED BY REPORT SURGICAL CODES.

2. CODES THAT BEGIN W/"A", "J", "Q" OR "S" ARE PD AT 100% (ACQUISITION)

NOTE: CROSS REFERENCE FOR DRUG NAMES AT END OF TEXT - REFERENCED PER PDR AND/OR MMIS.

A. IF NO INVOICE ATTACHED - DENY 196.
B. INVOICE ATTACHED: (IF INVOICE DOES NOT MATCH-RT TO MMIS/SANDY A)
1) MULTIPLE UNITS BILLED ON LINE:
A) F4 UNDER CODE TO CHECK STRENGTH.
B) MULTIPLY UNITS ON CLAIM X STRENGTH ON PDDD = QUANTITY USED.
C) DIVIDE PRODUCT DOSAGE ON INVOICE INTO PRICE FROM INVOICE TO IDENTIFY PRICE PER UNIT.
D) MULTIPLY PRICE PER X QUANTITY USED ON DETAIL LINE.
E) MANUAL PRICE W/EOB 552/373.
F) IF CANNOT COMPUTE OR HAVE ANY QUESTIONS - SEE SANDY IN MMIS OR ROUTE TO MMIS/SANDY/45564.
2) ONLY 1 UNIT BILLED ON LINE - REVIEW CLAIM FOR QUANITY USED:
A) QUANTITY USED IS LISTED ON CLAIM:
1. DIVIDE PRODUCT DOSAGE ON INVOICE INTO PRICE FROM INVOICE TO INDENTIFY PRICE PER UNIT.
2. MULTIPLY PRICE PER X QUANITY USED PER CLAIM.
3. MANUAL PRICE W/EOBS 552/373.
4. IF CANNOT COMPUTE OR HAVE ANY QUESTIONS - SEE SANDY IN MMIS OR ROUTE TO MMIS/SANDY/45564.
B) IF NO QUANTITY LISTED ON CLAIM - SEE SANDY/TRINA IN MMIS OR RT TO MMIS/SANDY OR TRINA/45564.
(MMIS, REVIEW FOR APPROPRIATE ADJUDICATION)

3. PROCEDURE 0501L (PT22) ASC (PROSTHETIC DEVICE/IMPLANT)
IF INVOICE - RT TO SANDY R/MMIS/45564. NO INVOICE- DENY W/EOB 196

LOC 14 ONLY - DRUG CROSS REFERENCE FOR J & Q CODE SECTION:

ADRIAMYCIN	IS	DOXORUBICIN
AMIFOSTINE	IS	ETHYOL
AREDIA	IS	PAMIDRONATE DISODIUM
CAMPTOSAR	IS	IRINOTECAN
CEREZYME	IS	IMIGLUCERASE

CYTOTEC	IS	MISOPROSTOL
DOCETAXEL	IS	TAXOTERE
DOXORUBICIN	IS	ADRIAMYCIN
ETHYOL	IS	AMIFOSTINE
FACTOR V28A	IS	NOVOSEVEN
FILGRASTIM	IS	NEUPOGEN
GAMMIMUNE	IS	IMMUNOGLOBULIN
GEMCITABINE ACETATE	IS	GEMZAR
GEMZAR	IS	GEMCITABINE ACETATE
HERCEPTIN	IS	TRASTUZUMAB
HYCAMTIN	IS	TOPOTECAN
IFEX	IS	IFOSFAMIDE
IFOSFAMIDE	IS	IFEX
IMIGLUCERASE	IS	CEREZYME
IMMUNOGLUBULIN	IS	GAMMIMUNE
INFLIXIMAB	IS	REMICADE
IRINOTECAN	IS	CAMPTOSAR
MISOPROSTOL	IS	CYTOTEC
MITOXATRONE HYDROCHOLRIDE	IS	NOVATRONE
NEUPOGEN	IS	FILGRASTIM
NOVOSEVEN	IS	FACTOR V28A/RECOMBINANT
NOVANTRONE	IS	MITOXANTRONE HYDRO
OCTREOTIDE	IS	SANDOSTATIN
PACLITAXEL	IS	TAXOL
PAMIDRONATE DISODIUM	IS	AREDIA
RECOMBINANT FACTOR V28A	IS	NOVOSEVEN
REMICADE	IS	INFLIXIMAB
SANDOSTATIN	IS	OCETREOTIDE ACETATE
TAXOTERE	IS	DOXETAXEL
TENOPISIDE	IS	VUMON
TOPOTECAN	IS	HYCAMTIN
TRASTUZUMAB	IS	HERCEPTINE

TEXT KEY TEXT DESC

377 --NOTE: IF THE REVENUE CODE IS NOT LISTED BELOW - OVERLOC TO 72.

100 - 3200318 - KINDRED (VENCOR) & 3200326 - REGIONAL
050 1. IF NO AUTHORIZATION ON THE CLAIM - DENY AT HEADER LEVEL WITH EOB 023.
2. IF AUTHORIZATION IS ON THE CLAIM:
EE: OVERLOC TO 23.
RES: A. IF CLAIM DATES OF SERVICE DO NOT MATCH THE DATES OF SERVICE ON THE AUTH FILE - DENY W/EOB 216.
B. IF CLAIMS DATES OF SERVICE MATCH DATES OF SERVICE ON AUTH FILE:
1. THEY MUST WRITE OFF THE FIRST $200 PER DAY IN PHARMACY CHARGES. THIS AMOUNT MUST BE ENTERED IN THE NON-COVERED CHARGES FIELD. IF PROVIDER HAS NOT MET THESE CONDITIONS - OVERLOC TO 72.
2. IF PROVIDER HAS MET THESE CONDITIONS - FORCE 377.

101 - PM&R LEVEL B - OVERLOC TO 72.

115, 125 & 135 - SEE INSTRUCTIONS FOR REV CODE 653.
129 - EFFECTIVE WITH ADMITS ON & AFTER 06/01/03 THIS REVENUE CODE REPLACES REVENUE CODE 168. USE THE SAME INSTRUCTIONS BELOW FOR REV CODE 129 THAT WERE USED FOR REV CODE 168. (PROVIDERS CAN USE REV CODE 168 UNTIL 08/01/03).
--THESE CLAIMS SHOULD BE A "S" CLAIM TYPE. IF CLAIM IS A DRG & IS NOT POSTING EXC 433 - OVERLOC TO 72.

160 - 3318904 - MADIGAN ARMY HOSPITAL
IF CHARGES APPEAR TO BE FOR SUBSISTENCE AT A CHARGE OF APPROX $25 PER DAY - MANUALLY PRICE AT THE BILLED AMT & FORCE 377. IF CHARGES APPEAR TO BE FOR NORMAL ROOM & BOARD - DENY W/EOB 339.

168 - CUP (CHEMICALLY USING PREGNANT) WOMEN PROGRAM
--APPLY THE FOLLOWING INSTRUCTIONS TO THESE PROVIDERS ONLY. ALL OTHER PROVIDERS - OVERLOC TO 72.

3304508 - ST JOHNS HOSPITAL
3305604 - DEACONESS HOSPITAL
3307907 - GRAYS HARBOR COMMUNITY HOSPITAL
3308905 - ST JOSEPH HOSPITAL - BELLINGHAM
3309200 - SWEDISH HOSPITAL MED CTR
3309606 - PROVIDENCE GENERAL MED CTR - SEATTLE
3315900 - VALLEY GENERAL HOSPITAL
3400017 - ST PETER CHEMICAL DEPENDENCY

1. FORCE IF CLAIM MEETS ALL OF THE FOLLOWING CRITERIA:
A. PRIMARY DX IS 648.33 OR 648.34 (DRUG DEPENDENCE) ...OR... 648.43 OR 648.44 (ALCOHOL DEPENDENCE).
B. SECONDARY DX IS 303 - 304.93.
C. LENGTH OF STAY IS 26 DAYS OR LESS.
2. ALL ELSE:

A. IF CLAIM IS FOR MORE THAN 26 DAYS:
EE: OVERLOC TO 46.
RES: FOLLOW THE INSTRUCTIONS IN THE EXCEPTION 109 TEXT.
B. IF PROVIDER IS NOT BILLING WITH THE PRIMARY AND SECONDARY DIAGNOSIS LISTED ABOVE (THEY MUST HAVE BOTH) - DENY AT HEADER LEVEL WITH EOB 756.

**IMPORTANT NOTE: DO NOT ALLOW ANY OTHER ROOM CODE (I.E. 126), DENY OR MANUALLY PRICE AT 0.00 WITH EOB 756.

403 - SCREENING MAMMOGRAPHY - OVERLOC TO 72.

430-439 - OCCUPATIONAL THERAPY

1. PM&R LEVEL A - (TO IDENTIFY LOOK FOR ONE OF MORE OF THE FOLLOWING: AUTH # BEGINS WITH 57/REVENUE CODE 128/PRIMARY DX V57.X/PROVIDER # BEGINS WITH 32).
   A. EE - OVERLOC TO 23.
   B. RES - WORK PER INSTRUCTIONS IN THE 343 TEXT UNDER DX CODES V57.4 - V57.9.

2. FORCE THE FOLLOWING:
   A. IF THE PATIENT IS UNDER 21 YEARS OLD.
   B. CLAIM FOR BURNS ON ANY PART OF THE BODY.
   C. PROVIDERS: 3304201 - SACRED HEART MEDICAL CENTER
   3306206 - CHILDRENS HOSPITAL & MED CENTER
   D. CLAIMS WITH DX CODES:

342 - 342.9	HEMIPLEGIA
344 - 344.9	OTHER PARALYTIC SYNDROMES
430 - 438	CEREBROVASCULAR DISEASE
800 - 804.9	FRACTURE OF THE SKULL
850.3 - 850.9	CONCUSSION
851 - 851.9	CEREBRAL LACERATION & CONTUSION
852 - 852.5	SUBARACHNOID, SUBDURAL & EXTRADURAL HEMORRHAGE FOLLOWING INJURY
853 - 853.1	OTHER & UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY
854 - 854.1	INTRACRANIAL INJURY OF OTHER & UNSPECIFIED NATURE
905.0	LATE EFFECT OF FRACTURE OF SKULL & FACE BONES
907.0	LATE EFFECT OF INTRACRANIAL INJURY WITHOUT MENTION OF SKULL FRACTURE
907.1	LATE EFFECT OF INJURY TO CRANIAL NERVE

   E. ALL ELSE DENY WITH EOB 047.

511 - INPATIENT PAIN MANAGEMENT

1. IF PROVIDER 3309309 (ST. JOSEPH HOSPITAL):
   A. "S" CLAIM - IF CLAIM IS FOR 21 DAYS OR LESS AND:
      1. ADMIT DATE IS 11/01/02 OR AFTER: MANUALLY PRICE REV CODE 511 AT $543 PER DAY WITH 001 IN 2ND EOB. FORCE 377.
      --NOTE: ALLOW REV CODE 511 ONLY. MANUALLY PRICE ALL OTHER REV CODES AT $0.00 W/EOB 339.
      2. ADMIT DATE IS 10/31/02 OR PRIOR: MANUALLY PRICE REV CODE 511 AT $285 PER DAY WITH 001 IN 2ND EOB. FORCE 377.
      --NOTE: ALLOW REV CODE 511 AND PHARMACY/DRUG REV CODES

ONLY. MANUALLY PRICE ALL OTHER REV CODES AT $0.00 WITH EOB 339.
B. IF BILLING FOR MORE THAN 21 DAYS - DENY W/EOB 339.
C. "M" CLAIM - DENY W/EOB 325 AT HEADER LEVEL.
2. IF ANY OTHER PROVIDER - DENY W/EOB 047.

546 - NEONATAL TRANSPORT TEAM
1. FORCE IF CLIENT IS AGE 6 MONTHS OR UNDER AND PROVIDER IS:
CHILDREN'S HOSP - 3306206
MARY BRIDGE CHILDREN'S HOSPITAL - 3300340
TACOMA GENERAL HOSPITAL - 3300332
ST JOSEPH HOSPITAL (TACOMA) - 3309309
2. IF ONE OF THE PROVIDERS LISTED ABOVE AND CLIENT IS OVER THE AGE OF 6 MONTHS - OVERLOC TO 72.
3. ALL OTHER PROVIDERS - IF CLAIM STATES "NEONATAL TRANSPORT", "TRANSPORT TEAM" OR SOMETHING SIMILAR - OVERLOC TO 72.
4. ALL ELSE - DENY W/EOB 047.

HOSPICE REVENUE CODES (650 THROUGH 659):

650-659 - OUT-OF-STATE NOT COVERED - OVERLOC TO 67.

652-CONTINUOUS HOME CARE - THIS IS AN HOURLY CODE PAYABLE FOR EACH HOUR OF CONTINUOUS CARE. EACH DATE OF SERVICE MUST BE ITEMIZED AND BILLED ON A SEPARATE LINE WITH A MINIMUM OF 8 UNITS (HOURS) AND A MAXIMUM OF 24 UNITS (HOURS) PER LINE.
--PROVIDERS 3990736 & 3990728 - IF CLAIM HAS B/U - OVERLOC TO 67 & ROUTE CLAIM AND BACKUP TO CHRISTINE C., MMIS SERVICES, MS 45564. IF NO BACKUP - DENY W/EOB 224.

ALL ELSE:
1. IF EACH DATE OF SERVICE IS NOT ITEMIZED AND BILLED ON A SEPARATE LINE - DENY W/EOB 295.

2. IF EACH DATE OF SERVICE IS ITEMIZED AND BILLED ON A SEPARATE LINE AND THE UNITS BILLED ARE:
A. LESS THAN 8 OR MORE THAN 24 - DENY W/EOB 012
B. 8 OR MORE (BUT NOT MORE THAN 24) - FORCE

653 - NURSING FACILITY ROOM & BOARD. EFFECTIVE DOS 10/1/03, REV 653 WAS REPLACED BY REV CODES 115, 125 & 135.
EE - ENTER NURSING HOME PROVIDER # IN THE "0-PROV" FIELD AND PA2. IF NURSING HOME PROVIDER # IS NOT PRESENT, BUT NAME IS, PF5 FOR THE NUMBER AND ENTER IN THE "0-PROV" FIELD AND PA2. IF NAME OR NUMBER IS NOT PRESENT - DENY W/EOB 447.
RES/ADJ - OBTAIN DAILY RATE FROM THE NURSING HOME FILE (SCREEN 6). USE CHARGE MODE 20 FOR APPROPRIATE DATES OF SERVICE. IF NO MODE 20 AND PROVIDER # BEGINS WITH "42", USE CHARGE MODE 26. OTHERWISE SEE SUPERVISOR. HOSPICE DAILY RATE IS CALCULATED AT 95% OF THE NURSING HOME CHARGE MODE TIMES THE # OF DAYS BILLED. MANUALLY PRICE AT A RATE NOT TO EXCEED THE BILLED AMOUNT.

655 - INPATIENT RESPITE CARE.

1. IF INDIVIDUAL DATES OF INPATIENT RESPITE CARE ARE NOT ITEMIZED ON THE CLAIM (OR IN THE COMMENTS FIELD) - DENY W/EOB 296.
2. IF DATES ARE ITEMIZED, ALLOW UP TO 5 CONSECUTIVE DAYS OF CARE AT A TIME, THEN THERE MUST BE AT LEAST A 1 DAY BREAK BEFORE ANOTHER 5 CONSECUTIVE DAYS CAN BEGIN. IF MORE THAN 5 CONSECUTIVE DAYS - DENY LINE W/EOB 296. OTHERWISE FORCE.

656 - GENERAL INPATIENT CARE - PROVIDER #'S 3990124 & 3990033.
DATES OF SERVICE PRIOR TO 10/01/01:
EXAM ENTRY - OVERLOC TO 47.
RESOLUTIONS - ROUTE WORKSHEET W/BACKUP TO PAM COLYAR MS: 45506
DSHQS/QFFS - IF DENYING CLAIM USE EOB 786.

659 - PALLIATIVE CARE (END OF LIFE GRANT) - OVERLOC TO 67.

723 - CIRCUMCISION - FORCE IF DX CODE 605 OR 607.1. OTHERWISE - DENY WITH EOB 047.

789 - TELEHEALTH ORIGINATING SITE FACILITY FEE: IF LINE HAS CPT CODE Q3014 IN ADDITION TO REVENUE CODE 789 - MANUALLY PRICE LINE AT AT $20.00. IF NOT BILLING W/CPT CODE Q3014 - DENY W/EOB 153.

897-898 - STEM CELL HARVESTING & REINFUSION - OVERLOC TO 72.

910-911 - 1. IF AUTH # BEGINS WITH "57" (PM&R):
A. EE - OVERLOC TO 23
B. RES - WORK PER INSTRUCTIONS IN THE 343 TEXT UNDER DX CODES V57.4 - V57.9.
2. ALL ELSE - DENY W/EOB 047.

940 - 3303500 - HARRISON MEMORIAL HOSPITAL *SH
1. MANUALLY PRICE (ALLOWED CHG FIELD) AT $45 PER UNIT BILLED (MAXIMUM 6 UNITS PER LIFETIME) WITH 0001 IN THE 2ND EOB.
2. ANY OTHER PROVIDER - DENY W/EOB 047.

948-949 - 3306909 - PROVIDENCE HOSPITAL
1. MANUALLY PRICE AT $200 PER DAY FOR REVENUE CODE 948 AND $100 PER DAY FOR REVENUE CODE 949.
2. ANY OTHER PROVIDER - DENY W/EOB 047.

INTERPRETER SERVICES/ASL (CODE 0997M & 0998M - PRIOR TO 10/01/03 AND T1013 & S0215 10/01/03 AND AFTER) - MANUAL PRICE ACCORDING TO CONTRACT AND BY INTERPRETER'S QUALIFICATIONS.

TEXT KEY TEXT DESC
378 UNABLE TO PRICE FOR THIS DATE OF SERVICE

PHYSICIANS (J)

1. 0100M (DENTAL ANESTHESIA) - DENY WITH EOB 036.

2. J9162 - DEPO-PROVERA -IF DX IS FOR BIRTH CONTROL (I.E. V25.9 OR V25.09) OR CLAIM OR COMMENTS INDICATE BIRTH CONTROL OR CONTRACEPTIVE MANAGEMENT - DENY W/EOB 302.

3. 93501-93553 (HEART CATHS) - IF BILLING TC MODIFIER - DENY 212.

4. THE SERVICE IS BILLED W/A MOD:
   A. THE PROCEDURE CODE IS "TYPE 6" NON-COVERED FOR DOS (PER PDDD) &:
      1) IF AUTH # ON CLAIM - O'LOC TO 23 FOR REVIEW PER 611 TEXT, OTHERWISE;
      2) PDDD NOTES STATE BUNDLED FOR CLAIM DOS - DENY W/EOB 800.
      3) PDDD NOTES DO NOT STATE BUNDLED FOR CLAIM DOS - DENY W/EOB 325.
   B. THE PROCEDURE IS A VALID/COVERED SERVICE FOR DOS (PER PDDD)
      1) 00100 - 01999 - DOS PRIOR TO 7/1/00 SEE (7) BELOW.
      2) MOD 54/55/56/78 BILLED W/ANY PROCEDURE EXCEPT (E&M) & HAS NO PRE/INTRA/POST SEGMENT ON PDDD: IF 222 IS POSTING, WORK IT FIRST, OTHERWISE, MANUAL PRICE AT 100% PER PDDD FOR THAT DOS. (THESE ARE PROCEDURES THAT WERE NOT ASSIGNED A SEPARATE (PRE/INTRA/POST) OP FEE, THUS WE WILL PAY AT MAX FEE.
      3) 10021/10022 - SEE EXCEPTION 169 IF POSTING. IF NOT O'LOC TO 83.

      NOTE: WE DID NOT TELL THE PROVIDERS WHICH PROCEDURES COULD AND COULD NOT BE BILLED W/MOD 54/78.
      NOTE: IF 222 IS POSTING - WORK IT FIRST.

      4) ALL ELSE - DENY W/EOB 036.

   C. ALL ELSE - DENY.

5. 8000M AND 8001M - DENY W/EOB 302.

6. J3490 OR 90399 (DESCRIPTION IS SYNAGIS) OR 90378 AND AUTH # ON CLAIM - O'LOC TO 35, LOC 35 IF CODE IS AUTHORIZED, BUT NOT VALID FOR DOS - ROUTE CLAIM/WORKSHEET TO MMIS/5564/SANDY FOR REVIEW.

7. ANESTHESIA CODES (00100-01999)
   A. PROCEDURE (01996) IF DOS IS 7/1/00-12/31/00 & ONLY 1 UNIT IS BILLED - MANUAL PRICE AT $21.70 W/EOB 589.

NOTE: DO NOT APPLY ANY MANUAL PRICING TO MOD 9T FOR CLAIMS PROCESSED AFTER 4/3/02 - 6/30/03 DOS, RETAIN THE MOD ON CLAIM.

   B. MOD 9T/ST BILLED ALONE (REVIEW FOR ANES MOD ON CLAIM/COMMENTS) - DENY W/EOB 285 & ENTER.
   C. IF MOD 9T/ST BILLED IN COMBO W/ANES MOD (AA,AD,QK,QX,QY,QZ) -

KEY MOD 99 & PA-2 TO LOC 09.

8. IF NOT ADDRESSED ABOVE & CODE ON PDDD FILE INDICATES CODE IS A VALID CODE FOR DOS & EXCEPTION 365 IS POSTING, WORK IT FIRST.

9. ALL ELSE, DENY.

MED VENDOR X-OVER (O) - HARDCOPY (TOS 9 OR R)
1. RR MODIFIER ON MEDICARE EOMB BUT NOT ON CLAIM THEN KEY MOD RR ON CLAIM AND ENTER.
2. ALL ELSE - DENY.

MED VENDOR X-OVER (O) - TAPE (TOS 9 OR R)
1. ANY DENIAL OR AUTO DENY OTHER THAN 430 EXC ON SAME LINE OR AT HEADER LEVEL - ENTER ALLOW SRCE "A" AND ENTER.
2. ALL ELSE - O'LOC TO 83.

PHYSICIAN X-OVERS (O) TOS 3 OR Z
1. IF MODIFIER IS PRESENT - THE SERVICE IS BILLED W/A MOD - SEE BELOW:
   A. THE PROCEDURE CODE IS NON COVERED - TYPE 6 FOR DOS PER PDDD &:
      1) DESCRIPTION STATES BUNDLED FOR DOS - DENY W/EOB 859. IF 430 EXCEPTION POSTING:
         A) MOD 26 - ENTER IN SLOT 2-4, KEY "X" IN LMC AND ENTER. IF ALLOWED SOURCE CODE IS "Q" - LEAVE MOD 26 IN SLOT 2 & ENTER. IF 222 EXC POSTING FORCE. OVCD MOD 26 IF NECESSARY.
         B) ALL ELSE - DENY 378 EXC W/EOB 030.
      2) IF 453 EXCEPTION IS POSTING - DENY THE 378 W/EOB'S 095/325.
   B. PROCEDURE CODES (00100-01999):
      1) 01996 (DOS 7/1-12/31/00) EE: PA-2; RES: USE $21.70 AS MAA ALLOWED.
      2) ALL ELSE - IF MOD IS OTHER THAN (AA, AD, QK, QX, QY, QZ)-DENY.
      3) MULTIPLE MODS - O'LOC TO 83.
      4) ANY QUESTIONS - O'LOC TO 83.
   C. ALL ELSE - ENTER MOD IN SLOT 2-4 OR REMOVE MODIFIER IF NECESSARY & KEY "X" IN LMC AND ENTER:
      1) IF 378 STILL POSTING:
         A) G0203-G0207 IF MOD 26 WAS THE ORIGINAL MOD ENTER MOD 26 IN 2-4 SLOT AND ENTER OR KEY MOD 26 IN SLOT 1 AND ENTER ALLOWED SOURCE CODE "A" AND ENTER IF ALL MODS SLOTS ARE FILLED.
         B) ANY DENIAL OR AUTO DENY OTHER THAN 430 EXC ON SAME LINE OR AT HEADER LEVEL - ENTER ALLOWED SOURCE CODE "A" AND ENTER.
         C) ALL ELSE - O'LOC TO 83.
      2) IF 378 NO LONGER POSTING:
         A) MOD'S 54/55/56/78 BILLED W/ANY PROCEDURE EXCEPT (E&M) & HAS NO PRE/INTRA/POST SEGMENT ON PDDD, LEAVE ORIGINAL MOD IN 2-4 SLOT AND ENTER OR IF NO OTHER MOD SLOT USE SLOT 1 AND ENTER ALLOWED SOURCE CODE "A" AND ENTER. MOD 78/54/55/56 MUST BE ON LINE. OVCD ALL OTHER MODS IF NECESSARY.
         B) MOD 26/TC WITH PROCEDURE CODES 10021/10022, ENTER MOD 26/TC IN SLOT 2-4 OR OVCD IF NECESSARY AND FORCE 222 EXC IF FAILING FOR DOS 07/01/02 AND AFTER. IF ALL MOD SLOTS ARE FILLED OVCD MOD 26/TC IF NECESSARY.

C) MOD 26 WITH PROCEDURE CODE THAT DOES NOT HAVE A PC SEGMENT ON THE PDDD FILE (PF-4 UNDER PROCEDURE CODE) FOR THE DOS, MOVE THE MOD 26 TO SLOT 2-4 AND ENTER. IF MOD SLOTS 2-4 FULL KEY MOD 26 IN SLOT 1 WITH ALLOWED SOURCE CODE "A" AND ENTER. OVCD IF NECESSARY.

D) ANY DENIAL OR AUTO DENY OTHER THAN 430 EXC ON SAME LINE OR AT HEADER LEVEL - KEY ALLOW SRCE "A" AND ENTER.

E) ALL ELSE - O'LOC TO 83.

2. NO MODIFIER PRESENT: CODES (00100-01999) - DENY.
3. IF PROCEDURE CODE 59500 - CHANGE TO 59514.
4. IF PROCEDURE CODE 93546 - CHANGE TO 93510. IF 222 IS FAILING - ADD MODIFIER 26.
5. IF AMBULATORY SURGERY CENTER (PT22) & PROCEDURE CODE 28296 - CHANGE TO 28306.
6. PROCEDURES (G0064-G0066) - DENY W/EOB 800 (EFF 01/01/98 DOS).
7. PROCEDURE STATES BUNDLED ON PDDD FOR DOS - DENY W/EOB 800.
8. PROCEDURE HAS NO RATE ON FILE FOR SOS -FACILITY (POS 1,2,5,7,8) OR NON-FACILITY (3,4,9) - DENY W/EOB 212.
9. MISSING POS:
   A. HARD COPY - DENY W/EOB O14.
   B. TAPE - TAKE SAMPLES TO MMIS/SANDY FOR REVIEW.
10. ALL ELSE:
   A. ANY DENIAL OR AUTO DENY OTHER THAN 430 EXC ON SAME LINE OR AT HEADER LEVEL - KEY ALLOW SRCE "A" AND ENTER.
   B. ALL ELSE - O'LOC TO 83.

HOSPITALS (R) & (S) CLAIMS - OVERLOC TO 72.

HOSPITALS (M):

1. KIDNEY CENTERS (PT 62)- EFFECTIVE DOS 8/1/03 & AFTER DENY REV CODES 270 & 636. ALL ELSE CHECK 367 TEXT TO VERIFY REV CODES. IF INVALID-DENY. IF VALID - OVERLOC TO 67.

2. RURAL HEALTH PROVIDERS (PROVIDER TYPE 88, SPECIALTY 70) - CAN BILL REVENUE CODE 521 - OVERLOC TO 74.
3. HOSPICE (PROVIDER TYPE 63) - EFFECTIVE DOS 11/1/03 - DENY REV CODE 653. ALL ELSE - DENY.
4. ALL ELSE - DENY.

TEXT KEY TEXT DESC

380 MODIFIER INDICATES ANESTHESIA BUT NO BASE RATE ON PDDD FILE.
X-OVER "O" - FOLLOW DIRECTIONS BELOW, IF QUESTIONS - SEE MMIS.
MODIFIERS AA,QZ,QX,AB,AC,AD,QJ,QO,QQ,47,QK,QY

1. CODES 00100 - 01998:
   A. DOS IS PRIOR TO 7/1/00 - DENY W/EOB 248.
   B. DOS 7/1/00 & AFTER:
      1. CODES 01953,01996 - DENY.
      2. PHYS (J) ONLY - PROCEDURE CODE NON-COVERED PER PDDD -
         DENY W/EOB 859, UNLESS:
         AUTH - O'LOC TO 23.
         LOC 23 - FOLLOW 611 TEXT.
  NOTE: XOVERS (O) SEE BELOW.
      3. PROCEDURE CODE HAS NO ANESTHESIA BASE FOR DOS:
         A. X-OVER "O" - IF MEDICARE HAS PAID:
            EE: O'LOC TO 36.
            RES LOC 36: PROCESS AS IF AUTH IS ON THE CLAIM USING PDDD
            FILE DESCRIPTION FOR BASE. IF NO BASE LISTED IN PDDD FILE
            DESCRIPTION, O'LOC TO 83.
         NOTE: CALCULATE ALLOWANCE PER 087 FORMULA FOR ANESTH. PAY PER
               MEDICARE'S OR MEDICAID'S ALLOWED, WHICHEVER IS LESSER.
         B. PHYSICIAN "J" - DENY.
      4. ALL ELSE -O'LOC TO 83.

2. CODE 0100M - DOS IS 10/1/01 & AFTER - DENY W/EOB 302.

3. 01999:
   A. IF NO REPORT ATTACHED - DENY W/EOB 190.
   B. IF REPORT ATTACHED - O'LOC TO 14 FOR REVIEW
   LOC 14: REVIEW & SEND TO OMD/LAURA PIERPOINT/DR.BAUMGARTNER/45506
   FOR REVIEW & PRICING. IF DR. B. DOES NOT ASSIGN A BASE, SEND TO
   MMIS/SANDY A FOR APPROPRIATE BASE.
4. AGE 17 & UNDER:
   A. NON COVERED PER PDDD - DENY W/EOB 859, UNLESS AUTH - O'LOC TO
      23.

   B. RADIOLOGY PROCEDURES W/THE WORD (TRANS) IN THE DESCRIPTION,
      IE (76830,76872,76873) - O'LOC TO 14.

   C. ALL ELSE - DENY W/EOB 302, UNLESS AUTH - O'LOC TO 23.

5. DOS IS PRIOR TO 07/01/00 & PROCEDURE CODE IS LISTED BELOW:
   A. EE: O'LOC TO 12.
   B. LOC 12: IF BILLED IN COMBO W/OTHER ANESTHESIA - ADD UNITS TO
      TOTAL TIME & DENY LINE W/EOB 542. NO OTHER ANES ON CLAIM -DENY.

11001,11101,11201,11732,11922,15001,15101,15121,
15201,15221,15241,15261,15351,15401,15787,17003,
19001,19126,20937,20938,22103,22116,22226,22328,
22585,22614,22632,22650,26125,26861,26863,27358,
27692,33530,33572,33924,35390,35400,35500,35681,

35682,35683,35700,36218,36248,37206,37208,37250,
37251,38102,38746,37847,43635,44015,44121,44131,
44955,47001,48400,49568,61795,63035,63048,63057,
63066,63076,63078,63086,63088,63091,63308,64443,
64623,64727,69990,92978,92979,92981,92984,92996,
92998,93571,93572,93623.

6. ALL ELSE - DENY UNLESS AUTH, THEN O'LOC TO 23.

----- LOC 23:
-- NON-COVERED CODES WITH AUTH NUMBER REVIEW CLAIM PER 611
TEXT:
----- LOC 14
-- RADIOLOGY PROCEDURES (70000 - 79999) FOR AGE 17 & UNDER
A. PROCEDURES W/THE WORD "TRANS" IN THE DESCRIPTION (IE 76830, 76872, 76873) MANUAL PRICE W/BASE OF 3, USING EOB 373. IF REPORT ATTACHED & PROCEDURE APPEARS MORE COMPLICATED, MANUAL PRICE W/A BASE OF 5 W/EOB 373. PER SANDY A/DR. BAUMGARTNER). PRICE PER 087 ANES FORMULA FOR DOS USING ASSIGNED BASE. FORCE EXCEPTION 332.
B. ALL OTHER RADIOLOGY PROCEDURES - DENY W/EOB 302.

TEXT KEY TEXT DESC

388 M CLAIM TYPE
PARAMETER 1050/1051 DIALYSIS LIMIT.
KIDNEY CENTERS ARE LIMITED TO THE FOLLOWING NUMBER OF DIALYSIS SESSIONS:

1. REV CODES 821, 831, AND 880 ARE LIMITED TO 14 PER CALENDAR MONTH.
REV CODES 841 AND 851 ARE LIMITED TO 31 PER CALENDAR MONTH.
IF UNITS BILLED OVER LIMIT, CUT TO MAX WITH INFO EOB 101.
*CC

2. IF AUTH NUMBER ON CLAIM WORK PER AUTH FILE.

3. ANY QUESTIONS OVERLOC TO 67.

P CLAIM TYPE
PARAMETER 1032 1 BOX SYRINGE (A4232) PER 2 MONTHS.
OVERLOC TO 83/KATHERIN-MMIS

TEXT KEY	TEXT DESC
398	1. CHECK PATIENT NAME AND SEX, IF ERROR PA-2 AND ROUTE MEMO TO ELIGIBILITY. 2. BABY ON PARENT(S) PIC - A. IF J0 (ZERO) AND BIRTHDATE IS IN ANY OCCURRENCE-FIELD & CORRESPONDING OCCURRENCE DATE BOX ON CLAIM, KEY INTO THE FIRST AVAILABLE OCCURRENCE CODE (OCC-CD) & OCCURRENCE DATE (OCC-DT) FIELDS. IF J0 AND DATE ARE NOT IN ONE OF THE OCCURRENCE-FIELD/DATE BOXES ON CLAIM - DENY WITH EOB 747. B. IF DATE OF ADMIT IS PRIOR TO BIRTH DATE - DENY WITH EOB 748. 3. BABY ON BABY'S PIC AND DATE OF ADMIT IS ON OR AFTER DATE OF BIRTH: A. IF DIAGNOSIS IS NOT NEWBORN RELATED - DENY. B. IF DIAGNOSIS IS NEWBORN RELATED AND ADMIT DATE IS SAME AS BIRTHDATE - DENY. 4. IF PATIENT STATUS CODE IS 65: ADMIT DATE IS 04/01/04 OR AFTER LOC TO 72. 5. ALL ELSE - DENY.

TEXT KEY
416

TEXT DESC

(J) PHYSICIANS: PROVIDER NUMBERS ARE USED FOR ID PURPOSE ONLY:

IF THE PROVIDER BILLS WITH A GROUP NUMBER IN BOX 33 (PIN) AND THE PREFORMING NUMBER IN BOX 33 (GROUP), EXAMPLE (7855461 IN PIN NUMBER AND 8183634 IN GROUP NUMBER) - KEY THE NUMBERS IN THE CORRECT FIELD.

EMC/SCANNER:
1. OUT OF STATE PROVIDERS - DO ALPHA,SSN, OR TAX ID SEARCH FROM PF5 SCREEN.
   A. ACTIVE # FOUND - KEY IT IN W/INFO EOB 510.
   B. TERMINATED, PENDING, OR ID ONLY # FOUND KEY IT IN & DENY W/EOB 510.
      NOTE: IF ALPHA SEARCH FOR CURRENT, ACTIVE # NOT SUCCESSFUL - SEARCH BY TAX ID # BEFORE KEYING IN TERMINATED, PENDING #.
   C. NO # OR MULTIPLE ACTIVE #'S FOUND - REMOVE 0011601 AND PA2.
      --NOTE: VERIFY THE NAME & ADDRESS ON PAGE 1 &/OR MAILING ADDRESS ON PAGE 2. IF NOT EXACT MATCH REMOVE 0011601 & PA-2.
      --NOTE: IF EXCEPTION 317 DOES NOT POST WHEN YOU FIND AND KEY IN # - REMOVE # & KEY 0011601 & ADJUDICATE PER 416 TEXT.

2. ALL ELSE - DENY.

TEXT KEY TEXT DESC

421

DENTAL:
RES - IF PERFORMING PROVIDER HAS TAKEN ABCD TRAINING PRIOR TO DATE OF SERVICE - FORCE. IF PROVIDER HAS NOT TAKEN ABCD TRAINING - DENY WITH EOB 711.

MED VENDOR:

4805A-DENY
S9445-DENY
8900N-8903N-DENY W/EOB 108

TEXT KEY	TEXT DESC
422	

TEXT KEY	TEXT DESC
427	

TEXT KEY TEXT DESC
432 SERVICES INCLUDED IN FACILITY RATE

ALL CLAIM TYPES:

EXAM ENTRY: IF A PRIOR AUTH# IS PRESENT - OVERLOC TO 23 UNLESS SOME-
THING IN THIS TEXT ALLOWS YOU TO FORCE IT.
RESOLUTIONS: REVIEW AUTH FILE & FORCE IF AUTHORIZED.

1. IF NOTED ANYWHERE ON CLAIM OR IN THE CLIENT'S FILE THAT THE CLIENT RESIDES IN AN "IMR" FACILITY - FORCE.

2. LOOK AT THE 3 SCREEN OF THE CLIENT'S ELIGIBILITY FILE.
THE FIRST COLUMN UNDER THE RECIPIENT INQUIRY NURSING HOME DATA FIELD IS LABELED "CL" WHICH STANDS FOR PATIENT CLASS CODE.
PATIENT CLASS CODE 23=IMR FACILITY
IF THE CL COLUMN HAS A 23 CORRESPONDING TO THE DATE OF SERVICE-FORCE

3. IF THE CLAIM OR THE CLIENT'S FILE INDICATES THE CLIENT IS IN ONE OF THE FOLLOWING "STATE OWNED" FACILITIES AND ANY OF THE FOLLOWING COMMENTS: 100% NUTRITION, TOTAL NUTRITION, NOT INCLUDED IN THE NURSING HOME PER DIEM, TUBE FED, MODIFIER 3N, 3Q, 3R, 3T, 3V, 3W, 4C, 4D, OR BO (TUBE FED), FORCE. ALL ELSE ADJUDICATE AS FOLLOWS:

   1. EMC (ELECTRONIC MEDIA CLAIM)-DENY

   2. ALL ELSE - DENY W/EOB 330 & ROUTE CLAIM TO DDD/MEDICAL LIASON (MS: 45310). ATTACH A NOTE WITH DESCRIPTION OF PROCEDURE CODE, WHICH SCHOOL THE CLIENT IS IN AND STATING THE SERVICE SHOULD BE AVAILABLE AT THE SCHOOL OR IN THE FACILITY RATE.

   IF THE CLIENT DOES NOT RESIDE IN ANY OF THE FACILITIES LISTED BELOW THEN ADJUDICATE PER REMAINING TEXT.

STATE OWNED FACILITIES

A. FIRCREST SCHOOL-15230 15TH N.E., SEATTLE, WA 98155-7130

B. FRANCES HADDON MORGAN CENTER-P.O. BOX 4009
WYCOFF STATION BREMERTON, WA 98310

C. INTERLAKE SCHOOL-P.O. BOX B, MEDICAL LAKE, WA 99022-0046

D. LAKELAND VILLAGE-P.O. BOX 200 MEDICAL LAKE, WA 99022-0200

E. RAINIER SCHOOL-P.O. BOX 600, BUCKLEY, WA 98321-1140

F. YAKIMA VALLEY SCHOOL- SPEYERS ROAD, SELAH, WA 98942

MEDICAL VENDOR (P)

--NOTE-- IF SUPPLIED ON DATE OF DISCHARGE FROM NH-FORCE

1. DISPOSABLE/NON-REUSABLE SUPPLIES-CATHETERS, TUBES, BAGS & CATHETER INSERTION TRAYS:
   A. IF DIAGNOSIS IS 580-589 (KIDNEY/RENAL FAILURE)-FORCE.
   B. IF DIAGNOSIS IS 788.2 (URINARY RETENTION)-FORCE
   C. IF COMMENT "PERMANENTLY IMPAIRED", "MALFUNCTIONING BODY ORGAN", OR "SEIZURES"-FORCE

2. PT 40(INFUSION THERAPY)-FEEDING TUBES OR FEEDING BAGS FOR MEDICAL NUTRITION AND ANY MEDICAL NUTRITION ACCESSORIES BILLED ON SAME CLAIM AS FEEDING TUBES AND BAGS-FORCE.

3. MEDICAL NUTRITION PRODUCTS BILLED WITH ANY OF THE FOLLOWING MODIFIERS OR ANY OF THE FOLLOWING COMMENTS-FORCE
   BO, 3N, 3Q, 3R, 3T, 3V, 3W, 4C, 4D(TUBE FED).
   "100% NUTRITION", "TOTAL NUTRITION", "NOT INCLUDED IN THE NURSING HOME PER DIEM", OR "TUBE FED"

4. ENTERAL FEEDING SUPPLY KITS(B4034, B4035, B4036) BILLED WITH ANY OF THE FOLLOWING COMMENTS-FORCE
   "100% NUTRITION", "TOTAL NUTRITION","NOT INCLUDED IN THE NURSING HOME PER DIEM", OR "TUBE FED"

5. DME (DURABLE MEDICAL EQUIPMENT) SUCH AS BEDS, WHEELCHAIRS, WALKERS, IF STATEMENT ON CLAIM "EQUIPMENT PROVIDED ONE WEEK PRIOR TO DISCHARGE"-FORCE

6. MODIFIERS X1-X9 OR A1-A9(PRIMARY OR SECONDARY DRESSING ON SURGICAL OR DEBRIDMENT WOUND & NUMBER OF WOUNDS DRESSED-6 WKS POST SURGERY)
   A. DRESSINGS, TAPES, BANDAGES-FORCE
   B. ALL ELSE-DENY (SUCH AS GLOVES, ALCOHOL, PEROXIDE, BETADINE...).
   C. IF ANY QUESTIONS SEE TRAINER/SUPERVISOR.

7. DIAPERS/PANTS/PADS
   IF STATEMENT ON CLAIM- "CONGREGATE CARE FACILITY", "CCF", "GROUP HOME", OR "CCF HOME"-FORCE

8. ALL ELSE DENY

PHYSICIANS (J)

1. FOOT CARE
   A. 703.0(INGROWN NAILS)-FORCE
   B. 703.8(ONYCHAUXIS)-FORCE

   C. 700(ROUTINE FOOT CARE)-DENY 342. IF CLAIM DIAGNOSIS OR DESCRIPTION INDICATES DIABETES-FORCE.
   D. 110.1(ONYCHOMYCOSIS & MYCOSIS)-DENY W/EOB 342 EXCEPT IF THE CLAIM INDICATES DIABETES, UNABLE TO WALK, OR OTHER MEDICAL COMPLICATIONS THAT WOULD MAKE THE DIAGNOSIS MEDICALLY NECESSARY OR CLIENT IS DDD(EXCEPTION 498 POSTING)-FORCE.
   E. ALL ELSE-DENY

2. OFFICE OR EMERGENCY/OUTPATIENT SERVICES FOR ACUTE MEDICAL CARE-FORCE

3. ALL ELSE-DENY

TEXT KEY TEXT DESC
433 SYSTEM INDICATES WRONG CLAIM TYPE FOR SERVICES BILLED

1. IF PATIENT STATUS CODE IS 65 AND ADMIT DATE IS 04/01/04 OR AFTER - OVERLOC TO 72.

2. BABY ON PARENT(S) PIC - "J0" (OCCURRENCE CODE FIELD) & THE BABY'S BIRTH DATE (OCCURRENCE DATE FIELD) MUST BE ENTERED FROM THE CLAIM. IF NOT PRESENT - DENY W/EOB 747. IF EXCEPTION 433 IS STILL POSTING WORK PER THE INSTRUCTIONS BELOW.

--NOTE-- THE INFORMATION BELOW AND ON THE FOLLOWING PAGES IS TO HELP YOU DETERMINE THE CORRECT CLAIM TYPE FOR HOSPITAL CLAIMS. IF YOUR SITUATION IS NOT ADDRESSED OR YOU CANNOT DETERMINE THE CORRECT CLAIM TYPE BY THE INFORMATION IN THIS TEXT - OVERLOC TO 72.

3. DRG "R" CLAIMS POSTING 433:
THE SERVICES LISTED ON THE FOLLOWING PAGES ARE EXEMPT FROM DRG AND SHOULD BE PROCESSED AS AN INPATIENT "S" CLAIM TYPE. UNLESS OTHERWISE INSTRUCTED - CHANGE THE CLAIM TYPE BY PUTTING A "S" IN THE "CLM TYPE" FIELD - THEN ENTER. --NOTE-- IF EXCEPTION 433 STILL POSTS AND THE SERVICE MEETS ONE OF THE CRITERIA LISTED BELOW - OVERLOC TO 72.

4. INPATIENT "S" CLAIMS POSTING 433:
IF THE SERVICE IS NOT LISTED ON THE FOLLOWING PAGES THE CLAIM SHOULD BE PROCESSED AS A DRG "R" CLAIM TYPE. UNLESS OTHERWISE INSTRUCTED - CHANGE THE CLAIM TYPE BY PUTTING AN "R" IN THE "CLM TYPE" FIELD - THEN ENTER. NOTE: IF EXCEPTION 433 STILL POSTS AND THE SERVICES "DO NOT" MEET ONE OF THE CRITERIA LISTED BELOW - OVERLOC TO 72.

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1. HOSPITAL TYPE 05 (EXEMPT) ALL SERVICES.
2. HOSPITAL TYPES 06, 07, AND 08. --EXCEPT SERVICES FOR CLIENTS ON A STATE ONLY (MI OR GAU) PROGRAM (PROGRAM CODES U, Q, W, OR M). THESE SERVICES ARE PAID AS A DRG "R" CLAIM TYPE.
3. PM&R SERVICES - PROVIDER # BEGINS WITH 32.....
4. DETOX SERVICES - PROVIDER # BEGINS WITH 36.....
5. PAIN CLINIC (REVENUE CODE 511) - CONVERT TO "S" IF PROVIDER IS ST. JOSEPH (3309309). OTHERWISE - DENY W/EOB 844 (DO NOT CONVERT).
6. CUP SERVICES (REV CODE 168) (BEGINNING WITH ADMITS ON & AFTER 06/01/03 - REV CODE 129)- IF THE CLAIM INDICATES CUP SERVICES BUT THE PROVIDER IS NOT BILLING REV CODE 168 (OR REV CODE 129 FOR ADMITS ON OR AFTER 08/01/03) - DENY W/EOB 756.
--NOTE-- PROVIDERS CAN USE REV CODE 168 UNTIL 08/01/03.
7. HIV/AIDS RELATED DX CODES 042.X-044.X, V08.X (ANYWHERE ON THE CLAIM) OR DRGS 700-716.
8. NEWBORN DRGS 385-389, 602-619, 621-624, 626-628, 630, 635, 637-641.
9. TRANSPLANT DRG'S 103, 302, 480, 795, 803, 804, 805, OR REVENUE CODES 897 AND 898.

10. ADMINISTRATIVE DAYS - REVENUE CODES 166 AND 169.
11. SWING/BED ANCILLARY CHARGES.
12. OUT OF STATE HOSPITALS (MUST ALSO BE POSTING EXCEPTION 317).
13. EFFECTIVE WITH DATES OF SERVICE 01/01/01 AND AFTER THE FOLLOWING DRG'S ARE TO BE PROCESSED AS INPATIENT "S" CLAIMS:

    006, 009, 011, 016, 017, 019, 022, 036, 038, 039, 040, 041, 042,
    043, 045, 046, 047, 049, 051, 056, 057, 059, 061, 064, 065, 066,
    067, 072, 073, 077, 083, 084, 085, 086, 092, 093, 094, 114, 115,
    117, 118, 119, 129, 135, 136, 137, 145, 162, 168, 173, 178, 186,
    199, 200, 201, 213, 216, 232, 237, 245, 246, 250, 251, 260, 262,
    265, 267, 268, 272, 273, 275, 283, 289, 291, 292, 293, 299, 306,
    307, 312, 313, 314, 317, 318, 319, 325, 326, 327, 328, 329, 330,
    332, 336, 338, 339, 342, 343, 344, 345, 346, 347, 348, 349, 351,
    352, 354, 362, 366, 367, 402, 404, 406, 407, 408, 409, 411, 412,
    414, 418, 423, 432, 439, 444, 445, 446, 447, 448, 453, 455, 456,
    457, 459, 461, 462, 465, 466, 467, 471, 472, 476, 534, 535, 548,
    554, 565, 570, 571, 572, 575, 578, 579, 586, 587, 633, 634, 636,
    744, 746, 749, 751, 752, 753, 754, 759, 760, 764, 765, 767, 780,
    781, 782, 783, 785, 790, 791, 794, 798, 799, 800, 801, 802, 806,
    807,

    THESE DRG'S NO LONGER HAVE A MEASURABLE RELATIVE WEIGHT.

TEXT KEY	TEXT DESC
437	

TEXT KEY TEXT DESC

438 DAYS BILLED EXCEED ITA ALLOWED:
-- IF CLIENT IS AGE 13 THROUGH AGE 17: 22 DAYS ARE ALLOWED.
-- IF CLIENT IS AGE 18 OR OVER: 20 DAYS ARE ALLOWED.

IF PROVIDER IS BILLING FOR DAYS BEYOND THE LENGTH OF STAY LIMITATIONS:
1. IF THE CLIENT IS UNDER THE AGE OF 18 & A REVOCATION IS INDICATED, WE WILL COVER 5 ADDITIONAL DAYS WITHOUT AN EXTENSION. IF THE DAYS BILLED ARE NOT MORE THAN 5 OVER THE LIMIT - FORCE. OTHERWISE - FOLLOW THE INSTRUCTIONS BELOW.
2. IF THERE IS NO RSN EXTENSION LETTER OR DSHS FORM 13-628 ATTACHED- DENY WITH EOB 940.
3. IF THERE IS A RSN EXTENSION LETTER OR DSHS FORM 13-628 ATTACHED:
A. IF EXTENSION HAS NOT BEEN SIGNED OR APPROVED BY THE RSN COUNTY DESIGNEE - DENY WITH EOB 940.
B. IF ADMIT DATE ON EXTENSION DOESN'T MATCH THE ADMIT DATE ON THE CLAIM - DENY WITH EOB 016.
C. IF EXTENSION HAS BEEN APPROVED AND SIGNED BY THE RSN COUNTY DESIGNEE AND COVERS ALL DATES OF SERVICE ON THE CLAIM - FORCE.
D. IF EXTENSION HAS BEEN APPROVED AND SIGNED BY THE RSN COUNTY DESIGNEE, BUT DOES NOT COVER ALL DATES OF SERVICE ON THE CLAIM - DENY WITH EOB 004.

TEXT KEY TEXT DESC

448

FYI--EFFECTIVE ICN JULIAN DATE 99305, HOME HEALTH PROVIDERS ARE ON A QUARTERLY REVIEW. CHECK THE COUNTY CODE ON THE PROVIDER FILE TO DETERMINE WHICH QUARTER THE PROVIDER IS ON REVIEW.

1ST QTR - ICN DATE NOV-JAN: OR,ID,05,06,08,14,16,18,21,23,25,30,34,35
2ND QTR - ICN DATE FEB-APR: 01-04,07,11-13,19,20,26,32,33,36,38,39
3RD QTR - ICN DATE MAY-JUL: 09,10,15,22,24,27-29,31,37
4TH QTR - ICN DATE AUG-OCT: 40

ICN DATE 99305 AND AFTER - ADJUDICATE PER INSTRUCTIONS FROM THE NURSE CARE CONSULTANT.

ICN DATE PRIOR TO 99305 - OVERLOC TO 67.

TEXT KEY	TEXT DESC
457	

TEXT KEY TEXT DESC

473

DENTAL:
RES - IF PROVIDER HAS NOT TAKEN THE ABCD TRAINING
PRIOR TO THE DATE OF SERVICE - DENY WITH EOB 711.

PHYSICIAN:
PROVIDER ENROLLMENT - CHECK FOR LETTER FROM CERTIFICATION BOARD,
IF LETTER ON FILE, REMOVE INFO FROM PAGE 2 ON PROVIDER FILE, IF
NO LETTER ON FILE - DENY W/EOB 711.
NOTE: FORCE PROCEDURES 59514 & 59620 UNTIL PEU LOADS THE CORRECT
SPANS ON PAGE 2.

TEXT KEY TEXT DESC

480

HOSPITAL CLAIMS (M/R/S):

EXAM ENTRY: AFTER WORKING ALL OTHER EXCEPTIONS - OVERLOC TO 72.

PRIVATE DUTY NURSING (PT 33) -

1. IF THE PROVIDER IS BILLING MULTIPLE MONTHS - DENY THE CLAIM 333 AND SPLIT THE CLAIM SO THE THRESHOLD IS NOT BREACHED.
2. IF THE PROVIDER IS NOT BILLING MULTIPLE MONTHS OVERLOC TO 48.

PHYSICIANS (J)
PUGET SOUND BLOOD BANK (PROVIDER NUMBER 2492700) BILLING PROCEDURE CODE Q0187 - OVER LOC TO 14.

TEXT KEY	TEXT DESC
481	TOOTH #/QUADRANT NOT REQUIRED OR APPROPRIATE FOR THIS PROCEDURE. IF EXCEPTION 326, 361 OR 378 ARE ALSO POSTING TO THIS DETAIL LINE - LEAVE TOOTH # AND HANDLE THE ABOVE EXCEPTIONS. 06010/D6010 IMPLANT - LEAVE TOOTH #, ARCH OR QUAD AND FORCE EXCEPTION 06930/D6930 RECEMENT FIXED PARTIAL DENTURE (BRIDGE) - LEAVE TOOTH #, ARCH OR QUAD DESIGNATION AND FORCE THE EXCEPTION. 07999/D7999 UNSPECIFIED ORAL SURGERY PROCEDURE - LEAVE TOOTH #, ARCH OR QUAD DESIGNATION AND FORCE THE EXCEPTION. 0075D - UNSPECIFIED DENTAL CODE - LEAVE TOOTH #, ARCH OR QUAD DESIGNATION AND FORCE THE EXCEPTION. IF OTHER THAN THE ABOVE - REMOVE TOOTH #/QUADRANT & KEY IN EOB 115 AS INFORMATIONAL.

TEXT KEY TEXT DESC
482 UNDOCUMENTED ALIEN

IF MEV CARD COVERS DOS & DOES NOT STATE "EMERGENT SERVICES/EMERGENT MEDICAL ONLY" - FORCE, OTHERWISE, SEE BELOW.

1. PHYSICIAN SERVICES (J) LISTED BELOW -DENY.
   A. ALL SERVICES RELATED TO TRANSPLANTS.
   B. PT 58 (SCHOOL SERVICES).

2. OUTPATIENT (M)
   A. HOME HEALTH (REVENUE CODES 421,431,441,551,558,571,580,590) - FORCE.
   B. ALL ELSE - DENY.

3. IF AUTH # - O'LOC TO 23 FOR REVIEW.

TEXT KEY TEXT DESC

483 TOOTH NUMBER IS NOT ALLOWED FOR THIS PROCEDURE:

D2710 - D2792 (CROWNS)
1. DOS PRIOR TO 4/1/99 AND TOOTH NUMBER 1-32 - FORCE.
2. DOS 4/1/99 AND AFTER:
   A. IF AUTHORIZATION NUMBER- EE: PA-2; RES: CHECK AUTH FILE AND IF TOOTH NUMBER IS AUTHORIZED - FORCE. IF TOOTH NUMBER IS NOT AUTHORIZED - DENY.
   B. IF CONSULTANT SIGNATURE:
      1) DOS 4/1/99 TO 6/30/99 - FORCE.
      2) DOS 7/1/99 AND AFTER - DENY.
   C. IF NO AUTHORIZATION - DENY.

D3310 (ANTERIOR ROOT CANAL) -
1. IF BILLED ON TOOTH #C-H OR M-R AND AUTHORIZED - FORCE.
2. OTHERWISE - DENY.

CONTINUED

D3330 (MOLAR ROOT CANAL):
1. IF BILLED ON TOOTH # 1, 16, 17 OR 32:
   A. DOS PRIOR TO 4/1/99 - FORCE.
   B. DOS 4/1/99 AND AFTER:
      1) IF AUTHORIZED - FORCE.
      2) IF NOT AUTHORIZED - DENY.
2. ALL ELSE - DENY.

D7210 (SURGICAL EXTRACTION) ON TOOTH NUMBERS 7-10 OR 23-26:
1. IF AUTHORIZED - FORCE
2. IF NOT AUTHORIZED - DENY WITH EOB 023.

PRU & MPAS:

FOR INFORMATIONAL PURPOSES ONLY (THE PRICING IS NOW DONE AUTOMATICALLY BY THE SYSTEM): (THIS PRICING MECHANISM REMOVED FOR DOS 6-1-99 AS THE PROVIDER SHOULD NOW BILL THE CORRECT PROCEDURE CODE OR BE DENIED IF THEY DON'T)
CODES 02330-02335 (COMPOSITE RESTORATIONS-WHEN DONE ON POSTERIOR TEETH WE PAY CORRESPONDING AMALGAM RATE)

1. EFFECTIVE 1/1/93 DOS AND AFTER:
   A. IF PATIENT IS 21 YEARS OF AGE OR OLDER, IF BILLED ON A-B, I-L, S-T, CUT 02330 TO $23.00, 02331 TO $33.00, 02332 TO $38.00, 02335 TO $45.00; IF BILLED ON 01-05, 12-21, 28-32, CUT 02330 TO $30.00, 02331 TO $44.00, 02332 TO $55.00, 02335 TO $67.00.

   B. IF PATIENT IS 20 YEARS OF AGE OR UNDER, IF BILLED ON A-B, I-L, OR S-T, CUT 02330 TO $28.00, 02331 TO $38.00, 02332 TO $46.00, 02335 TO $53.00; IF BILLED ON 01-05, 12-21, OR 28-32, CUT 02330 TO $30.00, 02331 TO $44.00, 02332 TO $55.00, 02335 TO $67.00.

2. EFFECTIVE 7/1/92 THRU 12/31/92 DOS:
   A. IF PATIENT IS 21 YEARS OF AGE OR OLDER - FOLLOW INSTRUCTIONS UNDER "C" BELOW.
   B. IF PATIENT IS 20 YEARS OF AGE OR UNDER, IF BILLED ON A-B, I-L, OR S-T, CUT 02330 TO $26.00, 02331 TO $35.00, 02332 TO $43.00, 02335 TO $49.00; IF BILLED ON 01-05, 12-21, OR 28-32, CUT 02330 TO $28.00, 02331 TO $41.00, 02332 TO $51.00, 02335 TO $62.00.

3. EFFECTIVE 1/1/90 DOS TO 6/30/92 DOS:
   IF BILLED ON A-B, I-L, S-T, CUT 02330 TO $23.00, 02331 TO $33.00, 02332 TO $38.00, 02335 TO $45.00; IF BILLED ON 01-05, 12-21, 28-32, CUT 02330 TO $25.00, 02331 TO $37.00, 02332 TO $46.00, 02335 TO $58.00.

THE END

TEXT KEY TEXT DESC

488 PROCEDURE CODE AND DIAGNOSIS REQUIRE APPROVAL
PHYSICIANS (J)

NOTE: IF DENYING THE CLAIM FOR MEDICARE OR MANAGED CARE EXCEPTIONS - DO NOT ADDRESS THE AUTH EXCEPTION.

NOTE: IF CLAIM AND SERVICES ARE FOR THE ASSIST - FORCE.

RES: IF SERVICE ON AUTH SCREEN HAS BEEN DENIED - DENY W/EOB 242.

IF 2 AUTH NUMBERS ON CLAIM, DENY W/EOB 407. DO NOT KEY ANY AUTH # ON SCREEN. SEND COPY OF CLAIM/WORKSHEET TO PRU, MS 5562 FOR PROVIDER TRAINING INDICATING PROBLEM ON PRU REFERRAL FORM.

-- (SECONDARY DX ON CLAIM MAY NOT REQUIRE APPROVAL) --

EXAM ENTRY/RES -IF 488 FAILS & IT IS NOT FORCEABLE PER TEXT OR 4-LINE.
1. THE PROVIDER HAS NOTED ANOTHER DX ON THE SAME DETAIL LINE, KEY THAT DX IN AND IF 488 DOESEN'T FAIL, LET IT PAY. IF 488 FAILS ON SEC-ONDARY DX AND IT IS NOT FORCEABLE PER TEXT, CHANGE BACK TO THE ORIGINAL DX AND DENY PER TEXT.
2. IF ANOTHER DX FOR SAME DOS/HOSPITAL STAY ON THE CLAIM, KEY AN X IN LMC TO SUSPEND, KEY THE OTHER DX AND IF 488 DOESEN'T FAIL, KEY THE PRIMARY DX BACK IN AND FORCE 488. IF 488 FAILS AND IS NOT FORCEABLE PER TEXT CHANGE BACK TO THE PRIMARY DX AND DENY PER TEXT.
NOTE: ABOVE DOES NOT APPLY TO HYSTERECTOMIES, FOLLOW TEXT.

EXAM ENTRY
1. HYSTERECTOMIES (58150-58285,56308 OR 59525) OVERLOC TO 17, DO NOT DENY ANYTHING ON THE CLAIM FOR APPROVAL. (LOC 17 ONLY) - IF APPROVAL CANNOT BE OBTAINED - DENY.
2. DIAGNOSIS IS 740 THRU 759.99 - FORCE DOS PRIOR TO 030190.
3. IF ONE OF THE FOLLOWING DIAGNOSIS-FORCE IF DOS IS PRIOR TO 4-1-92:

269.0-269.9	427.8-427.81	611	625.4
308.2	438	611.0	626-626.1
310.2	535	611.2-611.9	626.3-626.7
354-354.3	535.2	624-624.9	628-628.4
354.5-354.8	607.8-607.9	625-625.2	788.3

4. ADMITS (99221-99223)

A. IF DIAGNOSIS IS 290-319.99 AND THERE IS AN AUTH# ON CLAIM THAT BEGINS WITH (88) - FORCE THE 488. IF EXCEPTION 586 IS ALSO POSTING - WORK IT. DO NOT WORK THE 488.

B. IF PATIENT IS AGE 20 OR UNDER & DIAGNOSIS IS: 290 - 290.9, 293 - 301.9, 306 - 307.0, 307.2 - 307.49, 307.52 - 307.54, 307.6 - 307.80, 307.89 - 314.9 - FORCE.

C. IF NO AUTH #, DENY ADMIT. DENY INPATIENT SERVICES (POS 1) FOR

ENTIRE STAY W/EOB 438. (SAME OR CONSECUTIVE/CONTINUOUS CLAIMS)
EXCEPTION: IF ADMIT BILLED IN CONJ. WITH STERILIZATION
(55250, 55450, 58600-58605, 58611. 58615, 58982, 58983, 59101,
59106) W/WO AUTH # ON CLAIM - OVERLOC TO LOC 18.

D. IF PROVIDER BILLING 99221 & 90801 AND POS 2,3 OR 5 - FORCE.
THEY ARE NOT BILLING 99221 AS AN ADMIT, THEY ARE BILLING A
MEDICAL/PHYSICAL EXAM.

5. POLYSOMNOGRAM (95828) IF NO AUTH # DENY UNLESS
A. DOS IS PRIOR TO 3-1-91 - FORCE.
B. PATIENT IS UNDER AGE 1 - FORCE.
C. IF AUTH # PRESENT PA2

6. DIAGNOSTIC SURGERY (I.E. SCOPIES, BIOPSIES, GRAMS, GRAPHIES, ETC)
THAT DO NOT CONTAIN A SURGICAL/FIXATIVE PROCEDURE. IF IN DOUBT SEE
YOUR SUPERVISOR.
A. IF BILLED ALONE - FORCE.
B. IF BILLED W/ADMIT OR ANOTHER SURGERY THAT NEEDS APPROVAL AND
AUTH # ON CLAIM - PA2.
C. IF BILLED W/ADMIT OR SURGERY AND NO APPROVAL IS REQUIRED -
FORCE DIAGNOSTIC SURGERY.

7. OTHER THAN ABOVE AND NO AUTH # - DENY. IF AUTH # PRESENT - PA-2.

RESOLUTIONS

1. NO AUTH # - DENY.
2. AUTH # AND DOES NOT MATCH - DENY W/EOB 251 UNLESS 600 EXCEPTION
IS FAILING. IF SO, REFER THERE FIRST.
- EXCEPTION - IF PROCEDURE FAILING IS A DIAGNOSTIC PROCEDURE
(E.G. OSCOPIES, BIOPSIES, PUNCTURES, HEART CATHS) AND THE
MAJOR SURGERY OR ADMIT HAS BEEN APPROVED - FORCE. OTHERWISE -
DENY.
- EXCEPTION: 61712 & 64830 - IF PROCEDURE(S) AUTHORIZED AND MICRO-
DISSECTON CODE BILLED WITH PROCEDURE ITS ALLOWED WITH - (61712
ALLOWED W/61304-61711, 62010-62100, 63081-63308, 63704-63710 OR -
64830 ALLOWED W/64831-64907) - THEN FORCE 488.

3. PSYCHIATRIC PROCEDURE CODES (908__), FORCE UNLESS A LIMIT AUDIT
IS FAILING, THEN SEE AUDIT TEXT.

NOTE - RESOLUTIONS - IF SURGERY FAILING IS IN THE SAME CODE RANGE
PROCEDURE ON PA SCREEN, AND IS A CODE OF A LESSER LEVEL -
ROUTE TO DUS FOR UPDATE.

ADJUSTMENTS
1. PROCEDURES REQUIRING PRIOR APPROVAL - DENY & USE INFO EOB 236 IN
SECOND EOB SLOT.
2. OTHER THAN ABOVE, SEE YOUR SUPERVISOR.

TEXT KEY TEXT DESC
490 FFS VS. PREMIUM

1. DO NOT RECOUP AND DENY FEE FOR SERVICE IF ANY OF THE FOLLOWING:

   A. IF DATE OF SERVICE ON FEE FOR SERVICE CLAIM IS BEFORE 1/1/98 - FORCE.
   B. BABY VS MOM OR MULTIPLE BIRTHS - FORCE.
   C. IF COPY OF MEDICAL ID CARD ATTACHED COVERING DATE(S) OF SERVICE ON CLAIM AND SHOWING NO HMO COVERAGE - FORCE.
   D. CHECK 552 TEXT FILE NON-COVERED SERVICES FOR APPROPRIATE CLAIM TYPE & IF LISTED - FORCE.
   E. IF FOR ANY REASON YOU ARE DENYING THE PREMIUM.
   F. 490 VS PAID "O" CLAIM, FORCE 490 EXC, AND SEND DEAD WORKSHEET TO AUDREY FINNEGAN, DCS/COB STATING MEDICARE CLIENT ENROLLED IN MANAGED CARE.
   G. IF FEE-FOR-SERVICE ON ADMIT DATE FOR HOSPITAL CLAIM - FORCE.

2. ALL ELSE, FORCE 490 EXCEPTION AND RECOUP AND DENY FEE FOR SERVICE CLAIMS WITH 796 EOB.

TEXT KEY TEXT DESC
491 LOC. 57 ONLY

I. IF CLAIM IS FOR NEWBORN
A. FIND MOM'S PLAN INFORMATION
1. IF MOM IS IN THE PLAN FOR DOS ON BABY'S CLAIM - LOAD THE INFO TO BABY'S PIC.
2. IF MOM IS NOT IN THE PLAN FOR DOS ON BABY'S CLAIM - DENY.
3. IF YOU CAN'T DETERMINE WHO THE MOM IS RESEARCH THE CASE IN ACES.
B. IF NEWBORN IS IN A DIFFERENT PLAN FOR DOS ON CLAIM - DENY W/599.

II. ALL ELSE
A. CHECK THE COUNTY ON PAGE 2 OF THE ELIGIBILITY FILE.
B. CHECK ACES TO VERIFY COUNTY INFORMATION.
C. IF COUNTY IS DIFFERENT IN ACES. CHECK THE PLAN AND /OR FQHC NUMBER ON THE PCOP RATE SCREEN OF THE PLAN RECORD TO SEE IF THEY ARE PAYABLE IN THAT COUNTY.
A) IF PAYABLE, CHANGE THE RECORD FOR THE DOS IN MMIS.
B) IF THE FQHC ISN'T PAYABLE IN THE COUNTY - DENY W/972. AFTER CLAIM IS PROCESSED PUT "IF" IN THE PCOP INFO FIELD TO INDICATE INVALID FQHC.

D. IF CLIENT IS IN DIFFERENT PLAN FOR DOS - DENY W/599.

TEXT KEY	TEXT DESC
492	LOC. 57 ONLY

I. IF CLAIM IS FOR NEWBORN - FIND MOM'S ELIGIBILITY & PLAN INFORMATION.
   A) IF A PREMIUM WAS PAID & MOM WAS ELIGIBLE FOR DOS - LOAD ELIGIBILITY INFO TO BABY'S PIC.
   B) IF MOM IS NOT ELIGIBLE - DENY.

II. ALL ELSE - IF PREMIUM WAS PAID FOR DOS - RESEARCH ACES/ITIS.
   A) IF ELIG IS FOUND - LOAD INTO MMIS.
   B) IF ELIG IS NOT FOUND - CHECK PCOP PREMIUM GENERATION MICROFILM
      1) IF ELIG FOUND - LOAD INTO MMIS.
      2) IF ELIG NOT FOUND - CHECK WITH YOUR SUP.

TEXT KEY	TEXT DESC
496	

TEXT KEY TEXT DESC

504 PSYCH PROVIDER NUMBER AND NOT A PSYCH PRIMARY (1ST) DIAGNOSIS CODE.

1. PROVIDER NUMBER 3500337 (PUGET SOUND BEHAVIORAL HEALTH)

   A. IF THE DATES OF SERVICE ARE WITHIN 08/01/00-07/22/01 AND THEY HAVE BILLED DX CODE 648.33 IN EITHER THE ADMITTING OR THE PRIMARY (1ST) DX CODE FIELD AND REVENUE CODE 168 IS ON THE CLAIM - FORCE.
   --NOTE: CLAIM MUST MEET ALL OF THE ABOVE CRITERIA.

   B. IF BILLING DX CODE 648.4X AND CLAIM HAS RSN APPROVAL - FORCE. IF NO RSN APPROVAL - DENY.

2. IF THE PRIMARY (1ST) DIAGNOSIS IS 302-305.99 - FORCE IF ITA.
   OTHERWISE - DENY.

3. ALL ELSE - DENY.

TEXT KEY TEXT DESC
507 MEDICAL SERVICES CORPORATION - COLVILLE

-- IF DATES OF SERVICE 7/1/93 & AFTER GO TO PAGE 5 OF THIS TEXT --

1. NON-COVERED HMO SERVICES - FORCE.
   A. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT) &:
      1) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES - 635-636.9 OR V61.7)
      2) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
   B. ADULT DAY HEALTH CARE (PROVIDER TYPE 87)
   C. ALCOHOLISM DETOX TREATMENT (CODES 0025M, 0026M)
   D. ANNUAL FAMILY PLANNING (PROVIDER TYPE 71)
   E. BLOOD PRODUCTS AND COMPONENTS
   F. CASE MANAGEMENT (PROVIDER TYPE 23)
   G. CHIROPRACTORS
   H. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN - FORCE.
   I. DENTAL SERVICES (CLAIM TYPE K), DENTAL ANESTHESIA (0100M)
   J. DENTAL RELATED SERVICES
   K. DRUGS (CLAIM TYPE D)
   L. ENTERAL & PARENTERAL THERAPY IF MSC DENIAL ATTACHED
   M. EYEGLASSES
   N. FIRST STEPS DISCRETIONARY ADD-ON FEE (5970M - 5796M)
   O. FITTING FEE, DISPENSING & REPAIR OF EYEGLASSES
   P. HEARING AIDS (PROVIDER TYPE 63)
   Q. HOSPICE (PROVIDER TYPE 63)
   R. INDIAN HEALTH SERVICES (PROCEDURE CODE 5999M)
   S. MENTAL HEALTH DIAGNOSIS (2900 THRU 3190) FOR INPATIENT (R,S) (J & POS 1) AND/OR OUTPATIENT (M) (J & POS 2 OR 5).
   T. ITA CARE
   U. MATERNITY SUPPORT (PROVIDER TYPE 35)
   V. NEUROMUSCULAR CTRS (PT 36) - FORCE EXCEPT FOR EVALUATIONS, PROCEDURE CODES 0001M, 9255M AND 92506 - DENY.
   W. ORTHOPEDIC SHOES NOT ATTACHED TO A LEG BRACE
   X. COMMUNITY MENTAL HEALTH (PROVIDER TYPE 73)
   Y. PM&R SERVICES (ALL) - (J) 0030M - 0035M, (S) HOSPITALS
   Z. PSYCHOLOGICAL EVALUATIONS (PROCEDURE CODE 0070M)
   ZA. SUBSTANCE ABUSE (PROVIDER TYPE 75)
   ZB. TRANSPORTATION OTHER THAN AMBULANCE (PROVIDER TYPES 42,45,50,54, 55,96)
   ZC. OCCUPATIONAL THERAPY
   ZD. IF CLAIM STATES "LONG TERM REHABILITATION" & SERVICES ARE FOR PHYSICAL OR SPEECH THERAPY - FORCE.
   ZE. NUTRITIONAL COUNSELING (PROVIDER TYPE 40, PROV SPEC 68)
   ZF. WEIGHT LOSS (REVENUE CODES 942 & 949)
   ZG. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
   ZH. DEPO-PROVERA FOR BIRTH CONTROL (9913M) - FORCE.
   ZI. NORPLANT KIT (CODE 9910M)
   ZJ. REMOVAL OF NORPLANT SYSTEM (CODES 1798M, 1799M, 11976, 1197M)
   ZK. CIRCUMCISION OF NEWBORN ONLY (NOT MEDICALLY JUSTIFIED) - DENY WITH EOB 331; IF NOT NEWBORN & MEDICALLY JUSTIFIED (DX PHIMOSIS, ETC.)-

DENY.

2. IF THE CLAIM HAS AN HMO EOB/DENIAL ATTACHED AND IT STATES;
   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.

   E. IF EOB DOESEN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - DENY WITH EOB 217.

3. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
   A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
   B. NON-COVERED SERVICES - (SEE ABOVE) IF LISTED - FORCE. IF NOT - DENY.
   C. CHARGES APPLIED TO DEDUCTIBLE OR CO-PAY - DENY WITH EOB 151.
   D. ANY OTHER STATEMENT - DENY.

4. NO EOB ATTACHED/NO STATEMENT ON CLAIM:
   A. NON-COVERED SERVICES - FORCE.
   B. NO MEDICAL ID CARD ATTACHED - DENY.
   C. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT THE HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

IF DATE OF SERVICE IS 7/1/93 OR AFTER APPLY THE FOLLOWING

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY MSC):
   A. ALL CLAIM TYPES - IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) ITA SERVICES
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENTS UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.

8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES - DENY W/EOB 711.
9) IF PHYSICAL OR SPEECH THERAPY & CLAIM STATES "LONG-TERM REHABILITATION".

C. HOSPITALS (M,R,S CLAIM TYPES)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH)
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) PM&R SERVICES
5) REVENUE CODE 942 (DIABETIC COUNSELING)
6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949)
7) ITA SERVICES
8) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
9) IF CLIENT IS UNDER 21 YRS OLD & STERILIZATION DX CODE V25.2.
10) IF PHYSICAL OR SPEECH THERAPY & CLAIM STATES "LONG-TERM REHABILITATION".

D. MEDICAL VENDOR (P CLAIM TYPE)
1) ORTHOPEDIC SHOES NOT ATTACHED TO LEG BRACE.
2) ITA SERVICES
3) ENTERAL & PARENTERAL THERAPY IF MSC DENIAL ATTACHED.
4) IF PHYSICAL THERAPY & CLAIM STATES "LONG-TERM REHABILITATION".

E. PHARMACY (D CLAIM TYPE)
1) PRESCRIBED BY A DENTIST (PRESCRIBING NUMBER BEGINS WITH A "5" OR COMMENTS INDICATE DENTAL REFERRAL).
2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FILED. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 507 IS STILL POSTING - DENY.
A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OF STATEMENT ON CLAIM SAYS:
A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR - FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCEDDING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC

508 HMO - MEDICAL SERVICES CORPORATION OF SPOKANE
-- IF DATES OF SERVICE 7/1/93 & AFTER GO TO PAGE 5 OF THIS TEXT --

1. NON-COVERED HMO SERVICES - FORCE.
   A. ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC) &:
      1) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE. IE DX CODES - (635-636.9 OR V61.7)
      2) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
   B. ADULT DAY HEALTH CARE (PROVIDER TYPE 87)
   C. ALCOHOLISM DETOX TREATMENT (CODES 0025M, 0026M)
   D. ANNUAL FAMILY PLANNING (PROVIDER TYPE 71)
   E. BLOOD PRODUCTS AND COMPONENTS
   F. CASE MANAGEMENT (PROVIDER TYPE 23)
   G. CHIROPRACTORS
   H. CUP SERVICES - IF CLAIM OR NOTES IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN - FORCE.
   I. DENTAL SERVICES (CLAIM TYPE K), DENTAL ANESTHESIA (0100M)
   J. DENTAL X-RAY CODE 70350 (ORTHODONTIC CEPHALOGRAM)
   K. DENTAL RELATED SERVICES
   L. DRUGS (CLAIM TYPE D) IF PT 26 - FORCE. IF PT 85 (UNIT DOSE DRUG)- DENY.
   M. ENTERAL & PARENTERAL THERAPY IF MSC DENIAL ATTACHED.
   N. EYEGLASSES
   O. FIRST STEPS DISCRETIONARY ADD-ON FEE (5970M - 5976M)
   P. FITTING FEE, DISPENSING & REPAIR OF EYEGLASSES
   Q. HEARING AIDS (PROVIDER TYPE 84)
   R. HOSPICE (PROVIDER TYPE 63)
   S. INDIAN HEALTH SERVICES (PROCEDURE CODE 5999M)
   T. MENTAL HEALTH DIAGNOSIS (2900 THRU 3190) IF INPATIENT (R,S) (J IF POS 1) AND/OR OUTPATIENT (M) (J IF POS 2 OR 5).
   U. ITA CARE
   V. MATERNITY SUPPORT (PROVIDER TYPE 35)
   W. NEUROMUSCULAR CENTERS (PT 36) - FORCE EXCEPT FOR EVALUATIONS, PROCEDURE CODES 0001M, 9255M, 92506 - DENY.
   X. PROVIDER #7037740 (SPOKANE INDUSTRIAL PARK - PT) - ONLY DO LONG-TERM REHAB - FORCE.
   Y. ORTHOPEDIC SHOES NOT ATTACHED TO A LEG BRACE
   Z. COMMUNITY MENTAL HEALTH (PROVIDER TYPE 73)
   ZA. PM&R SERVICES (ALL) - (J) 0030M - 0035M, (S) HOSPITALS
   ZB. PSYCHOLOGICAL EVALUATIONS (PROCEDURE CODE 0070M)
   ZC. SUBSTANCE ABUSE (PROVIDER TYPE 75)
   ZD. TRANSPORTATION OTHER THAN AMBULANCE (PROVIDER TYPES 42,45,50,54, 55,96)
   ZE. OCCUPATIONAL THERAPY
   ZF. IF PHYSICAL OR SPEECH THERAPY & CLAIM STATES "LONG-TERM REHABILITATION - FORCE.
   ZG. NUTRITIONAL COUNSELING (CODES 0910M-0911M, 09100-09110)
   ZH. WEIGHT LOSS (REVENUE CODES 942 & 949)
   ZI. HEPATITIS B VACCINE (CODES 90731, 9069M-9072M)
   ZJ. DEPO-PROVERA FOR BIRTH CONTROL (CODE 9913M) - FORCE.
   ZK. NORPLANT KIT (CODE 9910M)

ZL. REMOVAL OF NORPLANT SYSTEM (CODES 1798M, 1799M, 11976, 1197M)

2. IF THE CLAIM HAS AN HMO EOB/DENIAL ATTACHED AND IT STATES:
   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. IF DENIAL STATES "NON-COVERED" AND SERVICE IS NOT LISTED ON THE "NON COVERED" LIST - DENY W/EOB 763.
   D. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
   E. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   F. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - DENY WITH EOB 217.

3. NO HMO EOB ATTACHED BUT STATEMENT ON CLAIM:
   A. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
   B. NON-COVERED SERVICES - (SEE ABOVE) IF LISTED - FORCE. IF NOT - DENY.
   C. CHARGES APPLIED TO DEDUCTIBLE OR CO-PAY - DENY WITH EOB 151.
   D. ANY OTHER STATEMENT - DENY.

4. NO EOB ATTACHED/NO STATEMENT ON CLAIM:
   A. NON-COVERED SERVICES - FORCE.
   B. NO COUPON ATTACHED - DENY.
   C. COUPON ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING THAT THE HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DEFFERENCE - DENY WITH EOB 229.

- IF DATE OF SERVICE IS 7/1/93 OR AFTER APPLY THE FOLLOWING -

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY MSC)
   A. ALL CLAIM TYPES - IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE.

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) ITA SERVICES
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR

THAT VISIT - DENY W/EOB 711.
9) SERVICES FOR CUP, DX CODE 648.33.
10) IF PHYSICAL OR SPEECH THERAPY & CLAIM STATES "LONG-TERM REHABILITATION".

C. HOSPITALS - (M,R,S CLAIM TYPES)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH).
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) PM&R SERVICES
5) REVENUE CODE 942 (DIABETIC COUNSELING)
6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
7) ITA SERVICES
8) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
9) IF CLIENT IS UNDER 21 YRS OLD & STERILIZATION DX CODE V25.2
10) IF PHYSICAL OR SPEECH THERAPY & CLAIM STATES "LONG-TERM REHABILITATION".

D. MEDICAL VENDOR (P CLAIM TYPE)
1) ORTHOPEDIC SHOES NOT ATTACHED TO LEG BRACE.
2) ITA SERVICES
3) ENTERAL & PARENTERAL THERAPY IF MSC DENIAL ATTACHED.
4) IF PHYSICAL THERAPY & CLAIM STATES "LONG-TERM REHABILITATION".

E. PHARMACY - D CLAIM TYPE
1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 508 IS STILL POSTING - DENY.
A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:
A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR-FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY	TEXT DESC
516	DIAGNOSIS NOT FOUND ON THE LENGTH OF STAY CRITERIA RECORD.

ELECTRONIC CLAIMS:
1. CHECK COMMENTS AND IF NO BACKUP INDICATED - DENY.
2. IF BACKUP INDICATED - STAGE CLAIM AND FOLLOW INSTRUCTIONS BELOW FOR HARD COPY CLAIMS.

HARD COPY CLAIMS:
1. STAGE
2. NO PAS EXTENSION ATTACHED - DENY.
3. IF PAS EXTENSION IS NOT SIGNED - DENY.
4. PAS EXTENSION APPROVED BUT DOES NOT COVER ALL DAYS - DENY 755/578.

IF PAS EXTENSION IS APPROVED AND COVERS DOS - FORCE EXC. 516 AND USE EOB 373 IN SECOND FIELD.

TEXT KEY TEXT DESC
521 MISSING PCCM REFERRAL #

NOTE: IF ITA SERVICES - FORCE.

1. TOS Z - IF PATIENT IS OVER 20 AND PROCEDURE CODE 55250, 56301, 56302, 58600, 58615 - FORCE.

2. HOSPITALS (M,R,S)
   A. IF COMMENTS INDICATE PCCM REFERRAL PROVIDER # - KEY # IN "O-PROV" FIELD & IF EXCEPTION CODE 521 STILL POSTING SEE BELOW:
   B. IF DENTAL RELATED SERVICES (DIAGNOSIS CODES 520 THRU 525.9)-FORCE.
   C. IF ABORTIONS & RELATED SERVICES (DX CODES 635-636.9 OR V61.7 - CHECK OP REPORT)
      1) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
      2) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
   D. IF CUP SERVICES (REVENUE CODES 129 & 168) FORCE.
   E. IF DIAGNOSIS IS 290.0 THRU 319.0 (MENTAL HEALTH) - FORCE.
   F. IF BABY ON MOM'S PIC - FORCE.
   G. ALL ELSE - DENY.

3. ALL OTHER CLAIM TYPES
--NOTE--HARD COPY CLAIMS - IF REFERRING PROVIDER # IS IN BOX 23 OR PCCM REFERRAL IS ON BACKUP DOCUMENT, KEY IT AND ENTER CLAIM, IF 521 DOES NOT GO AWAY, REMOVE NUMBER & SEE THE FOLLOWING TEXT.

   A. IF DENTAL RELATED SERVICES (DIAGNOSIS CODES 520-525.9)-FORCE.
   B. IF ABORTION RELATED SERVICES (DX CODES 635-636.9 OR V61.7 ANYWHERE ON THE DETAIL LINE - FORCE.
   C. IF SERVICES FOR CUP DIAGNOSIS CODE 648.33 - FORCE.
   D. IF DIAGNOSIS CODES 290.0-319.0 & POS 1,2,5,21,22,23,51,52 -FORCE.
   E. IF LAB/36415 AND/OR RADIOLOGY ARE THE ONLY SERVICES BILLED FOR (SAME DATE OF SERVICE) - FORCE. (SOME SERVICES SUCH AS 93325 ARE CONSIDERED PART OF RADIOLOGY PROCEDURES, THUS FORCEABLE)
   F. IF OTHER SERVICES BILLED W/LAB/36415 AND/OR RADIOLOGY CREATE A HEADER EXCEPTION AND DENY W/EOB 706. EXCEPTION: THE ABOVE APPLIES TO SAME DOS ONLY. DO NOT DENY THE ENTIRE CLAIM AT HEADER IF THE ABOVE DOES NOT APPLY TO ALL DOS, YOU MAY HAVE TO DENY AT DETAIL LINE(S).
   G. IF DELIVERY CODES 59409, 59412, 59414, 59514, 59612 OR 59620 AND CLAIM STATES EMERGENT OR DR ON CALL DELIVERED BABY - FORCE.
   H. ALL ELSE - DENY.

TEXT KEY TEXT DESC
525

THIS CLIENT IS ON THE FAMILY PLANNING SERVICES ONLY/TAKE CHARGE PROGRAM. ONLY SERVICES RELATED TO OBTAINING A FAMILY PLANNING METHOD ARE COVERED. SERVICES TO TREAT SEXUALLY-TRANSMITTED DISEASES CAN BE PROVIDED WHEN THEY ARE NECESSARY FOR MAKING A DECISION ABOUT USING A SPECIFIC BIRTH CONTROL METHOD. THE WAC DEFINITION: FOR THE PURPOSE OF THIS SECTION "FAMILY PLANNING SERVICES" MEAN SERVICES TO PLAN THE NUMBER OF ONE'S CHILDREN BY USE OF CONTRACEPTIVE TECHNIQUES.

NOTE: INDUCED/ELECTIVE ABORTIONS (635-636.9 OR I.E. 59840, 59841) ARE TO BE DENIED. WHEN DENYING THE ABORTION - DENY ALL OTHER SERVICES ON THE SAME DAY & ANY OTHER SERVICES THAT ARE RELATED. CREATE A HEADER EXCEPTION BY ENTERING AN "X" IN THE LMC FIELD AND DENY WITH EOB 564.

CLAIMS FOR TREATMENT OF COMPLICATIONS OF FAMILY PLANNING - OVERLOC TO 53. (I.E. COMMENTS LIKE INFECTION DUE TO IUD, DX CODE 996.32, 996.76)

IF THE FOLLOWING TEXT INDICATES THAT YOU SHOULD FORCE A PROCEDURE OR SERVICE & THE 525 IS FAILING AT HEADER, YOU WILL NEED TO FORCE THE 525 AND MANUALLY DENY THE LINES THAT ARE NOT FORCEABLE WITH EOB 564.

PHYSICIANS & EPSDT

1. PROCEDURE CODE 99201-99215 (OFFICE VISITS), 99381-99395 (SCREENS) & THERE IS A FAMILY PLANNING DIAGNOSIS ALSO REFERENCED TO THE DETAIL LINE, KEY THAT DIAGNOSIS AND LET PAY. ALSO, IF THERE IS A FAMILY PLANNING DIAGNOSIS ON ANOTHER DETAIL LINE FOR SAME DOS - FORCE THE OFFICE CALL.

2. A4266, A4267, A4268, A4269 - FORCE.

3. A4550 (SURGICAL TRAY) FORCE IF BILLED WITH 58300 OR 58301 (IUD INSERTION OR REMOVAL) OR 11975, 11976 OR 11977 (NORPLANT INSERT/REM) OR 55250 (VASECTOMY). IF NOT WITH A FAMILY PLANNING PROCEDURE- DENY.

4. J0456 - FORCE
   J1050, J1051, J9162,OR J9240 - DENY WITH EOB 302.
   J1380 - FORCE IF J1055 IS ALSO BILLED.
   J1885 - FORCE IF 58300 IS ALSO BILLED.
   J2000 - FORCE IF 55250 IS ALSO BILLED.

   J3490 - FORCE.

   J7302 - FORCE.
   J7303 - FORCE.

5. T1015 WITH DIAGNOSIS V25 THROUGH V25.9 FORCE.

6. 1113J, 1114J - FORCE.

7. 00840 BILLED WITH DIAGNOSIS V25.2 - DENY WITH EOB 302.
   00921 BILLED WITH DIAGNOSIS V25.2 - FORCE.

8. 36416 - FORCE.

9. 54056, 54060, 55450 - FORCE.

10. 64435 - FORCE IF BILLED WITH 58300 OR 55250.

11. 85004, 85032, 88174, 88175 - FORCE. IF OTHER LAB PROCEDURE CODES (8____) POSTING 525 - DENY EVEN IF FAMILY PLANNING DIAGNOSIS.

12. 9000M OR T1015(FQHC ENCOUNTER CODE) FORCE IF ANY SERVICE FOR SAME DATE IS RELATED TO FAMILY PLANNING.

13. 9814M - FORCE.

14. 99401 - IF DOS 7-1-03 OR AFTER - FORCE.

15. IF THERE ARE LAB PROCEDURES (80000-89999, Q0112, Q0144 OR 36415 ON THE CLAIM NOT POSTING THE EXCEPTION AND NO FAMILY PLANNING DIAGNOSIS (V25-V25.9 OR V99.9) ANYWHERE ON CLAIM,OR COMMENTS DON'T SUGGEST FAMILY PLANNING, CREATE A HEADER EXCEPTION AND DENY WITH EOB 564, OR IF BABY ON PARENT'S PIC - DENY WITH EOB 489.
    EXCEPTION: PROVIDER TYPE 43 USING DIAGNOSIS V72.6, ONLY DENY THE LINES POSTING.

16. IF NO INDICATION OF FAMILY PLANNING ON THE CLAIM - DENY.

--- ANY QUESTIONS OVERLOC TO 53.

DRG (R) AND INPATIENT (S)
1. IF ANY INDICATION OF COMPLICATION OF FAMILY PLANNING OR STERILIZATION OVERLOC TO 53.
2. IF DRG (R) AND ALSO POSTING EXCEPTION 252 - OVERLOC TO 72.
3. ALL ELSE - DENY.

OUTPATIENT
1. 85004, 85032, 88174, 88175 - FORCE.

2. IF THE ONLY DIAGNOSIS ON THE CLAIM IS FAMILY PLANNING (V25-V25.9) - FORCE.

3. IF A FAMILY PLANNING DIAGNOSIS (V25-V25.9) AND DIAGNOSIS UNRELATED TO FAMILY PLANNING ON THE SAME CLAIM - DENY ENTIRE CLAIM WITH EOB 768. NOTE: IF THE DIAGNOSIS IS BECAUSE OF COMPLICATION RELATED TO FAMILY PLANNING OR STERILIZATION - OVERLOC TO 53.

4. IF THE CLAIM HAS LINES THAT ARE NOT POSTING ALONG WITH LINES THAT ARE POSTING AND NOTHING ON THE CLAIM SUGGESTS FAMILY PLANNING OR STERILIZATION (DIAGNOSIS V25 - V25.9) - CREATE A HEADER EXCEPTION AND DENY THE ENTIRE CLAIM WITH EOB 564.

5. ALL ELSE - IF NO INDICATION OF FAMILY PLANNING - DENY.

HOSPITAL X-OVERS - DENY

TEXT KEY TEXT DESC
526 HMO - BLUE CROSS OF WA (CARENET)

1. FORCE THE FOLLOWING SERVICES (NON COVERED BY CARENET)
   A. ALL CLAIM TYPES-
      IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) ITA SERVICES
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
      9) SERVICES FOR CUP, DX CODE 648.33.

   C. HOSPITALS - (M,R,S CLAIM TYPES)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH)
      2) DENTAL DIAGNOSIS 520 THRU 525.9
      3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
      4) REVENUE CODE 942 (DIABETIC COUNSELING)
      5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
      6) ITA SERVICES
      7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
         A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
         B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
      8) MATERNITY RELATED DRG'S 370-375, 650-652 FROM 10/1/93 THROUGH 2/28/95 DATES OF SERVICE.
      9) IF CLIENT IS UNDER 21 YRS OLD & STERILIZATION DX CODE V25.2.

   D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES

   E. PHARMACY (D CLAIM TYPE)
      1) PRESCRIBED BY A DENTIST (PRESCRIBING # BEGINS WITH A (5) OR COMMENTS INDICATE DRUG REFERRAL)
      2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 526 IS STILL POSTING - DENY.

A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
527 HMO - ETHIX HEALTH PLAN

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY ETHIX HEALTH PLAN)
   A. ALL CLAIM TYPES-
      IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 AND CLIENT ENROLLED IN PROVIDER #'S 7500119, 7500267, 7500283 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE DOR M, J WITH POS 2, 3 OR 5).

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) ITA SERVICES
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
      9) SERVICES FOR CUP, DX CODE 648.33.

   C. HOSPITALS - (M,R,S CLAIM TYPES)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH).
      2) DENTAL DIAGNOSIS 520 THRU 525.9
      3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
      4) REVENUE CODE 942 (DIABETIC COUNSELING)
      5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
      6) ITA SERVICES
      7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
         A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
         B) IF SPONTANEOUS OR MEDICALLY JUSITIFIED ABORTION - DENY.
      8) IF CLIENT IS UNDER 21 YRS OLD & STERILIZATION DX CODE V25.2.

   D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES.

   E. PHARMACY - D CLAIM TYPE
      1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
      2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 527 IS STILL POSTING - DENY.
         A) PRESCRIBED BY FAMILY PLANNING CLINIC

B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC

528 HMO - PROVIDENCE HEALTH CARE PLAN & GRAYS HARBOR MEDICAL BUREAU

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY PHCP & GHMB)
   A. ALL CLAIM TYPES-
      IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER #'S 7500127, 7500242, 7500291 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, WITH POS 2, 3 OR 5).

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) ITA SERVICES
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OAR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
      9) SERVICES FOR CUP, DX CODE 648.33.

   C. HOSPITALS - (M,R.S CLAIM TYPES)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH)
      2) DENTAL DIAGNOSIS 520 THRU 525.9
      3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
      4) REVENUE CODE 942 (DIABETIC COUNSELING)
      5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
      6) ITA SERVICES
      7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
         A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
         B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
      8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

   D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES.

   E. PHARMACY (D CLAIM TYPE)
      1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
      2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 528 IS STILL POSTING - DENY.
         A) PRESCRIBED BY FAMILY PLANNING CLINIC

B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
529 HMO - KING COUNTY MEDICAL BLUE SHIELD

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY KING COUNTY MEDICAL)

A. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICE - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER #'S 7500135, 7500309 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

B. PHYSICIAN (J CLAIM TYPE)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
4) ITA SERVICES
5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATIN VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
7) SERVICES FOR CUP, DX CODE 648.33.
8) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
9) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.

C. HOSPITALS (M,R,S CLAIM TYPES)

1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH).
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) REVENUE CODE 942 (DIABETIC COUNSELING)
5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
6) ITA SERVICES
7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES.

E. PHARMACY (D CLAIM TYPE) - IF PRESCRIBING PROVIDER NUMBER BEGINS
1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 529 IS STILL POSTING - DENY.

A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
   H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
530 HMO - PACIFIC HEALTH PLAN

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY PHP)

A. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER # 7500143 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

B. PHYSICIAN (J CLAIM TYPE)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
4) ITA SERVICES
5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICE RELATED THAT VISIT - DENY W/EOB 711.
9) SERVICES FOR CUP, DX CODE 648.33.

C. HOSPITALS - (M,R,S CLAIM TYPES)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH).
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) REVENUE CODE 942 (DIABETIC COUNSELING)
5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
6) ITA SERVICES
7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" LIST - DENY WITH EOB 763.

G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR-FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY	TEXT DESC
535	WHEN THE 4TH SURGICAL PROCEDURE CODE IS ONLY 3 DIGITS AND THERE'S A DECIMAL, DO THE FOLLOWING: 1. IF THE MISSING DIGIT IS BEFORE THE DECIMAL, KEY A LEADING ZERO. FOR EXAMPLE: IF 7.41 - KEY 0741 2. IF THE MISSING DIGIT IS AFTER THE DECIMAL, KEY A TRAILING ZERO. FOR EXAMPLE: IF 74.1 - KEY 7410 3. IF EXCEPTION STILL POSTS - REMOVE THE ZERO & DENY.

TEXT KEY	TEXT DESC
536	WHEN THE 5TH SURGICAL PROCEDURE IS ONLY 3 DIGITS AND THERE'S A DECIMAL, DO THE FOLLOWING: 1. IF THE MISSING DIGIT IS BEFORE THE DECIMAL, KEY A LEADING ZERO. FOR EXAMPLE: IF 7.41 - KEY 0741 2. IF THE MISSING DIGIT IS AFTER THE DECIMAL, KEY A TRAILING ZERO. FOR EXAMPLE: IF 74.1 - KEY 7410 3. IF EXCEPTION STILL POSTS - REMOVE THE ZERO & DENY.

TEXT KEY	TEXT DESC
537	WHEN THE 6TH SURGICAL PROCEDURE CODE IS ONLY 3 DIGITS AND THERE'S A DECIMAL, DO THE FOLLOWING: 1. IF THE MISSING DIGIT IS BEFORE THE DECIMAL, KEY A LEADING ZERO. FOR EXAMPLE: IF 7.41 - KEY 0741 2. IF THE MISSING DIGIT IS AFTER THE DECIMAL, KEY A TRAILING ZERO. FOR EXAMPLE: IF 74.1 - KEY 7410 3. IF EXCEPTION STILL POSTS - REMOVE THE ZERO & DENY.

TEXT KEY TEXT DESC
538 HMO - PROVIDENCE HEALTH CARE PLAN

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY PHCP)

A. ALL CLAIM TYPES - IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED - FORCE.

B. PHYSICIAN (J CLAIM TYPE)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
4) ITA SERVICES
5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
9) SERVICES FOR CUP, DX CODE 648.33.

C. HOSPITALS - (M,R,S CLAIM TYPES)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH)
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) REVENUE CODE 942 (DIABETIC COUNSELING)
5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
6) ITA SERVICES
7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES.

E. PHARMACY (D CLAIM TYPE)
1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 538 IS STILL POSTING - DENY.
A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO OR STATEMENT ON CLAIM STATES

   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/COPAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
   F. IF DENIAL STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS, OR ANOTHER STATEMENT - DENY W/EOB 217.
   G. IF STATEMENT ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO VOVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.
   H. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION FOR ACTION CODE - DENY W/EOB 783.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR-FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
539 HMO - SELECTCARE

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY SELECTCARE):
   A. ALL CLAIM TYPES -
    - IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER #7500218 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THROUGH 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THROUGH 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THROUGH 525.9.
      4) SPEECH THERAPY FOR CONGENITAL CONDITIONS.
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) SERVICES FOR CUP, DX CODE 648.33.
      8) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      9) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.

   C. HOSPITALS - (M,R,S CLAIM TYPES)

      1) DIAGNOSIS CODES 290.0 THROUGH 319.0 (MENTAL HEALTH).
      2) DENTAL DIAGNOSIS 520 THROUGH 525.9.
      3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
      4) PM&R SERVICES
         A) IF DOS BEFORE 3/1/95 - FORCE.
         B) IF DOS 3/1/95 & AFTER & CLIENT ENROLLED IN PROVIDER # 7500218 - DENY.
      5) REVENUE CODE 942 (DIABETIC COUNSELING)
      6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949)
      7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
         A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
         B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
      8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

D. DRUGS (D CLAIM TYPE)

   1) PRESCRIBED BY DENTIST (PRESCRIBING NUMBER BEGINS WITH "5")
   2) MENTAL HEALTH DRUGS (THERAPEUTIC CLASSES 440-442, 444 & 430)
   3) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS

03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 539 IS STILL POSTING - DENY.
A) PRESCRIBED BY FAMILY PLANNING CLINIC.
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM STATES:

   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/COPAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT MENTIONED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS - DENY WITH EOB 217.

   H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
540 HMO - COWLITZ BLUE SHIELD

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY KING COUNTY MEDICAL)

A. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER # 7500226 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

B. PHYSICIAN (J CLAIM TYPE)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
4) ITA SERVICES
5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615 58982, 58983.
7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES - DENY W/EOB 711.
9) SERVICES FOR CUP, DX CODE 648.33.

C. HOSPITALS (M,R,S CLAIM TYPES)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH).
2) DENTAL DIAGNOSIS 520 THRU 525.9.
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) REVENUE CODE 942 (DIABETIC COUNSELING)
5) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
6) ITA SERVICES
7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

D. MEDICAL VENDOR (P CLAIM TYPE) - ITA SERVICES.

2. IF HMO EOB OR STATEMENT ON CLAIM STATES:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/COPAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.

F. IF DENIAL STASTES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

G. IF STATEMENT ON CLAIM SAYS PREMIUM NOT PAID PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY W/EOB 217.

H. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY W/EOB 783.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   1. NO MEDICAL ID CARD ATTACHED - DENY.
   2. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
541 OANAGED HEALTHCARE - KAISER OF COWLITZ

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY KAISER):
   A. ALL CLAIM TYPES-
      IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER # 7500234 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

   B. PHYSICIAN (J CLAIM TYPE)
      1) TREATMENT FOR MENTAL ILLNESS DX (290.0-319.0) INCLUDING ITA IN POS 1,2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) SPEECH THERAPY FOR CONGENITAL CONDITIONS.
      5) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      6) CLIENT UNDER 21 & SERVICES RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982, 58983.
      7) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      8) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
      9) SERVICES FOR CUP, DX CODE 648.33.

   C. HOSPITALS - (M,R,S CLAIM TYPES)
      1) TREATMENT FOR MENTAL ILLNESS INCLUDING ITA.
      2) DENTAL DIAGNOSIS 520 THRU 525.9
      3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
      4) PM&R SERVICES
         A) IF DOS BEFORE 3/1/95 - FORCE.
         B) IF DOS 3/1/95 OR AFTER & CLIENT ENROLLED IN PROVIDER # 7500234 - DENY.
      5) REVENUE CODE 942 (DIABETIC COUNSELING)
      6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949)
      7) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
         A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
         B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
      8) IF CLIENT IS UNDER 21 & STERILIZATION DX CODE V25.2.

   D. DRUGS (D CLAIM TYPE)
      1) PRESCRIBED BY DENTIST (PRESCRIBING NUMBER BEGINS WITH "5")
      2) MENTAL HEALTH DRUGS (THERAPEUTIC CLASSES 440-442, 444 & 430)
      3) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 541 IS STILL POSTING - DENY.

A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:
   A. OVER $ LIMITATION - FORCE.
   B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
   C. CHARGES APPLIED TO DEDUCTIBLE/COPAY - DENY WITH EOB 151.
   D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
   E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
   F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT LISTED ON THE "NON-COVERED" LIST - DENY WITH EOB 254.
   G. IF "DENIAL" STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, OR NO COVERAGE FOR DOS - DENY WITH EOB 217.
   H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS OR A SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
   A. NO MEDICAL ID CARD ATTACHED - DENY.
   B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC

545 HMO - PIERCE COUNTY MEDICAL BUREAU

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY PCMB)
   A. ALL CLAIM TYPES -
      IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER # 7500259 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

   B. PHYSICIAN (J CLAIM TYPE)
      1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2 OR 5.
      2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
      3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
      4) ITA SERVICES.
      5) SERVICES FOR CUP, DIAGNOSIS CODE 648.33.
      6) IF CLIENT IS UNDER 21 YEARS OLD & SERVICE IS RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982 OR 58983.
      7) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
      8) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
      9) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.
   C. HOSPITALS (M,R,S CLAIM TYPES)
      1) DIAGNOSIS IS 290.0 THRU 319.0 (MENTAL HEALTH).
      2) DENTAL DIAGNOSIS 520 THRU 525.9.
      3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
      4) PM&R SERVICES
         A) IF DOS BEFORE 3/1/95 - FORCE.
         B) IF DOS 3/1/95 OR AFTER & CLIENT ENROLLED IN PROVIDER # 7500275 - DENY.
      5) DIABETIC COUNSELING (REVENUE CODE 942)
      6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
      7) ITA CARE
      8) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
         A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
         B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
      9) IF CLIENT IS UNDER 21 YEARS OLD AND STERILIZATION DIAGNOSIS CODE V25.2.
   D. PHARMACY (D CLAIM TYPE)
      1) IF PRESCRIBING PROVIDER NUMBER BEGINS WITH "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.
      2) IF ONE OF THE FOLLOWING COMMENTS IS IN THE JUSTIFICATION OR COMMENTS FIELD, ENTER AN "X" IN THE ITA FIELD. IF DOS IS 03/1/95 THRU 09/30/95 - ENTER THE CLAIM. IF DOS IS 10/1/95 & AFTER, ENTER THE CLAIM, IF 545 IS STILL POSTING - DENY.

A) PRESCRIBED BY FAMILY PLANNING CLINIC
B) PRESCRIBED BY COMMUNITY MENTAL HEALTH CENTER
C) PRESCRIBED BY HEALTH DEPARTMENT
D) ABORTION RELATED PRESCRIPTION

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" & SERVICE IS NOT MENTIONED ON THE "NON-COVERED" LIST - DENY WITH EOB 763.
G. IF DENIAL EOB STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DATE OF SERVICE - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS, OR SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR- FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:
A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
546 HMO - BLUE CROSS/MULTICARE

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY BLUE CROSS):

A. ALL CLAIM TYPES - IF CLAIM OR COMMENTS STATE TRANSPLANT RELATED SERVICES - FORCE EXCEPT: IF DOS 3/1/95 OR AFTER AND CLIENT ENROLLED IN PROVIDER # 7500259 - DENY IF OUTPATIENT SERVICES (CLAIM TYPE D OR M, J WITH POS 2, 3 OR 5).

B. PHYSICIAN (J CLAIM TYPE)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE OF SERVICE IS 1, 2, OR 5.
2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
4) ITA SERVICES.
5) SERVICES FOR CUP DIAGNOSIS CODE 648.33.
6) IF CLIENT IS UNDER 21 YEARS OLD AND SERVICE IS RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982 OR 58983.
7) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATION VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
8) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
9) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.

C. HOSPITALS (M,R,S CLAIM TYPES)

1) DIAGNOSIS IS 290.0 THRU 319.0 (MENTAL HEALTH).
2) DENTAL DIAGNOSIS 520 THRU 525.9.
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) PM&R SERVICES.
A) IF DOS BEFORE 3/1/95 - FORCE.
B) IF DOS 3/1/95 OR AFTER & CLIENT ENROLLED IN PROVIDER # 7500259 - DENY.
5) REVENUE CODE 942 (DIABETIC COUNSELING)
6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
7) ITA CARE.
8) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
90 IF CLIENT IS UNDER 21 YEARS OLD AND STERILIZATION DIAGNOSIS CODE V25.2.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.

C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
E. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.
E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT MENTIONED ON THE "NON COVERED" LIST - DENY WITH EOB 763.
G. IF DENIAL EOB STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DATE OF SERVICE - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS, OR SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR - FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY	TEXT DESC
549	CLIENT IS ON SPECIAL LOW-INCOME BENEFICIARY (SLMB) PROGRAM, DSHS PAYS PART B PREMIUM TO MEDICARE ONLY. NURSING HOME CLAIMS - CHECK ACES FOR VALID ELIGIBILITY: 1. IF FOUND - UPDATE MMIS ELIGIBILITY AND PAY CLAIM. 2. IF NOT FOUND - CHECK FOR VALID AWARD LETTER (MUST COVER CLIENT, DATES OF SERVICE, AND PROVIDER) A. IF NOT FOUND - DENY WITH EOBS 792 & 492. B. IF FOUND- 1. FORCE, AND 2. COPY OF CLAIM AND AWARD LETTER TO AUDREY FINNEGAN, DUS/MRS, MAILSTOP 45510. NURSE DELEGATION SERVICES: (8900N-8903N) - FORCE PER AASA, MEDICARE WON'T PAY.

TEXT KEY TEXT DESC
550 HMO - KITSAP PHYSICIAN SERVICE - THURSTON CO

1. FORCE THE FOLLOWING SERVICES (NON-COVERED BY KPS - THURSTON CO.)

A. ALL CLAIM TYPES - IF CLAIM/COMMENTS OR BACKUP INDICATE TRANSPLANT RELATED SERVICES - FORCE.

B. PHYSICIAN (J CLAIM TYPE)
1) DIAGNOSIS CODES 290.0 THRU 319.0 (MENTAL HEALTH) AND PLACE SERVICE IS 1, 2, OR 5.
2) DENTAL DIAGNOSIS 520 THRU 525.9 IN ANY PLACE OF SERVICE.
3) IF PT 22 (ASC) & DENTAL DIAGNOSIS 520 THRU 525.9.
4) ITA SERVICES.
5) SERVICES FOR CUP DIAGNOSIS CODE 648.33.
6) IF CLIENT IS UNDER 21 YEARS OLD AND SERVICE IS RELATED TO STERILIZATION CODES 55250, 55450, 56301, 56302, 58600, 58605, 58611, 58615, 58982 OR 58983.
7) ABORTION RELATED SERVICES - DX IS 635-636.9 OR V61.7 OR STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION (PROCEDURES FOR ABORTION 59100,59840-59841, OR 59850-59852 MAY OR MAY NOT BE PRESENT ON THE CLAIM).
8) PT 24 - ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.
9) PT 20 & TB CODES (9011M-9014M) & ALL RELATED SERVICES FOR THAT VISIT - DENY W/EOB 711.

C. HOSPITALS (M,R,S CLAIM TYPES)

1) DIAGNOSIS IS 290.0 THRU 319.0 (MENTAL HEALTH)
2) DENTAL DIAGNOSIS 520 THRU 525.9
3) CUP SERVICES - IF CLAIM OR NOTE IN AUTH FILE SAYS CUP OR CHEMICAL USING PREGNANT WOMAN.
4) PM&R SERVICES.
5) REVENUE CODE 942 (DIABETIC COUNSELING)
6) WEIGHT LOSS SERVICES (REVENUE CODES 948 AND/OR 949).
7) ITA CARE.
8) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
9) IF CLIENT IS UNDER 21 YEARS OLD AND STERILIZATION DIAGNOSIS CODE V25.2.

D. PHARMACY (D CLAIM TYPE) - IF PRESCRIBING PROVIDER NUMBER BEGINS WITH A "5" (DENTIST) OR COMMENTS INDICATE DENTAL PRESCRIPTION.

2. IF HMO EOB/DENIAL LETTER OR STATEMENT ON CLAIM SAYS:

A. OVER $ LIMITATION - FORCE.
B. NOT AUTHORIZED/REFERRED - DENY WITH EOB 254.
C. CHARGES APPLIED TO DEDUCTIBLE/CO-PAY - DENY WITH EOB 151.
D. IF EOB SHOWS PAYMENT - DENY WITH EOB 229.

E. IF EOB DOESN'T HAVE THE PRINTED DESCRIPTION - DENY WITH EOB 783.
F. IF DENIAL STATES "NOT COVERED" AND SERVICE IS NOT MENTIONED ON THE "NON-COVERED " LIST - DENY WITH EOB 763.
G. IF DENIAL EOB STATES PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE OR NO COVERAGE FOR DATE OF SERVICE - DENY WITH EOB 217.
H. IF "STATEMENT" ON CLAIM SAYS PREMIUM NOT PAID, PRIOR TO EFFECTIVE DATE, AFTER TERMINATION DATE, NO COVERAGE FOR DOS, OR SIMILAR STATEMENT - DENY WITH EOB 217.

3. IF UNALTERED COPY OF MEDICAL ID CARD ATTACHED WITH NO HMO INDICATOR - FORCE.

4. IF NO EOB/STATEMENT ON CLAIM:

A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD ATTACHED STATING HMO - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS - WHEN ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
552 HMO - MHC PLANS & BHP PLUS

NOTE: EE: IF AUTH # ON CLAIM AND NOT ADDRESSED BELOW TO FORCE - O'LOC TO 23.
RES: REVIEW AUTH # FOR ETP OF SERVICES NORMALLY COVERED BY MANAGED CARE. SEE YOUR SUP IF ANY QUESTIONS.

1. FORCE THE FOLLOWING SERVICES (NON COVERED BY BHP PLUS AND OTHER MANAGED HEALTHCARE PLANS) UNLESS OTHERWISE NOTED.

A. ALL CLAIM TYPES-

1) INCARCERATED CLIENTS:
A) IF DENIAL EOB ATTACHED OR A STATEMENT ON THE CLAIM OR ON BACKUP INDICATING (INCARCERATED CLIENT, CLIENT IN JAIL OR SOMETHING SIMILIAR) - FORCE.
B) IF CLAIM IS FROM ANY OF THE FOLLOWING PROVIDER #'S - FORCE. (6008916, 7033731, 7033749, 7044019, 7099765, 7099773, 7099781).
C) OTHERWISE - DENY.

B. PHYSICIAN (J CLAIM TYPE)
1) SERVICES FOR CUP DIAGNOSIS CODE (648.33)FORCE ALL SERVICES FOR THE SAME MONTH AS A LINE W/A CUP DIAGNOSIS OF 648.33)

2) SERVICES FOR DENTAL DIAGNOSIS CODES (520-525.9) - FORCE ALL @ SERVICES ON THE CLAIM FOR THE SAME DOS AS A DATE W/DENTAL DIAGNOSIS OF 520-525.9

3) IF CLIENT IS UNDER 21 YEARS OLD AND SERVICE IS RELATED TO STERILIZATION/VASECTOMY CODES (00851,00869,56301-56302,58600, 58605,58611,58615,58670-58671,54690,55250,55450,56318,5911M, 5912M).
4) ABORTION RELATED SERVICES - DX IS 635-639.9 OR V61.7 OR @ STATEMENT ON THE CLAIM INDICATING VOLUNTARY OR INDUCED ABORTION. THIS MAY ALSO INCLUDE J9260 (50 MG METHOTREXATE OR J3490 (UNCLASSIFIED CODE WHICH CAN BE USED FOR MISOPROSTOL BUT CLAIM DOES NOT HAVE TO STATE DRUG NAME.) (PROCEDURES FOR ABORTION - 01964,59100,59812-59841,59850-59857 OR 5915M) MAY OR MAY NOT BE PRESENT ON THE CLAIM.

5) PT 24 -ALL SERVICES ON SAME DAY AS TB CODES (9011M-9014M) & RELATED TO VISIT - FORCE.

6) FQHC ENCOUNTER CODE FAILING HMO EXCEPTION AND AT LEAST ONE SERVICE ON THE CLAIM FOR THE SAME DOS AS THE ENCOUNTER CODE IS PAYING - FORCE THE HMO EXCEPTION.

7) DATES IN BOX 18 (HOSPITALIZATION DATES) OR EMC COMMENT FIELD &:
---(EE)---
A) IF ALL DETAIL LINE DOS ARE SAME DATE AS FIRST DAY

OF HOSPITALIZATION - DENY.
B) ALL ELSE - DOS ON CLAIM IS WITHIN OR PRIOR TO THE HOSPITAL-IZATON, POS 1 OR 21, AND NOT DENYING FOR OTHER REASONS- PUT AN "X" IN LMC FIELD, ENTER CLAIM & PA-2 THE 552 & 116.
NOTE: HARD COPY CLAIMS - ENTER HOSPITALIZATION DATES IN COMMENTS SCREEN.

---(RES)---
A) CHECK PCOP SCREEN & IF NOT IN HMO ON ADMIT DATE & POS IS "1" - FORCE.
B) ALL ELSE - DENY.

8) 90471/90472 - FORCE IF ANY IMMUNIZATION (90476-90749) OR (J1460-J2790) ON THE CLAIM NOT POSTING 552. IF REMARKS OR COMMENTS STATE "EXEMPT FROM MANAGED HEALTHCARE" - FORCE IF PROCEDURE CODE IS 90471 OR 90472 AND BILLED WITH 90476-90749 OR J1460-J2790.

9) 90780/90781 - FORCE IF ANY IMMUNE GLOBULIN (90281-90399) ON THE CLAIM NOT POSTING 552.

10) ALL ELSE - DENY.

C. HOSPITALS (M,R,S CLAIM TYPES)
1) DIAGNOSIS IS 290.0 THRU 319.0 (MENTAL HEALTH)
2) DENTAL DIAGNOSIS 520 THRU 525.9.
3) CUP SERVICES(REV CODES 129 OR 168) IF CLAIM INDICATES CUP SVCS, BUT THE PROV IS NOT BILLING REV CODE 129 OR 168 - DENY W/EOB 756, OTHERWISE FORCE.
4) ITA CARE.
5) ABORTIONS & RELATED SERVICES (REFER TO DX, OP REPORT, ETC.)
A) IF VOLUNTARY TERMINATION OF PREGNANCY - FORCE.
B) IF SPONTANEOUS OR MEDICALLY JUSTIFIED ABORTION - DENY.
6) IF CLIENT IS UNDER 21 YEARS OLD AND STERILIZATION DIAGNOSIS CODE V25.2.
7) PROCEDURE CODE 8719M (NEWBORN PKU & OTHER METABOLIC SCREENING)- FORCE.

D. MEDICARE X-OVERS - O & V CLAIM TYPE
1) IF MEDICARE BACKUP - FORCE 552 & OVERCODE 111.
2) IF MANAGED CARE (HMO/MHC) BACKUP - SEE "B" BELOW.
2. IF UNALTERED COPY OF MAID CARD ATTACHED WITH NO HMO INDICATOR-FORCE.
(HOSPITALS)-ID CARD ATTACHED WITH NO HMO INDICATOR FOR THE DATE OF ADMIT- FORCE.

3. IF NO EOB/STATEMENT ON CLAIM AND:
A. NO MEDICAL ID CARD ATTACHED - DENY.
B. MEDICAL ID CARD IS ATTACHED STATING HMO - DENY.

4. HMO EOB/DENIAL LETTER ATTACHED OR STATEMENT ON CLAIM AND:
A. EOB DOES NOT MATCH THE CLIENT, DATES OR SERVICES - DENY W/EOB 105.
B. ALL ELSE - DENY.

5. CLAIMS PROCESSING ADJUSTMENTS -
   A. IF ADJUSTMENT COMES IN FROM PROVIDER WITH EOB ATTACHED SHOWING HMO HAS PAID THEIR MAXIMUM ALLOWABLE AND THEY ARE TRYING TO BILL US THE DIFFERENCE - DENY WITH EOB 229.
   B. IF STATEMENT ON ADJUSTMENT REQUEST SAYS RELATING TO DENTAL PROCEDURE - FORCE.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
553

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) MUST BILL A MEDICAL ENCOUNTER (9000M OR T1015) FOR AN EVAL & MANGMNT (E&M) OFFICE CALL (99202-99205, 99212-99215). PAY ONLY ONE MEDICAL ENCOUNTER PER DAY, PER CLIENT. DENY ADDITIONAL ENCOUNTERS WITH EOB 910.

9000M OR 9001M ARE GOOD FOR DATES OF SERVICE ON OR BEFORE 9/30/03.
T1015 IS GOOD FOR DATES OF SERVICE ON OR AFTER 10/01/03.
IF BILLING THE WRONG ENCOUNTER FOR THE WRONG DATE OF SERVICE- DENY AND USE INFORMATIONAL EOB 302 IN THE SECOND SLOT OF THE ENCOUNTER.

EXCEPTIONS: MULTIPLE UNTS ARE ALLOWED WHEN 9001M OR T1015 W/MOD TH IS BILLED ON THE SAME CLAIM WITH : GLOBAL OB CODES (5947M, 5951M, 5952M, 59400, 59410, 59425, 59426, 59430, 59510, 59515, 59610, 59612, 59614, 59618, 59620, AND 59622).

1. IF DENYING EXCEPTION 281 - FORCE. @

2. IF THE E&M IS POSTING:
   A. WITH NO ENCOUNTER FOR SAME DATE OF SERVICE - DENY.
   B. AND THE MEDICAL/MATERNITY ENCOUNTER (9001M OR T1015 W/MOD TH IS ON THE CLAIM WITH SAME DATE OF SERVICE - FORCE.
   C. AND THE ENCOUNTER FOR THE SAME DATE OF SERVICE HAS BEEN DENIED AS A DUPE - FORCE.
   D. IF DENYING A BILLED ENCOUNTER - FORCE.

3. IF THE ENCOUNTER IS POSTING 553 AND:
   A. THERE IS NO E&M ON THE CLAIM FOR SAME DOS, DENY WITH EOB 714. OR
   B. THE E&M HAS BEEN DENIED FOR SAME DOS - DENY WITH EOB 714 UNLESS THE FOLLOWING APPLY:
      1.) IF DENYING ALL THE SERVECES ON THE CLAIM FOR THE SAME DATE OF SERVICE AS THE ENCOUNTER - PA2 (THE SYSTEM WILL AUTO DENY THE ENCOUNTER).
      2.) THE FOLLOWING SERVICES DO NOT QUALIFY FOR ENCOUNTERS: (36400-36425, 36511-36515, 38204-38215, 70000-79999, 80000-89999, 90281-90799, D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0321, D0330, D0460, D0501, D1203, P3000-P3001 AND ALL J CODES, Q CODES AND S CODES EXCEPT PROCEDURE RANGE S9445-S9470). IF THERE ARE OTHER PAYABLE SVCS ON THE CLAIM FOR THE SAME DOS; &, THEY ARE NOT ONE OF THE ABOVE - FORCE.

4. IF 553 IS POSTING ON BOTH THE E&M AND THE ENCOUNTER (DUE TO A DATE SPAN BILLING ERROR ON THE ENCOUNTER) - DENY THE OFFICE CALL WITH EOB 483 AND DENY THE ENCOUNTER W/EOB 305.

5. UNABLE TO DETERMINE, OVERLOC TO 83.

TEXT KEY	TEXT DESC
556	

TEXT KEY TEXT DESC

557 PROLONGED CARE, (99354-99357), IS BEING BILLED BY ITSELF OR WITHOUT ANOTHER APPROPRIATE CODE FOR DATE OF SERVICE. (IF THE NECESSARY CRITERIA IS ON THE PRECEDING OR FOLLOWING CLAIM OR IN HISTORY ON WORKSHEET - FORCE).

NOTE: IF PROLONGED CARE CODES ARE BILLED IN SPANS THE 557 EXCEPTION WILL FAIL EVEN IF ALL OF THE APPROPRIATE CODES ARE ON THE CLAIM. YOU MUST FORCE IF THE FOLLOWING REQUIREMENTS HAVE BEEN PROVIDED.

NOTE: EFFECTIVE W/DOS 7/1/03, PHYS/MID WIFE/BIRTH CNTRS WILL BE USING THE CPT PROLONGED PKG TO BILL FOR OLD LOCAL CODE 5935M (LABOR MANAGEMENT). ALL POLICY BELOW IS APPLICABLE. NOTE: THE ONLY EXCEPTION IS THAT PROLONGED PKG USED FOR LABOR MANAGEMENT MUST HAVE MOD (TH) & DX MUST BE (640-674.9, V22.0-V22.2 OR V23-V23.9) ON EACH SERVICE BILLED. IF PART OF THE CODES HAVE THE ABOVE CRITERIA AND PART DO NOT - DENY THE 557.
ANY QUESTIONS - SEE SANDY A/MMIS. IF NOT ADDRESSED IN THIS NOTE, CONTINUE ON WITH THIS TEXT. NOTE: PER RATES, CONSULT CODES 99251-99255,99261-99263 ARE NO LONGER APPROPRIATE FOR MATERNITY USE. SHOULD BE DENIED UNDER 169 EXCEPTION.

TO PROVIDE A 99354:
A 99201-99205, 99212-99215, 99241-99245 OR 99301-99350 MUST ALSO BE PROVIDED ON THE SAME DOS.

TO PROVIDE A 99355:
A 99354 AND ONE OF THE CODES REQUIRED FOR 99354 MUST BE PROVIDED ON SAME DOS. NOTE: IF MOD (TH) OR ONE OF THE NOTED DX FOR LABOR MNGMNT ON THE LINE, CUT UNITS TO 4 W/INFO EOB 101.

TO PROVIDE A 99356:
A 99221-99223, 99231-99233, 99251-99255, OR 99261-99263 MUST ALSO BE PROVIDED ON SAME DOS.

TO PROVIDE A 99357:
A 99356 AND ONE OF THE CODES REQUIRED FOR 99356 MUST BE PROVIDED ON SAME DOS. NOTE: IF MOD (TH) OR ONE OF THE NOTED DX FOR LABOR MNGMT ON THE LINE, CUT UNITS TO 4 W/INFO EOB 101.

IF YOU HAVE PROLONGED CARE AND THE ABOVE PROVISIONS HAVE NOT BEEN MET AND YOU HAVE OTHER PROCDEURES ON THE CLAIM - FORCE THE 557 AND MANUALLY PAY THE PROLONGED CARE AT 0.00 WITH EOB 812.

IF THE PROVIDER BILLS A PROLONGED CARE CODE AND EDIT 365 IS ALSO FAILING AND THERE ARE OTHER SERVICES ON THE CLAIM IN THE SAME PLACE OF SERVICE AS THE PROLONGED CARE, THE PROVIDER IS PROBABLY BILLING THE WRONG PROLONGED CARE CODE - MANUALLY PAY THE PROLONGED CARE AT 0.00 WITH EOB'S 812/302.

IF YOU ONLY HAVE PROLONGED CARE ON YOUR CLAIM - DENY.

NOTE: SYSTEM AND TEXT WAS UPDATED TO REFLECT CPT ON 9/14/01.

TEXT KEY TEXT DESC
563

AMBULANCE MILEAGE 0007A VS 0007A
A0425 VS A0425-SEE INSTRUCTIONS ON PAGE 3

THIS AUDIT BYPASSES THE DUP AUDIT, THEREFORE YOU MUST DETERMINE IF YOU HAVE A DUPLICATE OR SECOND TRIP OR MORE THAN ONE CLIENT IN SAME AMBULANCE TRANSPORTED TO THE SAME DESTINATION. IF THE CLAIM HAS OVERCODE OF 002,003, 004 OR 444 - RESEARCH FOR MULT TRIPS AND ADJUDICATE ACCORDINGLY.

IF YOU DETERMINE THAT MORE THAN ONE CLIENT IN SAME AMBULANCE WAS TRANSPORTED TO THE SAME DESTINATION (MOM & BABY) - PAY 2 BASE RATES BUT ONLY 1 MILEAGE. DENY 2ND MILEAGE CODE W/EOB 422

CHECK FOR ITA INDICATOR ON CLAIMS- IE (POSSIBLE TRANSPORT BETWEEN HOSPITALS (HARBORVIEW TO WESTERN STATE) AND TRANSPORT FROM INCIDENCE SITE TO HARBORVIEW.

ELECTRONIC/TAPE BILLINGS

1. CHECK FOR COMMENTS REGARDING SECOND/RETURN TRIP - IF PRESENT CHANGE CODE TO 0008A W/EOB 524 AND ENTER CLAIM.

2. IF NO COMMENTS BUT MILEAGE IS DIFFERENT, ASSUME THIS IS A SECOND, THIRD,ETC/RETURN TRIP AND CHANGE CODE TO 0008A W/EOB 524 AND ENTER CLAIM. (TWO CLAIMS INVOLVED)

IF TWO LINE ENTRY OF MILEAGE CODES 0007A OR 0008A WITH DIFFERENT UNITS ON SAME CLAIM - FORCE UNTIL 8/1/96, THEN DENY W/EOB 041

3. IF UNABLE TO DETERMINE IF SECOND/RETURN TRIP - DENY W/EOB 041

4. IF YOU HAVE MED VENDOR CLAIM VS X-OVER CLAIM, CHANGE CODE TO 0008A WITH EOB 524, EVEN IF MILEAGE IS SAME.

HARDCOPY BILLINGS

1. IF MILEAGE IS DIFFERENT, ASSUME THIS IS A SECOND,THIRD,ETC/RETURN TRIP AND CHANGE CODE TO 0008A W/EOB 524.

2. IF MILEAGE SAME AND UNABLE TO DETERMINE IF SECOND/RETURN TRIP, STAGE AND PROCEED WITH DETERMINATION AS ABOVE IN ITEMS 3,4 OF THE ELECTRONIC/TAPE BILLING TEXT ABOVE.

3. IF BILLING 0007A OR 0008A TWICE ON SAME CLAIM AND MILEAGE IS DIFFERENT, STAGE TO CHECK DESTINATION. IF DESTINATION IS 50 TO 100 MILES (YAKIMA TO EASTERN STATE HOSP, VANCOUVER TO WESTERN STATE HOSP, SPOKANE TO HARBORVIEW, SEATTLE, ETC) FORCE 563 EXCEPTION UNTIL 8/1/96, THEN DENY W/EOB 041. (PROVIDER NOTIFIED VIA RA NEWSLETTER ON HOW TO PROPERLY BILL THESE CODES).

4. HARDCOPY VS TAPE/ELECTRONIC

APPLY SAME CRITERIA AS ABOVE.

AMBULANCE MILEAGE A0425 VS A0425

THIS AUDIT BYPASSES THE DUPE AUDIT, THEREFOR YOU MUST DETERMINE IF YOU HAVE A DUPLICATE, SECOND TRIP OR MORE THAN ONE CLIENT IN THE SAME AMBULANCE TRANSPORTED TO THE SAME DESTINATION. IF THE CLAIM HAS AN

OVERCODE OF 444-RESEARCH FOR MULTIPLE TRIPS AND ADJUDICATE ACCORDINGLY.

IF YOU DETERMINE THAT MORE THAN ONE CLIENT IN THE AMBULANCE WAS TRANSPORTED TO THE SAME DESTINATION(MOM & BABY) PROVIDER SHOULD BILL WITH GM MODIFIER-PAY 2 BASE RATES BUT ONLY 1 MILEAGE. DENY 2ND MILEAGE CODE W/E0B 422.

CHECK FOR ITA INDICATOR ON CLAIMS-I.E.(POSSIBLE TRANSPORT BETWEEN HOSPITALS/HARBORVIEW TO WESTERN STATE) AND TRANSPORT FROM INCIDENCE SITE TO HARBORVIEW)

ELECTRONIC/TAPE BILLINGS:

1. CHECK FOR COMMENTS REGARDING SECOND/RETURN TRIP-IF PRESENT FORCE.

2. IF NO COMMENTS BUT MILEAGE OR MODIFIER ARE DIFFERENT-FORCE (TWO CLAIMS INVOLVED).

3. IF UNABLE TO DETERMINE IF SECOND/RETURN TRIP DENY W/EOB 041.

HARDCOPY BILLINGS

1. IF MILEAGE IS DIFFERENT, ASSUME THIS IS SECOND TRIP, THIRD TRIP ETC...-FORCE.

2. IF MILEAGE IS SAME AND UNABLE TO DETERMINE IF SECOND/RETURN TRIP, STAGE AND PROCEED WITH DETERMINATION AS STATED IN ELECTRONIC/TAPE BILLING TEXT.

HARDCOPY VS TAPE/ELECTRONIC

1. APPLY SAME CRITERIA AS ABOVE

TEXT KEY	TEXT DESC
564	

TEXT KEY TEXT DESC
566 POSSIBLE DUPLICATE OF SERVICE ALREADY PAID.

1. GROUND AMBULANCE (PT 51)

A. DIFFERENT MODS (I.E HN VS NH)
1. MED VENDOR(P) VS MCARE TAPE OR MCARE HARDCOPY (O) - FORCE
2. MCARE HARDCOPY (O) VS MEDICARE TAPE (O) - OVERLOC TO 83.

B. SAME MODS (PROCEDURE CODE DOES NOT NEED TO MATCH)
1. IF HX CLAIM IS BATCH 951-957 (CASH CONTROL)- REVIEW HX CLAIM ON THE 04 SCREEN. IF CLAIM PD AT $0.00 THEN DENY SUSPENDING CLAIM W/EOB 830.
2. MED VENDOR (P) VS MCARE TAPE (O) - FORCE
3. MED VENDOR (P) VS MCARE HARDCOPY (O) - FORCE
4. MCARE HARDCOPY (O) VS MCARE TAPE (O) - PAY TAPE CLAIM AND DENY HARCOPY W/EOB 960.

C. MOD VS NO MOD (PROC CODE DOESN'T NEED TO MATCH)
1. MED VENDOR (P) VS MCARE TAPE (O) - FORCE
2. MCARE HARDCOPY (O) VS MCARE TAPE (O) - REVIEW MCARE EOMB ON HARDCOPY CLAIM FOR MODIFIER. KEY IN MODIFIER & REWORK PER EARLIER INSTRUCTIONS.

2. DME SUPPLIES (GAUZE,CATHETERS,TAPE,ETC) - CHECK MONEY AMOUNTS ON BOTH CLAIMS.
1. IF MONEY IS DIFFERENT AND EXCEPTION 261 HAS BEEN FORCED, FORCE EXCEPTION 566.
2. IF MONEY IS DIFFERENT AND EXCEPTION 261 IS SUSPENDED - STAGE TO DETERMINE IF 261 SHOULD BE FORCED.
3. IF MONEY IS SAME, UNITS, SAME - WHETHER 261 IS FORCED OR NOT - STAGE TO BE SURE IS DUP THEN DENY W/EOB 041.
4. IF MONEY DIFFERENT BUT DOS, UNITS SAME & ELECTRONIC CLAIM VS TAPE (2) X-OVER CLAIM (THE MONEY DIFFERENCE PROBABLY DUE TO ADDITION OF TAX ON X-OVER CLAIM)- DENY W/EOB 041/937.

(THIS APPLIES PRIMARILY TO RENTAL DME ON X-OVER AND/OR "P" CLAIMS -I.E. CANE, WALKER, CRUTCH(S),ETC) (MEDICARE HAS CAPPED RENTAL & WE NORMALLY ONLY PURCHASE ITEM).

5. PHYSICAL THERAPY
WITH MEDICARE BACKUP - OVERLOC TO 83
WITHOUT MEDICARE BACKUP - DENY W/EOB 937

6. ALL ELSE - OVERLOC TO 83

TEXT KEY TEXT DESC

576 MEDICARE X-OVER WITH MPI OF 3 AND ALLOWED AMOUNT OF 0.00

1. NO MC EOMB ATTACHED AND NO DEDUCTIBLE/CO-INS INDICATED IN BOX 24D ON CLAIM FORM - DENY E/EOB 310.

2. LAB HANDLING & DRAWING FEES OR ANY OTHER PROCEDURE PAID AT 100% PER MC EOMB,(CHECK BACKUP UNDER ALLOWED FIELD AND UNDER PROV PD FIELD. 100% IF $ AMOUNTS MATCH.) CHANGE PI FIELD TO 1 AND ADJUDICATE PER 451 EXCEPTION.

3. MC EOMB ATTACHED - KEY INFO FROM DEDUCTIBLE AND OR CO-INS IN ALLOWED FIELD W/INFO EOB 310.

4. MC EOMB ATTACHED BUT UNABLE TO DETERMINE PROPER DEDUCTIBLE AND OR CO-INSURANCE - PA-2.

5. BE SURE FOR DOS 1/1/98 AND AFTER, THAT YOU KEY MEDICARE PAID AMT IN ON EACH LINE LEVEL IF MC EOMB ATTACHED. DO NOT KEY ANYTHING IN MEDICARE PAID AMT AT LINE LEVEL FOR DOS PRIOR TO 1998. IF PRESENT & DOS PRIOR 1998, REMOVE & KEY ONLY ZEROS.

6. ALL ELSE - OVERLOC 83.

TEXT KEY TEXT DESC

577 ADMINISTRATION CODES (90471 &/OR 90472) BILLED IN COMBO W/VACCINES (90476 - 90749)

INFORMATION ONLY: THIS EXCEPTION POSTS WHEN THE CLIENT IS UNDER 19 YRS OLD OR OVER 18 YRS W/A B IN THE ITA FIELD & AN ADMIN CODE (90471 AND/OR 90472 IS BILLED ON THE SAME CLAIM FOR THE SAME DOS, WITH ONE OF THE VACCINES THAT ARE AVAILABLE THROUGH THE HEALTH DEPT (HD SEGMENT ON PDDD FILE). ADMIN CODES ARE ONLY ALLOWED WITH VACCINES THAT DO NOT HAVE A (HD SEGMENT ON THE PDDD FILE FOR THE SAME DOS.
INFORMATION: EXCEPTION 242 WILL NOW POST ONLY ON VACCINES THAT HAVE A (HD SEGMENT ON PDDD) AND 577 WILL NOW POST ONLY ON ADMIN CODES.

1. BILLING CRITERIA:
   A. 90471 - IS FOR THE 1ST VACCINE BILLED ON CLAIM.
   B. 90472 - IS FOR THE 2ND THRU HOWEVER MANY VACCINES BILLED ON THE CLAIM.
   C. PAY BOTH CODES IN COMBINATION IF AT LEAST 2 VACCINES W/NO HD SEGMENT ON PDDD FILE.
   D. ONLY 1 LINE OF EACH CODE IS ALLOWED. IF MORE THAN 1 LINE OF EACH IS BILLED - DENY ADDITIONAL LINES W/EOB 365.

2. PAYMENT CRITERIA:
   A. 577 IS POSTING & ALL VACCINES ON CLAIM HAVE MOD 1H/SL OR HAVE EXCEPTION 242 POSTING ON THEM - DENY, OTHERWISE;
   B. THERE MUST BE AT LEAST ONE VACCINE ON CLAIM W/NO 1H/SL MOD OR 242 NOT POSTING TO FORCE 90471, OR;
   C. THERE MUST BE 2 OR MORE VACCINES ON CLAIM W/NO 1H/SL MOD OR 242 NOT POSTING TO FORCE 90472.

TEXT KEY TEXT DESC
582 CLAIM IS GROUPING TO TRANSPLANT DRG 103, 302, 480, 795, 803, 804, OR 805

OUT OF STATE HOSPITALS (WILL ALSO POST EXCEPTION 317):
1. IF NO AUTH - DENY W/EOB 023.
2. IF AUTH - EE: OVERLOC TO 23
RES: IF SERVICES BILLED MATCH AUTH - FORCE. OTHERWISE -
DENY WITH EOB 251.

IN STATE HOSPITALS:
1. IF HOSPITAL AND DRG ARE LISTED BELOW - FORCE.
2. IF HOSPITAL AND DRG ARE NOT LISTED BELOW:
A. IF NO AUTH - DENY.
B. IF AUTH - EE: OVERLOC TO 23.
RES: CHECK AUTH FILE - IF SERVICES BILLED MATCHES AUTH -
FORCE. IF SERVICES BILLED DO NOT MATCH AUTH - DENY
WITH EOB 251.

--NOTE--IF CLIENT IS MANAGED BY A PCCM AS FOUND ON PAGE 6 OF THE
ELIGIBILITY FILE & CLIENT IS REFERRED BY THE SAME PCCM - FORCE.

DRG CODE 103 (HEART)	3306206	CHILDREN'S HOSP & MED CTR - SEATTLE
	3358801	OREGON HEALTH SCIENCES UNIV - PORTLAND
	3304201	SACRED HEART MEDICAL CENTER - SPOKANE
	3348802	UNIVERSITY OF WASHINGTON
DRG CODE 302 (KIDNEY)	3306206	CHILDREN'S HOSP & MED CTR - SEATTLE
	3358801	OREGON HEALTH SCIENCES UNIV - PORTLAND
	3304201	SACRED HEART MEDICAL CENTER - SPOKANE
	3309200	SWEDISH HOSP & MED CENTER
	3348802	UNIVERSTIY OF WASHINGTON
	3315009	VIRGINIA MASON HOSPITAL
DRG CODE 480 (LIVER)	3306206	CHILDREN'S HOSP & MED CTR - SEATTLE
	3358801	OREGON HEALTH SCIENCES UNIV - PORTLAND
	3348802	UNIVERSITY OF WASHINGTON HOSPITAL
DRG CODE 795 (LUNG)	3304201	SACRED HEART MED CTR - SPOKANE
	3348802	UNIVERSITY OF WASHINGTON HOSPITAL
DRG CODE 803 (ALLOGENIC BONE MARROW TRANSPLANT)	3306206	CHILDREN'S HOSP & MED CTR - SEATTLE
	3094604	FRED HUTCHINSON CANCER RESEARCH CENTER
	3308707	GOOD SAMARITAN HOSP - PUYALLUP
	3361102	LEGACY GOOD SAMARITAN - PORTLAND
	3358801	OREGON HEALTH SCIENCES UNIV - PORTLAND (FOR DORENBACHER CHILDREN'S HOSPITAL)
	3302601	PROVIDENCE ST. PETER HOSPITAL
	3022936	SEATTLE CANCER CARE ALLIANCE
	3309309	ST JOSEPH'S HOSPITAL - TACOMA
	3309200	SWEDISH HOSP & MED CENTER
	3348802	UNIVERSITY OF WASHINGTON HOSPITAL
	3315009	VIRGINIA MASON HOSPITAL

	3304201	SACRED HEART MED CTR - SPOKANE (FOR INLAND NW BLOOD CTR)
DRG CODE 804	3306206	CHILDRENS HOSP & MED CTR - SEATTLE
(AUTOLOGOUS	3094604	FRED HUTCHINSON CANCER RESEARCH CENTER
BONE MARROW	3308707	GOOD SAMARITAN HOSP - PUYALLUP
TRANSPLANT)	3361102	LEGACY GOOD SAMARITAN HOSP - PUYALLUP
	3358801	OREGON HEALTH SCIENCES UNIV - PORTLAND (FOR DORENBACHER CHILDREN'S HOSPITAL)
	3302601	PROVIDENCE ST. PETER HOSPITAL
	3022936	SEATTLE CANCER CARE ALLIANCE
	3309309	ST JOSEPH'S - TACOMA
	3309200	SWEDISH HOSP & MED CTR
	3348802	UNIVERSITY OF WASHINGTON HOSPITAL
	3315009	VIRGINIA MASON HOSPITAL
	3304201	SACRED HEART MED CTR - SPOKANE (FOR INLAND NW BLOOD CTR)
	3300340	MARY BRIDGE CHILDREN'S HOSPITAL
DRG CODE 805	3348802	UNIVERSITY OF WASHINGTON HOSPITAL
(KIDNEY/	3315009	VIRGINIA MASON HOSPITAL
PANCREAS)	3358801	OREGON HEALTH SCIENCES UNIV - PORTLAND

TEXT KEY TEXT DESC
583 INVALID PROVIDER NUMBER TO PROCEDURE CODE.

ONLY APPROVED CENTERS OF EXCELLENCE CAN BILL ICD-9-CM SLEEP STUDY PROCEDURE CODES 89.17 OR 89.18.

1. IF CLAIM HAS DIAGNOSES CODE 780.51, 780.53, 780.57, OR 347, BUT NOT PROCEDURE CODE 89.17 OR 89.18 - FORCE.

2. IF CLAIM HAS PROCEDURE CODE 89.17 OR 89.18, IT MUST ALSO HAVE DIAGNOSES CODE 780.51, 780.53, 780.57, OR 347 AND BE ONE OF THE HOSPITALS LISTED BELOW.

A. IF CLAIM MEETS "ALL" OF THE CRITERIA LISTED ABOVE - FORCE.
B. IF CLAIM DOES NOT MEET "ALL" OF THE CRITERIA LISTED ABOVE - DENY.

3100062 - HARBORVIEW MEDICAL CENTER
3149401 - AUBURN REGIONAL MEDICAL CENTER
3309606 - HOLY FAMILY HOSPITAL - DENY DOS PRIOR TO 01/12/04. *SH
3300258 - ST CLARE HOSPITAL
3300332 - TACOMA GENERAL HOSPITAL
3300340 - MARY BRIDGE CHILDREN'S HOSPITAL
3302601 - ST PETER HOSPITAL/PROVIDENCE
3303104 - ST MARY MEDICAL CENTER
3303500 - HARRISON MEMORIAL - DENY DOS PRIOR TO 01/01/03.
3304201 - SACRED HEART MEDICAL CENTER/SPOKANE
3306206 - CHILDREN'S HOSPITAL & MEDICAL CENTER - DENY DOS 09/01/04 AND AFTER. *SH
3307402 - PROVIDENCE YAKIMA MEDICAL CENTER - DENY DOS 02/01/04 AND AFTER.
3308707 - GOOD SAMARITAN HOSPITAL/PUYALLUP - DENY DOS 10/01/02 AND AFTER.
3309200 - SWEDISH HOSPITAL MEDICAL CENTER
3309507 - SWEDISH MEDICAL CENTER/PROVIDENCE
3309609 - PROVIDENCE GENERAL MEDICAL CENTER (SEATTLE/EVERETT) - DENY DOS 02/01/04 AND AFTER.
3312204 - VALLEY MEDICAL CENTER/RENTON - DENY DOS 02/01/04 AND AFTER.
3315009 - VIRGINIA MASON HOSPITAL
3319506 - HIGHLINE COMMUNTIY HOSPITAL
3340809 - OVERLAKE HOSPITAL (EASTSIDE SLEEP DISORDERS CLINIC) - DENY DOS PRIOR TO 03/01/03.
3343407 - ST JOSEPH HOSPITAL/IDAHO
3347606 - MID-COLUMBIA MEDICAL CENTER/OREGON
3361102 - GOOD SAMARITAN HOSPITAL/PORTLAND

TEXT KEY TEXT DESC
585

LOC 57

I. LOOK FOR BABY'S PIC. IF FOUND - DENY. (NOTE) DENY EVEN IF CLAIM STATES "BABY'S DATE OF BIRTH > THAN 6 MONTHS ON NOT ON MEDICAID".

II. IF PIC NOT FOUND AND COMMENT ON CLAIM STATES: MOVED OUT OF STATE, BABY ADOPTED, FOSTER CARE, BABY DIED, BABY'S DATE OF BIRTH > THAN 6 MONTHS AND NOT ON MEDICAID - FORCE.

TEXT KEY TEXT DESC

586

PSYCHIATRIC CLAIM WITH NO "88" AUTHORIZATION NUMBER.

1. FORCE THE FOLLWING:
   A. SWING BEDS
   B. LATE CHARGES
   C. CUP (REVENUE CODE 168)
   D. ITA ADMITS PRIOR TO 01/01/99

2. ALL ELSE - IF NO "88" AUTH NUMBER - DENY.

TEXT KEY TEXT DESC

589 PSYCHIATRIC CLAIMS FOR TREATMENT (90804-90899) OR (G0071-G0094). THE ABOVE SERVICES ARE CURRENTLY NOT PAYING THE CORRECT AMOUNT TO THE PROVIDER.

IF DATES OF SERVICE ARE 1/1/98 AND AFTER DO THE FOLLOWING:
1. IF ATTACHED EOMB HAS REASON CODE PR-122 ON THE LINE FOR THE ABOVE CODES, CLAIMS PROCESSING MUST DO THE FOLLOWING:
   A. KEY "2" IN THE MPI FIELD.
   B. FORCE THE 589 EXCEPTION AND ENTER.
2. IF ATTACHED EOMB HAS NO PR-122 ON THE LINE FOR THE ABOVE CODES:
   A. KEY "3" IN THE MPI FIELD.
   B. FORCE THE 589 EXCEPTION AND ENTER.

IF DATES OF SERVICE ARE BEFORE 1/1/98 DO THE FOLLOWING:
1. IF ATTACHED EOMB HAS REASON CODE PR-122 ON THE LINE FOR THE ABOVE CODES, CLAIMS PROCESSING MUST DO THE FOLLOWING:
   A. KEY "2" IN THE MPI FIELD.
   B. IF MEDICARE REMITTANCE NOTICE IS ATTACHED, ADD THE REDUCTION AMOUNT (RC-AMT) IN THE FAR RIGHT COLUMN TO THE DEDUCTIBLE &/OR CO-INSURANCE FOR EACH DETAIL LINE AND INSERT IN ALLOWED AMOUNT FIELD ON THE SCREEN. IF NO (RC-AMT) - ENTER ONLY CO-INSURANCE/ DEDUCTIBLE FOR EACH DETAIL LINE IN THE ALLOWED AMT FIELD ON THE SCREEN.
   C. IF EXCEPTION 856 POSTS AFTER ENTERING, ALSO ADD THE REDUCTION AMOUNT (RC-AMT'S) TO THE MEDICARE ALLOWED $ AND INSERT IN THE MEDICARE ALLOWED FIELD ON THE SCREEN.
   D. FORCE THE 589 EXCEPTION AND ENTER.
2. IF ATTACHED EOMB HAS NO PR-122 ON THE LINE FOR THE ABOVE CODES:
   A. KEY "3" IN MPI.
   B. FORCE THE 589 EXCEPTION AND ENTER.
3. IF NO CO-INSURANCE OR BACKUP - DENY W/EOB'S 310/224.
4. IF 856 IS STILL POSTING - O'LOC TO 83.

TEXT KEY	TEXT DESC
593	

TEXT KEY TEXT DESC

596 IF EXCEPTION 452 FAILING, WORK IT FIRST & IF DENYING THE 452 DO NOT WORK EXCEPTION 596.

IF EXCEPTION 263 IS POSTING, MDCR EOMB HAS REMARK CODE OA-23 (CHARGES PD BY ANOTHER PAYOR), MDCR PAID AT $0.00, - FORCE EXCEPTION 596. (MAA OWES NO PAYMENT & CLAIM WILL GO TO TPL).

CONTRACT ADJUST TOS (9)
1. MED VENDOR TOS 9 - PHYSICAL THERAPY (PT 34) IF MEDICARE ALLOWED & THE BACKUP HAS A SIX DIGIT NUMBER, OR SIX DIGIT NUMBER FOLLOWED BY "A" ON TOP OF RA/EOMB, DENY W/EOB 565.

2. MED VENDOR TOS 9 - GROUND OR AIR AMBULANCE (PT 51 OR 53) EE - PA2, RESOLUTIONS: SEE 856 TEXT TO ADJUDICATE.

3. MED VENDOR TOS 9-BACKUP HAS MEDICARE EOB CO-29 DENY W/ EOB 334.

PHYSICIAN TOS (3 OR Z) - MEDICARE BACKUP INDICATES NO PAYMENT TO THE PROVIDER OR ALL THE PAYMENT IS ON 1 LINE ON A MULTIPLE LINE CLAIM AND THERE IS OTHER INS BACKUP ATTACHED, IT IS PROBABLY MSP.
1. IF NO DEDUCTIBLE/CO-INS - DENY AT HEADER W/EOB 904.
2. IF DEDUCTIBLE/CO-INS. - O'LOC TO 83.
3. IF PSYCH CODES (908--) OR G00--) - O'LOC TO 83.

PHYSICIAN TOS (3 OR Z) - KEY ALL INFO FROM THE BACKUP INTO THE APPROPRIATE FIELDS ON THE SCREEN. IGNORE THE CONTRACT ADJUST INFO. IF CLAIM BALANCES PROCESS. IF CLAIM DOES NOT BALANCE, CHECK KEYING, IF KEYED CORRECTLY AND BACKUP INDICATES ONE OF THE FOLLOWING, DENY W/EOB 565.

1.CLAIM CANNOT BE PROCESSED BECAUSE THE RA ATTACHED IS NOT SPLIT OUT, INFO IS NOT ON CLAIM AND YOU CANNOT SPLIT. DO NOT APPLY THIS RULE TO AMBULANCE SVS - EE: PA2 RES: SEE 856 TEXT.

2.PROVIDER # (6 DIGIT) AT TOP OF RA/EOMB BEGINS W/A (5)

3.RURAL HLTH, COMMUNITY HLTH OR HOSPITAL IS INDICATED IN PROVIDER NAME FIELD ON RA/EOMB.

4.BILL TYPE ON RA/EOMB BEGINS W/A (1). IE (141)

5.BACKUP STATES PART A. DO NOT APPLY THIS IS TO AMBULANCE SVS EE:PA2 RES: SEE 856 TX.

6. BACKUP HAS MEDICARE EOMB CO-29 - DENY W/EOB 334.

7. OTHERWISE - NO AMOUNT ON MDCR BACKUP - DENY.

8.ANY OTHER ISSUE IN QUESTION - SEE YOUR SUP TO ASSIST IN PROCESSING.

TEXT KEY TEXT DESC
597

BILLING PROVIDER # ON CLAIM IS SAME AS PERFORMING PROVIDER # ON OTHER CLAIM OR BILLING #'S ON BOTH CLAIMS ARE DIFFERENT AND PERFORMING PROVIDER #'S ARE SAME OR BILLING # ON BOTH CLAIMS ARE SAME & PERFORMING #'S ARE DIFFERENT.
NOTE: HISTORY ADJUSTMENTS WITH BATCH RANGE 951-957 AND 928 OR 931 EOB - FORCE. EXCEPTION: IF DETAIL LINE PROCEDURE, MONEY & UNITS ARE AN EXACT MATCH - IF CARRIER CODE ON HX CLAIM IS (1111) - FORCE, OR IF "ADJ-R" IS "E" - FORCE, OTHERWISE - DENY W/EOB 830. EXCEPTION: IF CLAIM IN HISTORY IS (HX ONLY ADJ) FOR QRS/PIP AND CAMERA/REEL # IS (77) - SEE YOUR SUP BEFORE PROCESSING.

NOTE: IF 101/102/599 FAILING ON THE SAME LINE(S) AS 597 AND THE HISTORY IS THE SAME - WORK THE DUPE. IF YOU FORCE THE DUPE THEN ALSO FORCE THE 597. IF THE HISTORY IS DIFFERENT - SEE YOUR TRAINER.

NOTE: SERVICES FOR BABY VS PARENT - FORCE.

NOTE: MODIFIER (AN) VS BLANK - FORCE. (EXCEPTION: IF LOOKS LIKE A REBILL, SEE APPROPRIATE SECTION).

NOTE: IF EVERY DETAIL LINE IS NOT FAILING 597 AND CLAIM TOTALS ARE SAME - REVIEW FOR POSSIBLE DUPE, IF SO, DENY APPROPRIATELY.

1. E & M PROCEDURES (99201-99456)
   A. SAME SERVICES - DENY. NOTE: IF EVERY DETAIL LINE IS NOT FAILING, CHECK HISTORY CLAIM FOR POSSIBLE DUPE, IF SO, DENY APPROPRIATLEY.
      1) ER VS ER (99281-99285)
         A) UNRELATED DX - FORCE
         B) DIFFERENT TIMES - FORCE
         C) OTHERWISE - DENY. (IF BOTH SUSPENDING - PAY HIGHER)
      2) ADMIT (99221-99223) - FORCE IF UNRELATED DX

   NOTE: ANY UNUSUAL CIRCUMSTANCES - SEE YOUR TRAINER

   B. DIFFERENT SERVICES/DIFFERENT LEVELS
      1) ADMIT VS CRITICAL CARE - FORCE.
      2) ADMIT (99221-99223) VS ADMIT - FORCE IF UNRELATED DX
      3) CONSULTATION (99241-99263) VS CRITICAL CARE (99291-99292)- FORCE.
      4) CONSULTATION (99241-99263) VS ROUTINE N.B CARE (99431) - FORCE
      5) CONSULTATION (99241-99245) VS ER (99281-99285) - FORCE.
      6) HOSPITAL DISCHARGE (99238/99239) VS NURSING FACILITY (99301-99303, 9311-99313, 99321-99323, 99331-99333) - FORCE
      7) CRITICAL CARE (99291-99292) VS N.B. RESUC (99440) - FORCE.
      8) CRITICAL CARE (99291-99292) VS ANYTHING - UNRELATED DX - FORCE OTHERWISE, PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 825. IF HX IS PAID, DENY OR RECOUP AND DENY THE LESSER W/EOB 825.
      9) CRITICAL CARE (99291 VS 99292) - FORCE.

10) N.B. CARE (99431) VS NICU (99295-99297) OR N.B. RESUC (99440)- FORCE
11) N.B. CARE 99431) VS ANYTHING ELSE W/UNRELATED DX - FORCE
12) NICU (99295-99297) VS E & M W/MOD 25 - FORCE
13) NICU (99295-99297) VS PROLONGED CARE (99354-99354) OR RESUC (99440) - FORCE
14) TEAM CONF (99361-99362), PHONE CALLS (99371-99373) OR CARE PLAN SERVICES (99375-99376) VS ANYTHING - FORCE.
15) ER (99281-99285) VS ER
A) UNRELATED DX - FORCE
B) DIFFERENT TIMES - FORCE
C) OTHERWISE - DENY. IF BOTH SUSPENDING - PAY HIGHER
16) ALL ELSE - PAY THE HIGHER IF BOTH SERVICES ARE SUSPENDING, DENY THE LESSER W/EOB 106. IF HX IS PD, DENY THE CURRENT.

NOTE: ANY UNUSUAL CIRCUMSTANCES - SEE YOUR TRAINER

2. IMMUNIZATIONS/INJECTIONS
A. REBILLS - DENY.
B. IF CONSECUTIVE/MULTIPLE SERVICES ALLOWED - FORCE.
C. FLU IMMUMIZATION (90724), DIFFERENT STRAINS - FORCE
D. THERAPEUTIC/DIAGNOSTIC INJECTIONS (90782-90799) - MULTIPLES BILLED W/DIFFERENT "J" OR "Q" CODES - FORCE.
E. ALL ELSE - DENY

3. EYE SERVICES
A. ANESTHESIA MODIFIER VS ANY MODIFIER OR BLANK - FORCE.
B. PT 22 AMBULATORY SURGERY VS ANY PROVIDER TYPE OTHER THAN 22 - FORCE.
C. ALL ELSE - DENY, UNLESS UNUSUAL CIRCUMSTANCES, SEE YOUR TRAINER

4. RADIOLOGY
NOTE: IF CLAIM INDICATES SEPARATE/DIFFERENT TIMES OF DAY - FORCE.
NOTE: IF DIFFERENT POS ARE BILLED - FORCE. EXCEPT RADIATION ONCOLOGY CLINICAL TREATMENT PLAN (77261-77263), RADIATION TREATMENT DEL (77401-77416,77418), RADIATION TREATMENT MANAGEMENT (77427, 77431-77432,77470,77499) AND PROTON BEAM TREATMENT DELIVERY (77520,77522-77523,77525) SEE BELOW.
NOTE: IF MRI'S - OVERLOC TO LOC 83 FOR REVIEW.

(DIFFERENT BILLING PROVIDERS)
A. MODIFIER TC VS BLANK MODIFIER PAID IN HISTORY - DENY W/EOB 455.
B. MODIFIER 26 VS BLANK MODIFIER PAID IN HISTORY - DENY W/EOB 455 EXCEPT IF MOD 77 OR O'CODE 223 - FORCE.
C. BLANK MODIFIER SUSPENDING VS TC MODIFIER PAID - DENY W/EOB 975.
D. BLANK MODIFIER SUSPENDING VS 26 MODIFIER PAID - DENY W/EOB 975 EXCEPT IF MOD 77 OR O'CODE 223 - FORCE.
E. MODIFIER TC VS BLANK MODIFIER, BOTH SUSPENDING - PAY BLANK MOD AND DENY TC MODIFIER W/EOB 455.
F. MODIFIER 26 VS BLANK MOD, BOTH SUSPENDING - PAY BLANK MOD & DENY 26 MOD W/EOB 455. EXCEPT: MOD 77 OR O'CODE 222 - FORCE.
G. BLANK MOD VS BLANK MOD
1) IF PERFORMING PROVIDERS ARE SAME- DENY.
2) OTHERWISE - DENY W/EOB 280.
H. TC VS TC MOD

1) IF PERFORMING PROVIDERS ARE SAME - DENY.
2) OTHERWISE - DENY W/EOB 280.

I. RT VS RT MOD OR LT VS LT MOD
1) IF PERFORMING PROVIDERS ARE SAME - DENY.
2) OTHERWISE - DENY W/EOB 280.

J. RT OR LT MOD VS BLANK MOD - BOTH SUSPENDING, PAY BLANK MOD AND DENY LT/RT MOD W/EOB 280. OTHERWISE, ONE PAID - DENY CURRENT W/EOB 280.

K. 1M MOD VS 26 MOD - FORCE.

L. ANESTHESIA MOD VS ANY OTHER MODIFIER OR BLANK - FORCE.

M. 26 VS 26 MOD -
1) DIFFERENT PERFORMING PROVIDER - FORCE.
2) SAME PERFORMING PROVIDER - DENY.

N. MOD 1R VS MOD 26 - FORCE, EXCEPT MRI & CT SCAN.

O. MOD 77/O'CODE 223 VS ANY - FORCE. EXCEPT MRI/CAT SCAN.

P. IF NOT ADDRESSED ABOVE - SEE YOUR SUP.

(SAME BILLING PROVIDER # AND DIFFERENT PERF. PROV)

A. 26 VS 26 MOD-
1) IF IT LOOKS LIKE A REBILL - DENY.
2) IF CONSECUTIVE CLAIM OR NOT A TOTAL CLAIM REBILL - FORCE.
EXCEPTION - RADIOTION ONCOLOGY CLINIC TREATMENT PLAN (77261-77263), MEDICAL RADIATION PHYSICS (77399), AND RADIATION TREATMENT MANAGEMENT (77427,77431-77432,77499) - DENY.

B. MOD 26 OR TC VS BLANK MOD PAID IN HX - DENY W/EOB 455.

C. BLANK MOD SUSPENDING VS 26/TC MOD PAID - DENY W/EOB 975.

D. MOD 1R VS MOD 26 - FORCE, EXCEPT MRI & CT SCAN.

E. MOD 77/O'CODE 223 VS ANY - FORCE. EXCEPT CAT SCANS/MRI.

F. BLANK MOD VS BLANK MOD: LOOKS LIKE EXACT REBILL - DENY W/EOB 280.
1) IF IT LOOKS LIKE AN EXACT REBILL - DENY.
2) IF CONSECUTIVE CLAIM OR NOT A TOTAL CLAIM REBILL - FORCE, EXCEPTION: SEE 3) BELOW.
3) RADIATION ONCOLOGY MEDICAL RADIATION PHYSICS (77336,77370), RADIATION TREATMENT DELIVERY (77401-77416,77418), RADIATION TREATMENT MANAGEMENT (77427,77431,77432,77470,77499) & PROTON BEAM TREATMENT DEL (77520,77522-77523,77525) - DENY.

G. TC MOD VS TC MOD - RADIATION ONCOLOGY MEDICAL RADIATION PHYSIC (77399), RADIATION TREATMENT MANAGEMENT (77431-77432, 77499) - DENY.

H. ALL ELSE - OVERLOC TO 83.

5. LAB INCLUDING (36415)
A. DIFFERENT BILLING # & SAME PP # - DENY W/EOB 102/106.
B. BILLING # ON 1 CLAIM IS SAME AS PP # ON ANOTHER CLAIM - DENY W/EOB 102/106.
C. SAME BILLING # & DIFFERENT PP #:
1) 36415 (BLOOD DRAW) - 2 SEPARATE TESTS (DIFF LAB PROCEDURES BILLED) - FORCE.
2) MOD 90:
A) HX PD W/MOD 90 - DENY CURRENT.
B) CURRENT BILLED W/MOD 90 - FORCE AND R/D HX CLAIM W/EOB 106.

C) BOTH CLAIMS ARE SUSPENDING - PAY THE CLAIM W/MOD 90 AND DENY THE OTHER CLAIM.

3) PROVIDER IS BILLING THE FOLLOWING CODES FOR MOD 26 & BLANK IN COMBINATION - FORCE. REASON: THE TECH (TC) SEGMENT HAS BEEN REMOVED FROM PAYMENT FIELD ON PDDD & BILLING THE BLANK MOD PROCEDURE IS THE ONLY WAY THEY CAN RECEIVE THE TECHNICAL PORTION.
83020,83912,84165,84181,84182,85390,85576,86255,86256,86320
86325, 86327, 86334, 87164, 87207, 88151, 88157, 88371,
88372,89060,P3001.

4) ALL ELSE - DENY.

D. ALL ELSE - OVERLOC TO 34. LOC 34 - IF COMBINATION OF CLAIMS INDICATE A LAB (PT 43) AND PHYSICIAN (PT 20, ETC) BILLING FOR 100% VS 100%, TC OR PC - RT TO MMIS, SANDY,MS 45564-INDICATING THE SITUATION.

6. MATERNITY SUPPORT SERVICES PT 35

A. PROCEDURE CODES (0400M-0405M) OR (0420M-0421M): ALLOW 1 PER DAY OF EXACT CODE MATCH; OTHERWISE - DENY WITH EOB 910.

B. MSS/FQHC PT 35/SPEC 90: IF DENYING THE ABOVE MSS PROCEDURE CODE, MANUALLY DENY MSS ENCOUNTER 9006M WITH EOB 837 ON SAME CLAIM.

TEXT KEY TEXT DESC

599 EXACT DUPLICATE FOR PT 73 OR 35 & PROVIDERS WITH SPECIALTY 90.

1. COMMUNITY MENTAL HEALTH (PT 73)
   A. IF CODES 0852J-0853J, 0855J-0857J (CLOZARIL) - DENY WITH EOB 910.
   B. IF X-OVER CLAIM & MEDICARE HAS ALLOWED - FORCE.
   C. CHM-PHP TIER PAYMENTS (0450M,0451M,0452M,0453M) - PAY ONLY ONE, DENY ALL OTHERS.
   D. "HARCOPY" WITH PROCEDURE CODES
      1) ON SEPARATE OR NON CONSECTUTIVE CLAIMS - DENY.
      2) IF ON SAME OR CONSECUTIVE CLAIMS - FORCE.

      "ELECTRONIC"- ALL OTHER CODES AND DUPLICATE SERVICES BILLED ON SAME CLAIM,CONSECUTIVE CLAIM OR ANY CLAIM IN THE JULIAN DATE (2ND-5TH DIGIT) OF THE ICN - FORCE.
   E. RES & ADJUSTMENTS-IF PROVIDER STATES "NOT A DUPLICATE, DIFFERENT STAFF, DIFFERENT TIME" OR NAME OF DIFFERENT PERFORMING PROVIDER - FORCE. ALSO, IF CLAIM OR ADJUSTMENT STATES "SERVICES IN ADDITION TO PREVIOUSLY BILLED SERVICES" - FORCE.
   F. T1015 W/MOD HE (DATES OF SERVICE 10/01/03 & AFTER) ONLY ALLOW ONE FQHC ENCOUNTER PER DAY - DENY ADDITIONALS.

2. MATERNITY SUPPORT SVCS. (PT 35):
   A. PROC CODES (0400M-0405M) OR (0420M-0421M) -
      1. FOR DATES OF SERVICE 9/30/03 & BEFORE, ALLOW 1 PER DAY OF EXACT CODE MATCH; DENY ADDITIONALS. DENY MSS ENCOUNTER 9006M WHEN DENYING ABOVE PROCEDURE ON SAME CLAIM.
      2. FOR DATES OF SERVICE 10/01/3 & AFTER, ALLOW MULTIPLE UNITS FOR SAME DATE OF SERVICE. EXCEPTION: IF ENTIRE CLAIM OR LINE APPEARS TO BE A DUPE, DENY WITH EOB 102.
   B. T1015 (PT 35-MSS WITH SPEC. 90-FQHC) FOR DATE OF SERVICE 10/01/03 AND AFTER, ALLOW ONE FQHC ENCOUNTER PER DAY - DENY ADDITIONALS.
   C. T1017 WITH MOD HD, MULTIPLE UNITS ARE ALLOWED FOR SAME DATE OF SERVICE. EXCEPTION: IF ENTIRE CLAIM OR LINE APPEARS TO BE A DUPE, DENY WITH EOB 910. (NEW INFANT CASE MANAGEMENT)

3. FQHC'S (SPECIALTY 90) - T1015 - ENCOUNTER AS OF 10/01/03 & AFTER:
   ONLY ALLOW 1 PER DAY. DENY ADDITIONALS W/EOB 910.
   EXCEPTION: ONLY ALLOW MULTIPLES WHEN T1015 IS BILLED WITH MODIFIER TH WHEN BILLING IN COMBO WITH A GLOBAL MATERNITY PROCEDURE CODE.

-- ALL ELSE THAT FAILS, SEE THE 101 TEXT FILE AND THE APPROPRIATE AREA FOR ADJUDICATION. --

TEXT KEY TEXT DESC

601 CLIENT IS IN MANAGED HEALTHCARE & POS "1"

*IF EXCEPTION 552 AND/OR 520 IS FORCEABLE PER THE RELEVANT TEXT - ALSO FORCE THE 601.

EXAM ENTRY

1. IF TOTALLY DENYING CLAIM FOR OTHER SUPER SUSPEND (1 STATUS) EXCEPTION POSTING - FORCE EXCEPTION CODE 601.

2. IF DATES IN BOX 18 (HOSPITALIZATION DATES) &:

   A. IF ALL DETAIL LINE DOS ARE THE SAME DATE AS FIRST DAY OF HOSPITALIZATION - DENY.

   B. ALL ELSE - DOS ON CLAIM IS WITHIN OR PRIOR TO THE HOSPITALIZATION, POS "1" PUT AN "X" IN LMC FIELD, ENTER CLAIM AND PA-2 THE 601 & 116. (NOTE: ENTER HOSPITALIZATION DATES ON THE COMMENT SCREEN.)

   C. ALL ELSE - PUT AN "X" IN LMC FIELD, ENTER CLAIM AND PA-2.

RESOLUTIONS

1. IF AUTH NUMBER ON CLAIM WORK PER 552 TEXT.
2. CHECK PCOP SCREEN & IF NOT IN HMO ON ADMIT DATE - FORCE 601 & ALSO 552 OR 520.
3. ALL ELSE - DENY.

TEXT KEY TEXT DESC

602 NO RECORD OF THIS AUTHORIZATION ON FILE.

PHYSICIANS (J):

1. IF PROCEDURE/SERVICE DOES NOT REQUIRE AUTHORIZATION - REMOVE THE AUTH # FROM CLAIM.
2. EFF DOS 3/98 - (LOC 23) DENY ONLY DETAIL LINES THAT REQUIRE AUTH OR ARE POSTING FOR A LIMIT AUDIT. IF DENYING ON DETAIL LINE- FORCE 602 EXCEPTION.
3. IF OTHER THAN THE ABOVE, CHECK AUTH ON 11 SCREEN
   A. IF A VALID PURGED AUTH # - SEND TO DHSQS/QFFS/NCC/45506/ W/PURGED DATE TO BE REBUILT.
   B. IF INVALID AUTH #, DO PIC SEARCH FOR VALID AUTH, IF FOUND - KEY IN AND REVIEW, IF NO VALID AUTH - DENY W/EOB 237.
4. IF AUTH # APPEARS TO BE FOR EXPEDITED AUTH (3/1/98 DOS & AFTER) - IF "87" & LAST "3 DIGITS" ARE SUBMITTED - RE-KEY THE #,OTHERWISE - DENY.

HOSPITALS CLAIMS (M,R,S): CHECK KEYING, IF CORRECT - DENY.

TEXT KEY TEXT DESC

603 CHECK PRIOR AUTHORIZATION SCREEN TO SEE IF NOTES INDICATE THAT FURTHER JUSTIFICATION OR INFORMATION IS NEEDED.

1. STERILIZATIONS - OVERLOC TO 18.
2. HYSTERECTOMIES - OVERLOC TO 18.
3. PENDING FOR ELIGIBILITY AND RECIPIENT IS ELIGIBLE:
   A. DENTAL - DENY.
   B. PHARMACY - OVERLOC TO 22.
   C. OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES - OL TO 22.
   D. ALL ELSE - OVERLOC TO 47.
4. IF SCREEN IS BLANK
   A. DENTAL - OVERLOC TO 25.
   B HOME HEALTH - OVERLOC TO 31.
   C. PHARMACY AND OUTPATIENT PT, OT OR SPEECH THERAPY - OVERLOC TO 22.
   D. PHYSICIANS - REMOVE AUTH #.
5. INFO ON AUTH SCREEN INDICATES THAT THE PROCEDURES ARE APPROVED (E.G. UNITS, MONEY, SOMETHING IN THE NOTES, ETC.) OR IF PENDING FOR OTHER MEDICAL REASONS OR ISSUES SUCH AS (PENDING DX, PENDING HARD COPY, CONSULTANT WANTS TO REVIEW PROCEDURES, AIDS PATIENT, OR REQUESTING OF OE/TRSR), THEN MANUALLY ROUTE ROUTE WORKSHEET, CLAIM &/OR BACKUP TO DMM/PMAS/NCC, MS 5506.

   NOTE - BE SURE TO WRITE CLEAR INSTRUCTIONS ABOUT WHAT UPDATE SHOULD BE MADE OR WHAT THE ISSUE IS.

6. ALL ELSE - DENY.

TEXT KEY TEXT DESC
604 RECIPIENT ON CLAIM DOES NOT MATCH RECIPIENT IN AUTH FILE

1. DENTAL
   A. EXAM ENTRY - PA2.
   B. RES - IF PIC HAS TIEBREAKER "3" OR FOSTER CARE - GIVE TO SUP.

2. MED VENDOR (P)
   A. EXAM ENTRY - PA2.
   B. RES -
      1) IF DIFFERENT CLIENT ON CLAIM THAN IN AUTH FILE - DENY.
      2) REVIEW FOR KEYING ERROR IN THE AUTH FILE (E.G. DATE MISS KEYED) AND CONTACT THE APPROPRIATE PERSON IN QUS TO CORRECT - AFTER IT HAS BEEN CORRECTED - ENTER & PA2 604.

TEXT KEY TEXT DESC
606 DOS ON CLAIM NOT ON PA FILE

ADJUSTMENTS: AUTHORIZATION ISSUES ARE TO BE ADDRESSED ONLY IF THE CORRECTION IS TO MATCH SERVICES ORIGINALLY AUTHORIZED. TRANSPORTATION - DENY 237. ANYTHING ELSE - DENY 236.

RES AND ADJUSTMENTS: WHEN THIS TEXT SAYS TO FORCE 606, ALSO FORCE EXCEPTIONS 341/349/353 IF FAILING ON SAME LINES.

1. STERILIZATIONS - OVERLOC TO 18.

2. PHYSICIAN CLAIMS HYSTERECTOMIES - OVERLOC TO 17. HOSPITAL CLAIMS FOR HYSTERECTOMIES OVERLOC TO 26.

3. OUTPATIENT HOSPITAL CLAIMS - PHYSICAL THERAPY OR MRI - DENY. HOME
   A. PHYSICAL THERAPY OR MRI - DENY.
   B. HOME HEALTH (PT 44) IF DATES DON'T MATCH - SPLIT LINE & DENY DATES NOT LISTED W/EOB 717.
   C. ALL ELSE - DENY.

4. TRANSPORTATION (P) - OVERLOC TO 83.

5. DENTAL (K)
   A. GAU/MIP - IF APPROVED WITHIN 3 DAYS AFTER THE FACT, SEND TO QUS FOR UPDATE, OTHERWISE DENY.
   B. ORTHODONTIC CODES (0806D-0875D) - IF UNITS LEFT UNUSED OVERLOC TO 25.
   C. PARTIAL DENTURES (05213-05214, D5213-D5214) - DENY.
   D. ALL ELSE - IF UNITS OR MONEY APPEAR ON AUTH SCREEN, SEND TO QUS FOR UPDATE. IF NO UNITS OR MONEY - FORCE.

6. SPECIAL DUTY NURSING - IF ALL DATES NOT COVERED ON AUTH SCREEN,
   A. IF ALL THE DATES ARE NOT COVERED ON THE AUTH SCREEN - DENY ENTIRE LINE.
   B. IF PARTIAL DATE WITHIN THE DATE SPAN APPROVED - OVERLOC TO ALLON PETERMAN, LOCATION 83.
   C. COVERED DATES OF SERVICE RUN INTO NEXT MONTHS BILLING - OVERLOC TO ALLON PETERMAN, LOCATION 83.

7. ANYTHING ELSE WITH AUTH # BEGINNING WITH/51, OVERLOC TO 47.

8. 6247E, 6277E, 6711E, 6631E, (LOW VOLUME COMPRESSORS) - IF THESE PROCEDURE CODES AND CLIENT IS FIVE YEARS OF AGE OR UNDER - FORCE.

9. ALL ELSE, DENY.

TEXT KEY	TEXT DESC
607	

MED VENDOR (CLAIM TYPE P)

WORK 101/102 EXC FIRST. IF CLAIM IS DUPLICATE DENY DUP EXCEPTION AND PA2 607 & 353. (ALWAYS REVIEW AUTH ALONG WITH HX CLAIM.)

IF SYSTEM PRICE IS MORE THAN THE AMOUNT AUTHORIZED, MANUALLY PRICE AUTHORIZED AMOUNT W/INFO EOB 213.

IF CLAIM IS SENT TO QUS FOR PRICING ADJUDICATE PER THEIR INSTRUCTIONS USING 213 INFO EOB.

IF BILLING 0799E OR 0899E (MISC.) WITH MONEY REMAINING ON AUTH FILE, MANUALLY PRICE THE REMAINING AMOUNT W/INFO EOB 213.

IF NECESSARY TO DENY 607 THEN PA2 353.

REFER TO UNIT MANUAL FOR ADDITIONAL DIRECTION.
IF ANY QUESTIONS SEE TRAINER/SUPERVISOR.

TEXT KEY TEXT DESC

608 ADJUSTMENTS ONLY - AUTHORIZATION ISSUES ARE TO BE ADDRESSED ONLY IF CORRECTION IS TO MATCH SERVICES ORIGINALLY AUTHORIZED - DENY 236. WHENEVER THIS TEXT SAYS TO FORCE 608 - ALSO FORCE EXCEPTION 353 IF FAILING ON SAME LINE.

ATTENTION MED VENDOR CLAIM TYPE: IF IT BECOMES NECESSARY TO FORCE ANY AUTHORIZATION EXCEPTION THEN AUTH FILE MUST BE UPDATED MANUALLY. SEE TRAINER OR SUPERVISOR IF UNSURE WHO SHOULD DO UPDATE.

1. RESEARCH CODES FOR OTHER PROBLEMS SUCH AS INCORRECT TOS ON PA RECORD, DIFFERENT TOOTH #, MULTIPLE MRI'S, ETC, AND DETERMINE IF THERE ARE AVAILABLE UNITS.

2. MRI'S - (1 UNIT ON THE SCREEN AND IT HAS BEEN USED) - IF YOUR CLAIM IS FOR PROF COMP, DO HX SEARCH, IF YOU FIND THAT THE TECH HAS BEEN PD, SEND TO DHSQS/QFFS/NCC'S/MS 45506 & REQUEST AN ADDTIONAL UNIT FOR THE PROF. IF THEY FIND THAT THE HOSP SHOULD HAVE BILLED THE TECH, THEY WILL PUT THE UNIT BACK ON THE AUTH SCREEN AND RETURN THE CLAIM TO YOU TO PAY AND R & D THE TECH COMP W/EOB 975. IF YOUR CLAIM IS FOR TECH COMP, DO HX SEARCH, IF YOU FIND THAT THE PROF PD, DO AS ABOVE. IF THEY FIND THAT THE HOSP SHOULD BE BILLING THE TECH, THEY WILL RETURN THE CLAIM TO YOU TO DENY W/EOB 975.

3. IF THERE ARE UNITS AVAILABLE - SPLIT LINES TO USE UNITS. WHEN CLAIM CYCLES, THE SYSTEM WILL USE THE UNITS FROM THE PA RECORD. DENY ANY LINES W/UNAUTHORIZED UNITS WITH EOB 246.
EXCEPTION: SPECIAL DUTY NURSING (PT 33) - IF NOT ENOUGH UNITS ON AUTH SCREEN TO COVER UNITS BILLED - DENY ENTIRE LINE.

4. WHEELCHAIR PARTS & ACCESORIES - ADJUST UNITS TO MATCH AMOUNT AUTH'D W/INFO EOB 101. IF ANY QUESTIONS SEE TRAINER/SUPERVISOR.

5. WORK DUP EXC FIRST BUT ALWAYS REVIEW AUTH FILE ALONG WITH HX CLAIM. IF DUPLICATE - DENY DUP EXCEPTIONS & PA2 608 AND 353.

6. OTHER THAN THE ABOVE, DENY.

TEXT KEY TEXT DESC
610

NOTE: PT 48/49 (ANESTHESIOLOGIST), MODIFIER 80,81,82 (ASSIST AT SURGERY) - FORCE. PT 22 (AMBULATORY SURG) W/PROCEDURES (67311 - 67343) - FORCE. ALL ELSE - DENY, EXCEPT PM&R - SEE BELOW.

PM&R - IF YOU HAVE A CLAIM WITH A PROVIDER BILLING # THAT DOES NOT MATCH THE PROVIDER FIELD # ON AUTH FILE,

1. CHECK TO SEE IF THE PROVIDER # ON YOUR CLAIM IS MENTIONED OR
2. YOUR PERFORMING PROVIDER OR SOMEONE IN THE SAME FACILITY "THAT YOUR PROVIDER MAY BE COVERING FOR" IS MENTIONED OR
3. IF THE PROVIDIR #'S ON CLAIM OR AUTH SCREEN ARE ASSOCIATED IN ANY WAY, "MEMBER OF GROUP, 2 PROV IN SAME GROUP, ETC" OR
4. IF THE FOLLOWING PM&R PROVIDERS; 1130517,1055623,1130525,1922905 ON THE WORKSHEET OR AUTH SCREEN AND THE FOLLOWING COVER PROVIDERS; 1923804, 1077999 ARE ON THE WORKSHEET OR THE AUTH SCREEN -----

   IF SO ---
   A. ADMIT (0035M) SEND TO DHSQS/QFFS/NCC, PM&R, MS 5506 AND ASK TO USE YOUR CLAIM PROVIDER # ON SCREEN.
   B. FOLLOW-UP SERVICES (0030M-0034M) - FORCE.

   IF NOT ---
   READ YOUR NOTES TO SEE IF THERE IS INFORMATION THAT NEEDS TO BE CONSIDERED BEFORE DENYING, OTHERWISE - DENY.

ADJUSTMENTS: AUTHORIZATION ISSUES WILL BE ADDRESSED ONLY IF CORRECTIONS ARE BEING MADE TO MATCH SERVICES ORIGINALLY AUTHORIZED.
TRANSPORTATION - DENY W/EOB 237. ANYTHING ELSE, DENY W/EOB 236.

TEXT KEY TEXT DESC

611 ADJUSTMENTS: AUTHORIZATION ISSUES WILL BE ADDRESSED ONLY IF THE CORRECTIONS ARE BEING MADE TO MATCH SERVICES ORIGINALLY AUTHORIZED.

NOTE: NEVER PRICE AT MORE THAN THE BILLED AMOUNT ON CLAIM.

OUTPATIENT HOSPITAL (M)

1. IF ALSO POSTING EXCEPTION 772 - WORK THAT EXCEPTION FIRST. IF DENYING EXCEPTION 772 - PA2 EXCEPTION 611.
2. PROC CODE 90378 (SYNAGIS) - WORK EXCEPTION 353 FIRST:
   A. IF DENYING EXC 353 - PA2 EXC 611.
   B. IF FORCING EXC 353 - MANUALLY PRICE PER THE INSTRUCTIONS IN THE AUTHORIZATION FILE. KEY 373 IN THE 2ND EOB.
3. THERAPIES:
   A. IF EXPEDITED AUTH (BEGINS WITH 87) - DENY W/EOBS 828/251
   B. ALL ELSE - O'LOC TO 75.
3. ALL ELSE - OVERLOC TO 72.

DENTAL

1. PROCEDURE IS NOT ON AUTH SCREEN - DENY WITH EOB 325/251.
2. D6010 IF AUTHORIZED:

   A. DOS 3-1-96 TO 11-30-99 MANUAL PRICE AT $900.00
   B. DOS 12-1-99 TO PRESENT MANUAL PRICE AT $828.95
3. D4271, D5911-D6100, D6199, D7286, D7320, D7960 - PRICE PER AUTH *JH FILE.
4. ALL ELSE - OVERLOC TO 83.

RES/ADJ (LOC 23) (PHYSICIANS/ASC)

1. AUTH # ON THE CLAIM & NO DIRECTION OR PRICING IN THIS TEXT, ROUTE TO MMIS/SANDY/45564 FOR REV & PRICING (REF 611 TEXT)
   A. IF DOS DO NOT MATCH AUTH # - DENY W/EOB 245.
   B. IF UNITS ARE USED - DENY W/EOB 246.
   C. IF DETAIL LINE ON AUTH # IN DENIED STATUS - DENY W/EOB 242.
2. ANESTHESIA SERVICES W/APPROVAL - IF NO DIRECTION IN TEXT OR PDDD, RT TO MMIS/SANDY/45564 FOR REVIEW & PRICING. (REF 611 TEXT)
3. ASC (PT 22)
   A. L8614 (COCHLEAR DEVICE/SYSTEM) IF AUTHORIZATION # OL TO 14. IF NO AUTH - DENY AND ALSO USE INFO EOB 023. LOCATION 14 - IF AUTHORIZED, MANUALLY PRICE AT:
   DOS 9-1-99 TO 6-30-00 - $14,087.00
   DOS 7-1-00 AND AFTER - $14,227.77
   B. 69930 (COCHLEAR IMPLANT) - MANUAL PRICE AT:
   DOS 9/1/99 - 6/30/00 = $522.96
   DOS 7/1/00 & AFTER = $533.42
   C. ALL ELSE - IF APPROVED PER AUTH FILE:
   1. MANUAL PRICE PER PRICING CRITERIA ALLOWED IN AUTH FILE.
   2. OTHERWISE, ROUTE TO MMIS/CHRISTINE/MS 45564 & ASK FOR PRICING.

4. COCHLEAR IMPLANTS, VNS & SYNAGIS: RES - O'LOC TO 14

LOC 14:
90378/90399 (SYNAGIS)S & SYNAGIS: RES - O'LOC TO 14
(PRIOR TO 10/01/01)
PAY PER NOTES PAGE ON AUTH # W/INFO EOB 373.
IF 177 POSTING & YOU ARE PAYING THE CLAIM - FORCE THE 177, IF YOU ARE DENYING THE CLAIM - PA-2. DO NOT DENY FOR MULTIPLE UNITS ON 1 LINE, PAY UP TO 2 BY DOUBLING THE MANUAL PRICE. AUTH # WILL REFLECT APPROPRIATE PAYMENT PER UNIT. AUTH # IS FOR 5 MONTHS & SHOULD ONLY BE BILLED X 1 PER MO.

(EFFECTIVE FOR AUTH #'S THAT WERE BUILT 11/01/01 AFTER)
LOC 14: REVIEW AUTH, PAGE 1 WILL REFLECT DATE SPANS/UNITS.
PRICE EA LINE UP TO THE AMT AUTHORIZED FOR THE DOS/MO, NOT TO EXCEED THE BILLED AMT. USE INFO EOB 373. THE PROVIDER SHOULD BE BILLING 1 UNIT FOR EVERY 50 MG HE USED AND RECEIVED AUTHORIZATION FOR. (IF PROVIDER DOES NOT BILL UNITS CORRECTLY, PRICE ACCORDING TO HIS CLAIM) AND HE WILL HAVE TO BILL AN ADJUSTMENT .
AFTER PRICING THE CLAIM, E-MAIL CHARLES AGTE AT DMO/MO
TO USE UNITS FROM AUTH #, GIVE THE FOLLOWING INFO:
AUTH #, PROCEDURE CODE, DOS ON CLAIM, UNITS USED.
(THIS MUST BE DONE IN ORDER TO KEEP THE AUTH # FROM BEING USED OUTSIDE OF THE ASSIGNED UNITS/DOLLAR LIMITS).
AN EXAMPLE OF WHAT THE AUTH NOTES SHOULD SAY IS:
MANUAL PRICE AT 150MG PER DATE SPAN AT $1726.OO DIVIDED BY 3 = $575.33 PER UNIT BILLED ON CLAIM. (IE) IF CLAIM HAS 2 UNITS, YOU WOULD MANUAL PRICE AT $1150.66 W/EOB 373. ANY QUESTIONS OF ANY KIND IN DIRECTIONS, SHOULD BE ADDRESSED TO SANDY ASBACH/MMIS.

(EFFECTIVE FOR DOS 7/1/03 - 12/01/03) UNDER AGE 1 SHOULD BE MANUAL PRICE AT $598 PER UNIT OF 50MG. OVER AGE 1 REVEIW THE AUTH # TO SEE IF SPECIAL AUTH FOR OVER AGE 1. OTHERWISE, ANY QUESTIONS - SEE SANDY A.

61885,61888,64573,64585 (VNS)
PAY PER NOTES PAGE ON AUTH # W/INFO EOB 373.

69930 (COCHLEAR IMPLANT SURGERY)
PAY PER NOTES PAGE ON AUTH #, W/INFO EOB 373. NOTE: 69990 (MICRO) MAY ALSO BE AUTHORIZED, IF SO, PAY W/69930 AT SYSTEM PRICE.
NOTE FOR ALL OF ABOVE: IF NO ALLOWANCE, CANNOT DETERMINE PRICING OR NOTES & TO USE UNITS ON AUTH FOR ALL OF THE ABOVE, SEND AN E-MAIL INDICATING QUESTION OR DIRECTION TO:
(SYNAGIS) - CHARLES AGTE
(VNS/COCHLEAR IMPLANTS) - CONNIE CHASE

----ANY CODES THAT START WITH (L) AND HAVE BEEN AUTHORIZED, PLEASE DO NOT PROCESS AT THIS TIME, ROUTE TO SANDY A/MMIS.
ANY QUESTIONS ON THE ABOVE - E-MAIL SANDY ASBACH/MMIS WITH AUTH # AND QUESTION.

4. B9998 (ENTERAL PRODUCT) - PAY PER AUTH # NOTES SCREEN FOR PHYSICIANS.

E-MAIL KERI DANSEREAU DMM/MO TO USE UNITS FROM AUTH SCREEN. ADVISE HER OF THE ICN AND AUTH # ALONG WITH YOUR REQUEST.

5. PROCEDURE CODE MATCHES AUTH SCREEN - IF ONE OF THE PROCEDURE CODES LISTED BELOW - PRICE ACCORDING TO DOS FOR A YR PERIOD. WHEN THE PRICE IS MORE THAN 1 YR OLD, TREAT AS CODE NOT LISTED IN TEXT. IF PROCEDURE IS NOT LISTED OR PRICE NEEDS UPDATING, E-MAIL SANDY ASBACH/MMIS & ASK FOR NEW OR CURRENT PRICING PER RBRVS/RATES ANALYST. PLEASE INCLUDE THE CODE(S)/DOS/AUTHORIZATION #/ICN.

6. NEW RATES WILL BE ENTERED IN THIS TEXT BELOW BY MMIS.

NOTE: NEVER PRICE AT MORE THAN THE BILLED AMOUNT ON CLAIM.

NOTE: IF CLAIM IS FOR ASSIST (MOD 80,81,82) - PRICE AT 20% OF THE FEE BELOW FOR THE SPECIFIC DOS. IF CLAIM IS FOR CO-SURGEON OR TEAM SURG (MOD 62,66) - PRICE AT 62.5% OF THE FEE BELOW FOR THE SPECIFIC DOS. IF YOU RECEIVE A CLAIM FOR ONE OF THE ABOVE & NO SURGEON FEE LISTED BELOW, NOTE ON REQUEST TO MMIS THAT A FEE FOR SURGEON IS NEEDED & UPON RETURN, PRICE PER ABOVE INSTR. YOU WILL NEED TO CHECK THE PDDD FILE TO SEE IF ASSIST, CO-SURG, TEAM INDICATOR IS "Y". IF NOT, AUTH # IS NOT VALID UNLESS AUTH NOTES SPECIFICALLY STATE ASSIST/CO-SURG/TEAM APPROVED. APPROVAL FOR A NON-COVERED SERVICE IS NORMALLY FOR THE MEDICAL NECESSITY. ANY QUESTIONS - SEE YOUR TRAINER.

NOTE: IF FEE IS A % PROCEDURE - DO NOT CUT TO ASSIST/CO-SURG/TEAM %. PAY PER INDICATED %.

NOTE: IF PRICING PER FEE BELOW & AUTH # INDICATES UNITS - E-MAIL KERI DANSERUAU/DMM W/ICN/AUTH#/DOS W/UNITS USED & ADVISE HER TO MANUALLY USE APPROPRIATE UNITS FROM AUTH #.

L0C 23 PRICING FOR PHYSICIANS

PROCEDURE	7/1/99	1/1/00	7/1/00	7/1/01	7/1/02	7/1/03
11960						
15822			N=252.56 F=225.49	N=284.16 F=234.18		
15823		350.44	N=363.29 F=333.98	N=382.31 F=331.00	N=426.11 F=339.20	
15831			494.82	496.83	489.58	
15832				461.65	467.28	
15837						
15838			N=301.32 F=301.32	N=300.97 F=300.97	N=301.89 F=301.89	
15839				N=367.08 F=341.08	N=402.45 F=364.23	
15877	PAY 45% OF BILLED----------					
19316	512.28 F=512.28 F=478.27 F=458.51 N=512.28 N=478.27 N=458.51					
19340	307.02					
22520				302.31	313.72	

30400	456.68	443.15				
30410						
30420	753.51		687.09	667.03	660.21	
30430	313.16	3140.7	327.41		337.60	
30450	690.11	716.29	687.09		764.86	
43842	652.64	631.06				
43844						
43846	784.44	764.16	747.82	890.89	880.65	
43847		839.32	827.38	995.54	985.76	
43848			889.90	1084.49	1070.16	
44135			PAY AT 45 % OF BILLED----------			

PROCEDURE	7/1/99	1/1/00	7/1/00	7/1/01	7/1/02	7/1/03
50320						
53850	368.86		372.68			
53852						
54410						521.66
54450						
55400					322.37	
56345						
58672			434.87	442.15	468.19	
58673				476.88		
58760						
58770						
61885			218.78			
64573	181.14		278.95			
65760						45% OF BILL
65765						
69300	296.96		261.95	F=254.80		
					N=254.80	
78810 PROFF	FEE ONLY W/MOD 26)			69.12	45.72	
78810 TECH	FEE ONLY W/MOD TC)			SEE NOTE AT END OF TEXT		
78810				SEE NOTE AT END OF TEXT		
83019						
88142			14.60			
92065				24.43	35.95	
99315					35.26	
L4386						124.58

PROCEDURES	7/1/99	1/1/00	7/1/00	7/1/01	7/1/02	7/1/03	01/01/04

7. ALL ELSE - IF NOT SPECIFICALLY MENTIONED OR CODE IS NOT ON OR DOES NOT MATCH AUTH SCREEN - DENY W/EOB'S 859/251. *BJS

NOTE: PET SCANS FOR DOS PRIOR TO 07/01/01 OR AFTER 03/31/02.
A. TECHNICAL COMPONENT (MOD TC) - MANUAL PRICE AT 45% OF BILLED AMOUNT UP TO 1850.00 MAX W/EOB 373.
B. GLOBAL (100%) - MANUAL PRICE AT 45% OF BILLED AMOUNT UP TO 1895.00 MAX W/EOB 373.

MED VENDOR (P)

1. L9999 - DENY W/EOB 302.

2. PHYSICAL THERAPY (PT 34) IF SPAN OF PROCEDURE CODES ON AUTH FILE AND NOTES STATE (E.G. "ADDITIONAL 24 OR 48 VISITS") AND NOTES DO NOT SPECIFICALLY ADDRESS THE NON-COVERED PROCEDURE - DENY. ANY QUESTIONS, SEE MMIS SERVICES.
3. ALL ELSE - REVIEW AUTH FILE & IF CODE DOES NOT MATCH SERVICES AUTHORIZED DENY WITH EOB 251, IF AUTH MATCHES, PAY PER AUTH. ANY QUESTIONS - OL TO 83.

TEXT KEY	TEXT DESC
619	

MEDISET IS NOT PAYABLE FOR CLIENTS DURING HOSPITAL STAY.

1. IF DOS IS DATE OF DISCHARGE - FORCE.
2. IF DOS IS OTHER THAN DATE OF DISCHARGE BUT DURING HOSPITAL DOS - DENY.

TEXT KEY TEXT DESC
620 INPATIENT CLAIM REQUIRES APPROVAL

1. IF ALSO POSTING EXC 248 - WORK THAT EXC FIRST.

2. FORCE THE FOLLOWING:
   A. SWING BED CHARGES.
   B. LATE CHARGES ONLY IF THERE IS A PAID CLAIM IN MMIS.
   C. DX CODE IS DENTAL RELATED & THE CLIENT IS AGE 20 OR UNDER.
   D. CLIENT IS DDD (ALSO POSTING EXC 498).
   E. DX CODE 303.3 - 303.9 OR 303.5 & THE CLIENT IS AGE 16 OR UNDER.
   F. ADJUSTMENTS IF THE ORIGINAL CLAIM HAD AUTHORIZATION OR DID NOT REQUIRE AUTHORIZATION.
   G. "S" CLAIMS WITH AN ATTACHED & APPROVED PAS EXTENSION -OR- COMMENTS /REMARKS ON ELECTRONIC BILLINGS THAT STATE THE PAS EXTENSION IS APPROVED & GIVES THE CONSULTANTS NAME, DATE OF APPROVAL, & NUMBER OF EXTENSION DAYS APPROVED. --ALSO KEY A "Y" IN THE LMC FIELD.
   H. CUP SERVICES (REV CODE 129 OR 168). NOTE: IF THE PROV INDICATES CUP, BUT IS OT BILLING REV CODE 129 OR 168 - DENY W/EOB 756.

3. IF CLAIM HAS AUTHORIZATION:
   A. IF SERVICES BILLED MATCH SERVICES AUTHORIZED - FORCE.
   B. IF DOS BILLED ARE NOT COVERED ON THE AUTH FILE - DENY W/EOB 245.
   C. IF SERVICES BILLED DO NOT MATCH SERVICES AUTH'D - DENY W/EOB 251.

--NOTE: IF EITHER THE PRIMARY OR THE ADMITTING DIAGNOSES CODE DOES NOT REQUIRE AUTHORIZATION - FORCE. THE ONLY TIME WE WANT TO DENY FOR AUTH IS WHEN BOTH THE ADMITTING & THE PRIMARY DX CODES REQUIRE AUTH. --EXCEPTION: IF THE PROCEDURE CODE IS 44.56, 44.31, 44.39, 57.89, 59.30-59.79, 68.30-68.70, 68.90 OR 85.30-85.36 - FOLLOW THE INSTRUCTIONS IN #4-7 BELOW.

4. 44.50, 44.31, 68.30-68.70, 68.90, 85.30-85.36 - DENY IF NO AUTH.

5. 44.39 - IF DX IS 278.0 OR 278.01 - DENY IF NO AUTH. OTHERWISE FORCE.

6. 59.30 - 59.79 OR 57.89 - IF CLIENT IS 45 YEARS OF AGE OR OLDER & HAS A COMBINATION OF BLADDER REPAIR & HYSTERECTOMY (PROC CODES 68.30 - 68.70, OR 68.90 - FORCE. OTHERWISE DENY IF NO AUTH.

7. 57.89 - IF ONLY POSTING ON THIS PROCEDURE & THE CLIENT IS MALE - FORCE. OTHERWISE DENY IF NO AUTH.

8. ALL ELSE - IF NOT FORCIBLE PER THIS TEXT - DENY.

TEXT KEY TEXT DESC

624

FOLLOW STEPS 1-8 BELOW.

1. THE 624 NOTIFICATIONS ARE RECIEVED ON GREEN BAR REPORT BWMC6500-R005.
2. THIS REPORT IS MATCHED TO A COPY OF THE TAD BY PIC.
3. TO VERIFY INSURANCE COVERAGE, GO TO THE 09 SCREEN BY PIC, ENTER AND F4 TO ACCESS THE INSURANCE SCREENS.
4. IF THERE IS INSURANCE INFORMATION IN THE TPL SCREEN, CALCULATE DAYS PAID (SEE #6 BELOW), ENTER THE INSURANCE CARRIER CODE AND L IN THE TOI SECTION.
5. IF THE 09 SCREEN HAS NO INSURANCE INFORMATION, CALCULATE DAYS PAID (SEE #6 BELOW), ENTER THE 5555 CARRIER CODE AND L IN THE TOI SECTION.
6. IF THE TAD COMMENTS INDICATE A SPECIFIC $ AMOUNT, ENTER THAT AMOUNT ONTO THE CLAIM. IF AMOUNT IS MORE THAN THE BALANCE OF CLAIM, ONLY ENTER UP TO THE BALANCE LEFT ON THE CLAIM OR IF THE TAD COMMENTS INDICATE A SPECIFIC # OF DAYS, CALCULATE THE PAID AMOUNT BY MULTIPLYING THE DAILY DSHS RATE TIMES THE # OF DAYS COVERED ON THE TAD AND ENTER THAT AMOUNT. IF THE AMOUNT IS MORE THAN THE BALANCE, ONLY ENTER UP TO THE BALANCE LEFT ON THE CLAIM. USE EOB 031 IF A BALANCE IS LEFT ON THE CLAIM AFTER THE INSURANCE PAYMENT IS APPLIED. USE EOB 032 IF THE INSURANCE PAYMENT EXCEEDS THE DSHS ALLOWABLE FEE.
7. IF THE CLAIM PAID AT ZERO, FORC THE 624.
8. SEND A COPY OF THE TAD COMMENTS TO: COB NURSING HOME DESK MS 46656.

TEXT KEY 625

TEXT DESC

EVALUATION OF LAB WITH AUTO DENY.

EFFECTIVE FOR DOS 7/1/98, AUTOMATED AND NON AUTOMATED MULTI-CHANNEL TESTS MAY OR MAY NOT BE PART OF A DISEASE ORGAN PANEL. WE WILL PAY EITHER THE INDIVIDUAL TEST OR THE PANEL. THE SYSTEM WILL AUTOMATICALLY PRICE WITH THE FOLLOWING SOURCES. THE SYSTEM IS CURRENTLY ONLY ABLE TO LOOK AT THE CURRENT CLAIM, OTHER SUSPENDING OR PAID CLAIMS ARE NOT INCLUDED IN PRICING.

(C) PDDD "DISEASE ORGAN PANEL, ADDITIONAL NON AUTOMATED TESTS".
(1) ROLLED UP DISEASE ORGAN PANEL "ALL AUTOMATED/NON AUTOMATED TESTS THAT MAKE UP A PANEL"
(2) INTERNAL CODING "AUTOMATED TESTS THAT DO NOT MAKE UP A PANEL"

1. IF AUTO DENY ON LINE AND YOU WANT TO PAY THAT LINE - FORCE THE AUTO DENY. ENTER THE 625. THE SYSTEM WILL INCLUDE ALL LINES IN THE PAYMENT OF THE CLAIM AND PAY WITH THE CORRECT SOURCE.

2. IF AUTO DENY AND YOU WANT TO DENY:
ENTER THE AUTO DENY AND FORCE THE 625. THE SYSTEM WILL LOOK AT THE ENTIRE CLAIM "PAID AND DENIED LINES" AND DETERMINE THE CORRECT SOURCE FOR THE LINES THAT ARE PAYING.

NOTE: EFFECTIVE 1/16/99 CONSULTEC FIXED THE SYSTEM TO LOOK AT DIFFERENT DOS ON A CLAIM.

ANY QUESTIONS - SEE YOUR SUP/MMIS.

TEXT KEY TEXT DESC

627 1. REVENUE CODE 100 - LTAC - ONLY REGIONAL HOSPITAL (3200326) & KINDRED HOSPITAL (3200318) CAN BILL REVENUE CODE 100:

A. IF NOT ONE OF THE HOSPITAL'S LISTED ABOVE - DENY.
B. IF PROVIDER IS ONE OF THE ABOVE HOSPITALS AND OCCURRENCE CODE "LT" APPEARS IN EITHER THE OCCURRENCE CODE FIELD, CONDITION CODE FIELD, OR COMMENTS - KEY "LT" IN THE OCCURRENCE CODE FIELD AND ENTER.

*** EFFECTIVE 04/01/03 THE PROVIDER IS NOT REQUIRED TO BILL WITH THE "LT". HOWEVER, THE CLAIM WILL NOT PAY CORRECTLY IF THE "LT" IS NOT ENTERED ON THE SCREEN. KEY THE "LT" IN THE OCCURRENCE CODE FIELD, EVEN IF IT IS NOT ON THE CLAIM.

2. REVENUE CODE 101 - PM&R LEVEL B - OVERLOC TO 72.

TEXT KEY TEXT DESC

632 1. IF HOSPITAL & PROCEDURE ARE LISTED BELOW - FORCE.

2. IF HOSPITAL IS BILLING FOR A PROCEDURE NOT LISTED BELOW:
A. IF NO AUTH - DENY.
B. IF AUTH - EE: PA2
RES: CHECK AUTH FILE - IF PROCEDURE BILLED MATCHES
AUTH - FORCE. IF PROCEDURE BILLED DOES NOT MATCH
AUTH - DENY WITH EOB 251.

--NOTE: OUT OF STATE TRANSPLANTS REQUIRE APPROVAL. IF AUTH ON CLAIM
FOLLOW INSTRUCTIONS IN 2.B ABOVE. OTHERWISE - DENY W/EOB 023.

--NOTE: PERIPHERAL (HEMATOPOIETIC) STEM CELL TRANSPLANTS ARE IDENTIFIED
BY REVENUE CODES 897 OR 898 (OR PF4 UNDER THE SURGICAL PROCEDURE
CODE(S) TO DETERMINE THE TYPE OF STEM CELL TRANSPLANT PERFORMED)

--NOTE: STEM CELL TRANSPLANTS (PSC-T) AND BONE MARROW TRANSPLANTS (BMT)
ARE NOT THE SAME PROCEDURE. MAKE SURE THE PROVIDER IS APPROVED
FOR THE PROCEDURE THEY ARE BILLING BEFORE FORCING THE CLAIM.

3022936 - SEATTLE CANCER CARE ALLIANCE

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

3094605 - FRED HUTCHISON CANCER RESEARCH CENTER

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

3300340 - MARY BRIDGE CHILDREN'S HOSPITAL

AUTOLOGOUS - STEM CELL (PSC-T)
NOTE: DATES OF SERVICE PRIOR TO 05/02/02 - OVERLOC TO 72.

3302601 - PROVIDENCE ST PETER HOSPITAL:

AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

3304201 - SACRED HEART MEDICAL CENTER - SPOKANE:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)
KIDNEY
HEART
LUNG
HEART/LUNG(S)

3306206 - CHILDREN'S HOSPITAL & MED CENTER - SEATTLE:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

LIVER
HEART
KIDNEY

3308707 - GOOD SAMARITAN HOSPITAL - PUYALLUP:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

3309200 - SWEDISH HOSP & MED CENTER - SEATTLE:

AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)
KIDNEY

3309309 - ST JOSEPH'S HOSPITAL - TACOMA

AUTOLOGOUS - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

3315009 - VIRGINIA MASON HOSPITAL:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)
KIDNEY
PANCREAS
KIDNEY/PANCREAS

3348802 - UNIVERSITY OF WASHINGTON MED CTR:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)
HEART
LUNG
HEART/LUNG(S)
KIDNEY
LIVER
PANCREAS

3358801 - OREGON HEALTH SCIENCES UNIVERSITY - PORTLAND:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)
HEART
LIVER
KIDNEY
PANCREAS

3361102 - LEGACY GOOD SAMARITAN HOSPITAL - PORTLAND:

AUTOLOGOUS & ALLOGENEIC - BONE MARROW (BMT)
AUTOLOGOUS & ALLOGENEIC - STEM CELL (PSC-T)

TEXT KEY TEXT DESC
636

EE (J AND O CLAIMS):
1. SURGERY CODES (10000-69999, 92975-92997, 93501-93536, 96405, 99170, G0104, G0127, G0160, G0168) - O'LOC TO 36.
2. BI-SURG INDICATOR ON PDDD FILE IS "Y" - O'LOC TO 36.
3. ALL ELSE - FORCE.

RES LOC 36 ONLY - CHECK THE PDD FILE:

PHYSICIANS (J):
1. NO ANESTHESIA BASE FOR ANY DATE OF SERVICE - FORCE.
2. ANESTHESIA BASE WAS VALID & HAS ENDED - DENY.
EXCEPTION: IF CHILD AGE 12 & UNDER - DENY W/EOB 302.

CROSSOVERS (O):
1. NO ANESTHESIA BASE FOR DATE OF SERVICE -
   A. PROCEDURE CODE DESCRIPTION HAS THE WORDING "INJECTION":
      1) ANATOMY/DESCRIPTION ALLOWS OR PDDD DUPE CHK = 1 - FORCE.
         EXAMPLE: 20600 - ANATOMY/DESCRIPTION/PDDD DUPE
                  CHECK ALL ALLOW MULTIPLES - FORCE.
      2) ANATOMY/DESCRIPTION DOES NOT ALLOW OR PDDD DUPE CHK IS BLANK - O'LOC TO 83.
         EXAMPLES: 20553 OR 64405 - O'LOC TO 83.
   B. COMPARE MEDICARE ALLOWED VS PDDD MAX ALLOWED:
      1) IF MEDICARE'S ALLOWED IS CLOSER TO THE PDDD MAX ALLOWED FOR 1 UNIT - CUT UNITS TO 1 WITH EOBS 431/589.
      2) ALL ELSE - O'LOC TP 83.

2. ALL ELSE - O'LOC TO 83.

TEXT KEY	TEXT DESC
638	EXCEPTIONAL THERAPY CARE

J-CLAIMS (PROVIDER TYPE 80 - SPECIALTY 46)

IF "EXCEPTIONAL THERAPY CARE APPROVAL LETTER" IS ATTACHED AND COVERS THE DATE(S) OF SERVICE - OVERLOC TO 67. ALL ELSE - DENY.

TEXT KEY	TEXT DESC
649	THE REFERRING PROVIDER NOT A CERTIFIED DIETICIAN.

MED VENDOR (P) MEDICAL NUTRITION:

IF COMMENTS ON CLAIMS: SUSAN YAKE AT BREMERTON NAVAL HOSPITAL IS A DIETICIAN REGISTERED WITH THE HEALTH PROFESSION QUALITY ASSURANCE DIVISION. DUE TO HER MILITARY STATUS SHE DOES NOT HAVE A STATE DIETICIAN NUMBER-FORCE

PRIOR AUTH # ON CLAIM:

- RESOLUTIONS - IF AUTHORIZED (PROC CODE/DATE OF SERVICE) - FORCE
IF PROC CODE DOES NOT MATCH - DENY W/EOB 251
IF DATE DOES NOT MATCH - DENY W/EOB 245.

ALL ELSE DENY

TEXT KEY	TEXT DESC
657	FQHC DOESN'T MATCH CLIENT'S PCOP SCREEN

LOCATION 57

I. IF CLAIM IS FOR NEWBORN:

A. FIND MOM'S FQHC FOR DATE OF SERVICE ON BABY'S CLAIM.
B. LOAD THE INFO TO BABY'S PIC.
1. IF MOM IS NOT IN THE FQHC FOR THE DOS ON BABY'S CLAIM - DENY.
2. IF YOU CAN'T DETERMINE WHO MOM IS - RESEARCH THE CASE IN ACES
3. IF NEWBORN IS IN A DIFFERENT FQHC FOR DOS ON CLAIM - DENY.

II. IF CLAIM IS NOT FOR NEWBORN- DENY.

III. EFFECTIVE 1/31/02 FQHC'S ARE NO LONGER ENROLLED ON THE 6 SCREEN.
A. IF PLAN IS BILLING 0357M FOR DOS AFTER 1/31/02 - DENY.

TEXT KEY TEXT DESC
702 LAB TESTS INCLUDED IN ORGAN DISEASE PANELS

NOTE: AUDIT 702 & 007 MAY BOTH POST ON THE CLAIM FROM 1/1/98-6/30/98. 702 AUDIT SUPERCEDES 007. IF FORCING 702, WORK 007. IF DENYING TESTS TO BILL A ORGAN DISEASE PANEL, DO NOT INCLUDE THOSE TESTS IN THE 007.

NOTE: IF MOD QP (NOT DONE AS A PANEL) THROUGH 6/30/98 DOS - FORCE.
IF MOD QR (REPEAT TEST) OR O'CODE 221 FOR 7/1/98 DOS AND AFTER - FORCE.

UNDER THE FOLLOWING ORGAN DISEASE PANELS ARE LISTS OF TESTS. IF ALL THE
1. IF ALL THE TESTS UNDER EACH PANEL ARE BILLED - DENY THE TESTS TO BILL THE APPROPRIATE PANEL.
2. IF ONLY PART OF THE TESTS UNDER THE PANEL ARE BILLED - FORCE. SAME TEST.

SEE NEXT PAGE FOR PANELS AND THEIR COMPONENT TESTS.

80050 80055 80059 80061 80072 80090 80091 80092

85022 85022 86704 82465 84550 86644 84436 84436
85025 85025 86706 83718 85651 86694 84479 84443
84443 86592 86708 84478 86255 86762 84479
82040 86762 86803 86430 86777
82250 86850 87340
82310 86900
82435 86901
82565 87340
82947
84075
84132
84155
84295
84520

SEE NOTE NEXT PAGE:
ALL PANELS HAVE BEEN REMOVED FROM THIS AUDIT, TESTS WILL NO LONGER POST AGAINST PANELS AND VISA VERSA.

4 PANELS AND THEIR TESTS HAVE ALSO BEEN REMOVED, THE TESTS WILL BE CUT BACK BY SYSTEM CSR TO PAY AT TOTAL PANEL PRICE IF ALL TESTS ARE BILLED. THE PANELS ARE 80049,80051,80054,80058. THESE PANELS HAVE ONLY COMPONENT TESTS UNDER THEM. THIS HAS BEEN DISCUSSED WITH REVIEW AND THE AUDIT QUALITY SECTION.

POST PAY REVIEW WILL BE DONE.

TEXT KEY	TEXT DESC
707	ONE PHYSICAL THERAPY EVALUATION ALLOWED PER CALENDAR YEAR, PER DIAGNOSIS ANY PROVIDER. IF AUTHORIZATION PRESENT, REVIEW FOR POSSIBLE PAYMENT. OUTPATIENT ONLY: IF PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY ON THE SAME CLAIM - DENY W/EOBS 968/365 AT HEADER. CHECK THE DIAGNOSIS ON ALL CLAIMS. IF THE CONDITION IS RELATED AUTH IS REQUIRED. EXAMPLE: 723.1 CERVICALGIA (NECK PAIN) VS 847.0 NECK SPRAIN WOULD BE DENIED AS RELATED IF NO PRIOR AUTHORIZATION PRESENT. EVALUATION VS EVALUATION: IF DIFFERENT DATE OF SERVICE & UNRELATED DIAGNOSIS - FORCE. ALL ELSE - DENY. ANY UNUSUAL SITUATIONS, OL 83. NOTE: RE-EVALUATION CODE 97002 REMOVED FROM AUDIT ON 101300 PER ANN LAWRENCE & PATTY BALESTRA.

TEXT KEY	TEXT DESC
708	12 HOURS PSYCH ALLOWED PER CALENDAR YEAR.

NOTE: ANESTHESIA (PT 48/49) VS ANY OTHER PT - FORCE.

IF 015 EXC POSTING WORK IT FIRST.

HALF-HOUR PSYCH CODES:
90804,90805,90810,90811,90816,90817,90823, AND 90824.

FULL-HOUR PSYCH CODES:
90806,90807,90812,90813,90818,90819,90826, AND 90827.

OTHER PSYCH CODES:
90845,90847,90853,90857,90870,90871 AND 90899.
CONSIDER ALL "OTHER" PSYCH CODES AS FULL-HOUR CODES.
(NOTE: 90862 WAS REMOVED FROM THIS AUDIT ON 7/8/02 PER CYN SMITH.)

1. PAY UP TO 12 HOURS, DENY ALL ELSE, SEE BELOW:
2. SUSPENDING HOUR CODE & 11.5 HRS PAID IN HX - DENY W/EOB'S 339/302.
3. SUSPENDING COMBINATION OF HR/HALF HR CODES POSTING AGAINST PAID &/OR SUSPENDING CLAIMS - PAY UP TO 12 HRS, IN DOS ORDER IF POSSIBLE UTILIZING HALF HR CODES IF AVAILABLE TO EQUAL 12 HRS. IF NECESSARY, DENY/RECOUP & DENY THE NEWEST DOS HOUR CODE W/EOB'S 339/302.
NOTE: IF HALF HR CODE AVAILABLE TO PAY UP TO THE 12 HOUR MAX, PAY THE HALF HR CODE AND DENY ALL OTHERS W/EOB 339.
4. IF OVERPAYMENT IS NOTED IN HX - RECOUP & DENY APPROPRIATELY.
5. IF PROBLEMS IN RESOLVING - SEE TRAINER/MMIS.

TEXT KEY TEXT DESC

711 J CLAIMS

PARAMETER (1007 & 1008)

PSYCH PROCEDURE & E&M NOT ALLOWED IN COMBINATION ON THE SAME DAY, UNLESS DX IS COMPLETELY UNRELATED. EG PSYCH DX VS MEDICAL DX.

1. IF BOTH SUSPENDING - PAY THE HIGHER, DENY THE LOWER,
2. OTHER WISE - DENY CURRENT CLAIM.
   ANY QUESTIONS - SEE SANDY A/MMIS.

NOTE: IF EXCEPTION 105 POSTING, WORK IT FIRST.

NOTE: IF DIFFERENT DAYS POSTING AGAINST EACH OTHER - FORCE. THERE WAS AN INDICATOR ERROR FROM 8/1/02 THRU 8/6/02.

TEXT KEY	TEXT DESC
712	

TEXT KEY 713

TEXT DESC

AMBULANCE CODE 0010A -(OXYGEN) - MULT CODES SAME DAY

1. IF MILEAGE (0007A,0008A) IS OVER FIFTY - ALLOW UP TO TWO 0010A CODES.

2. IF SECOND TRIP INDICATED ALLOW ONE 0010A PER TRIP UNLESS CRITERIA ABOVE IS MET.

3. IF BILLING MULTIPLE CODES OF 0010A AND/OR MILEAGE IS UNER 50 AND/OR SECOND TRIP NOT INDICATED - PAY HIGHER ALLOWED AND DENY LOWER W/EOB 339.

EFFECTIVE WITH DATES OF SERVICE 10/16/03-0010A IS NO LONGER A VALID CODE. THIS CODE WILL BE BUNDLED INTO THE BLS RATE.

TEXT KEY	TEXT DESC
715	ACTIVE WOUND CARE MANAGEMENT (97601-97602) NOT ALLOWED IN COMBINATION. ALLOW ONE 97601 OR 97602 PER DAY, DENY ADDITIONAL. BOTH CODES PAY THE SAME RATE, SO ALLOW FIRST CLAIM OR LINE BILLED, DENY ADDITIONAL. SYSTEM GENERATED EOB 825 = PROCEDURE CODES ARE NOT ALLOWED IN COMBINATION. PLEASE REFER TO THE BILLING INSTRUCTIONS. REDID AUDIT 072401, AND ON TEST WITH AN EFFECTIVE BACKDATE OF 010101. WORK UP TEXT AND CHECK THAT THE SYSTEM GENERATED EOB WORKS FOR ALL SITUATIONS.

TEXT KEY TEXT DESC
720 J CLAIMS

PARAMETER (1009)

1 PRENATAL ASSESSMENT (5930M OR T1001/TH)ALLOWED PER BILLING PROV-
DENY. EXCEPTION: IF CLAIM /COMMENTS INDICATE DIFFERENT /NEW/ 2ND
PREGNANCY, ETC- FORCE AND OVERCODE 555.
NOTE: FQHC (PT 90)
IF NOT PAYING PRENATAL ASSESSMENT, MANUALLY DENY ENCOUNTER 9000M,
9001M OR 5900M WITH EOB 757.
EXCEPTION:
1. IF MONTHLY TRIMESTER/HIGH RISK MANAGEMENT CODES ARE PAYING
ON SAME CLAIM FOR SAME DAY/MONTH, PAY ENCOUNTER.
2. IF MONTHLY TRIMESTER/HIGH RISK MANAGEMENT CODES ALSO NOT
PAYING ON SAME CLAIM, MANUALLY DENY ENCOUNTER W/EOB'S 757/189
WHEN BLOOD DRAWS, LAB, X-RAYS, J CODES &/OR 59000 SERIES CODES
PAYING FOR SAME DOS. THESE LAST CODES DO NOT GET AN ENCOUNTER
W/O A PAID TRIMESTER, HIGH RISK, OR PRE-NATAL ASSESSMENT.

PARAMETER (1010)

1 LABOR MANAGEMENT (5935M) ALLWD PER PREGNANCY - DENY.
EXCEPTION: IF CLAIM/COMMENTS INDICATE DIFFERENT/ NEW/ SECOND

PREGNANCY, ETC- FORCE AND OVERCODE 555.

PARAMETER (1023)
1 DOH NB SCREEN PER CLIENT - DENY.
EXCEPTION: DIFFERENT TWIN OR TRIPLET BILLED UNDER MOM'S PIC/ PAY ONCE
PER BABY.

PARAMETER (1024)

1 NORMAL NB CARE PER CLIENT - DENY.
EXCEPTION: DIFFERENT TWIN OR TRIPLET BILLED UNDER MOM'S PIC/ PAY ONCE
PER BABY.

P CLAIMS
PARAMETER (1029/1030)
PARENTERAL NUTRITION SOLUTIONS - ON TEST - OL TO 83.

TEXT KEY 721

TEXT DESC

LABOR MANAGEMENT (5935M)

1. LABOR MANAGEMENT SHOULD ONLY BE BILLED BY THE PROVIDER WHO MANAGED CARE,"ANTEPARTUM"BUT DOES NOT PERFORM THE ACTUAL DELIVERY.
2. THE ASSISTANT MAY BILL FOR LABOR MANAGEMENT.

NOTE: IF YOU SEE THE HIGH RISK C-SECTION W/NO MOD 80 BEING BILLED BY THE SAME DR. WHO ASSISTED AT DELIVERY - DENY THE HIGH RISK W/562. IF YOU SEE THE HIGH RISK VAGINAL W/NO MOD 80 BEING BILLED BY THE SAME DR. WHO ASSISTED AT DELIVERY - DENY THE HIGH RISK W/318.

3. FORCE AGAINST DELIVERY W/MOD 80 OR PROCEDURE 5947M.
4. FORCE AGAINST HIGH RISK W/MOD 80.
5. IF YOU ARE DENYING THE HIGH RISK BECAUSE NO MOD 80 WAS USED - FORCE THE 721.
6. DENY THE LABOR MANAGEMENT BILLED BY THE DELIVERING PHYSICIAN, IF A DIFFERENT PERFORMING PROVIDER - FORCE.
7. IF YOU HAVE ANY QUESTIONS - SEE YOUR SUPERVISOR.

TEXT KEY	TEXT DESC
723	97770 - IF DATE OF SERVICE BEFORE 070198 FORCE AND DO NOT APPLY AUDIT. IF DOS 070198 & AFTER, DO NOT COUNT CLAIMS FROM PT 34 37 OR 40 TOWARDS LIMIT AUDIT. ANY UNUSUAL SITUATIONS, OVERLOC TO 83. AUDIT SET TO PAY 07-13-00, NEURODEVELOPMENTAL CENTERS ONLY SERVE CHILDREN AND ADOLESCENTS WHO HAVE NO LIMITS. ADULTS ARE NOT SERVED.

TEXT KEY TEXT DESC

725 J CLAIMS

ORTHOTIC LIMITS/COMBINATIONS
NOTE: IF NOT ADDRESSED BELOW - O'LOC TO 59.
NOTE: 1600L, 1602L, 1603L MUST BE BILLED W/MOD RT OR LT - IF NO MOD DENY W/EOB 235. (EDIT 340 WILL POST TO CATCH MODS/NO MODS)
PARAMETERS (1012,1013,1014,1015,1016,1017)

1600L (SINGLE FABRICATED ORTHOTIC):
LIMIT 2 UNITS PER CALENDAR YR, 1 FOR LT & 1 FOR RT & MUST BE BILLED ON DIFFERENT DAYS, OTHERWISE:
1. LIMIT OF 1 PER DOS
   A. MULTIPLES ON SAME LINE - DENY W/EOB 302, SHOULD BE BILLING 1601L.
   B. MULTIPLES ON DIFF LINES
      1) HX PD - DENY CURRENT W/EOB 302/189.
      2) ALL SUSPENDING - DENY W/EOB 302/189.
         A) SAME CLAIM - DENY W/EOB 302.
         B) C DIFFERENT CLAIMS - DENY BOTH CLAIMS W/EOB 302.
2. LIMIT OF 2 ON DIFF DOS - DENY OVER LIMIT W/EOB 339.
3. 1600L CANNOT BE BILLED IN SAME YEAR W/1601L/1603L, PAY EITHER 2 1600L OR 1 1601L OR 2 1603L - DENY W/EOB 825.
4. ALL ELSE - FORCE.

1601L (PAIR FABRICATED ORTHOTICS)
1. LIMIT 1 UNIT PER CALENDAR YR - OTHERWISE DENY W/EOB 339. IF MULTIS ON SAME LINE, CUT TO 1 W/EOB 431.
2. 1601L CANNOT BE BILLED IN COMBO W/1600L OR 1603L - PAY EITHER 2 1600L OR 1 1601L OR 2 1603L - DENY W/EOB 825.
3. IF SINGLE 1600L/1603L PAID IN HX - SAME PROV DENY, SAME DOS - DENY W/EOB 825/189. DIFFERENT PROVIDER - DENY W/EOB 825.
4. ALL ELSE - FORCE.

1602L (IMPRESSION CASTING)
1. LIMIT 2 UNITS PER CALENDAR YR, 1 FOR LT & 1 FOR RT, OTHERWISE DENY W/EOB 339.
   A. 2 UNITS ON 1 LINE - MUST HAVE LT/RT ON DETAIL LINE. KEY LT IN MOD FIELD 7 RT IN O'CODE.
   B. 2 UNITS/1 MOD - KEY MOD & CUT 1 UNIT W/INFO EOB 101.
   C. ONLY APPLY A & B IF WITHIN POLICY PER #1 (ABOVE).
2. 1602L CANNOT BE BILLED IN COMBO W/1604L, PAY EITHER 2 1602L OR 1 1604L - DENY W/EOB 825.

3. ALL ELSE - FORCE.

1603L (PREFABRICATED ORTHOTIC)
LIMIT 2 UNITS PER CALENDAR YR, 1 FOR LT & 1 FOR RT.
1. LIMIT 2 UNITS PER CALENDAR YR, 1 FOR LT & 1 FOR RT, OTHERWISE DENY W/EOB 339.
   A. 2 UNITS ON 1 LINE - MUST HAVE LT/RT ON DETAIL LINE. KEY LT IN MOD FIELD & RT IN O'CODE.
   B. 2 UNITS/1 MOD - KEY MOD & CUT TO 1 UNIT W/INFO EOB 101.

C. ONLY APPLY A & B IF WITHIN POLICY PER #1 (ABOVE).
2. 1603L CANNOT BE BILLED IN COMBO W/1600L OR 1601L, PAY EITHER 2 1603L OR 2 1600L OR 1 1601L - DENY W/EOB 825.
3. INVOICE REQUIRED FOR PRICING IF OVER $50, IF NO INVOICE - DENY W/ EOB 196.
4. ALL ELSE - FORCE.

1604L (IMPRESSION CASTING CUSTOM SHOES)
1. LIMIT 1 UNIT PER CALENDAR YR - OTHERWISE DENY W/EOB 339.
IF MULTIS ON SAME LINE - CUT TO 1 W/EOB 431.
2. 1604L CANNOT BE BILLED IN COMBO W/1602L - PAY EITHER 1 1604L OR 2 1602L - DENY W/EOB 825.
A. IF ALL ARE IN SUSPENSE - PAY 1604L.
B. IF 1 OR 2 1602L'S PAID - DENY 1604L.
C. IF 1604L PAID - DENY ALL 1602L'S.
3. REMOVE MOD RT/LT IF POSSIBLE W/INFO EOB 359.
4. ALL ELSE - FORCE.

TEXT KEY	TEXT DESC
728	

TEXT KEY TEXT DESC

731 INSERTION TRAY & CATHETER - LIMIT 120 PER CLIENT, PER MONTH.
A4310 (INSERTION TRAY)
A4351, A4352, A4353 (INTERMITTENT CATHS)

NOTE: DENY 352 EXC IF POSTING & PA2 731.
NOTE: CONSIDER DUPS BEFORE WORKING 731 EXC, IF DENYING, PA2 731.
NOTE: AFTER DUPS WORK EXCEPTIONS 741 & 746 AND IF DENYING PA2 731.

---DO NOT APPLY AUDIT TO A4353 PRIOR TO DOS 8/15/00 - FORCE.---

IF NO PRIOR AUTH # ON CLAIM:

CUT BACK TO ALLOWED AMOUNT W/INFO EOB 101 OR DENY AND OR RECOUP W/339.

NOTE: PA2 731 EXC AFTER CUTTING UNITS BACK TO MAXIMUM ALLOWED.
NOTE: FORCE 731 EXC WHEN TOTAL UNITS PAID WILL EXCEED MAXIMUM
BECAUSE OF ADDITIONAL UNITS BEING AUTH'D.
NOTE: BE SURE AND CONSIDER ANY PRIOR AUTH CLAIMS IN HX BEFORE
CUTTING BACK UNITS OR DENYING EXCEPTION. (WATCH FOR 'Y' IN
LMC/APP FIELD ON HX CLAIM)

IF PRIOR AUTH # ON CLAIM:
---
1. REVIEW AUTH FILE FOR ADDITIONAL AMOUNT THAT HAS BEEN APPROVED.
2. IF CODE ON CLAIM DOES NOT MATCH CODE AUTH'D
DENY 353 EXC W/EOB 251 & PA2 731 EXC.
3. IF 608/353 IS POSTING AND ADDITIONAL AMOUNT IS APPROVED, FORCE
608/353/731 & SEND W/S TO AUTH UNIT TO "USE" UNITS.

TEXT KEY	TEXT DESC
733	MAXIMUM LIMIT OF 90 PER MONTH.

IF CUTTING BACK UNITS ON SUSPENDING CLAIM USE INFO EOB 101.
IF DENYING SUSPENDING CLAIM BECAUSE LIMIT HAS ALREADY BEEN
REACHED - DENY W/EOBS 339/391.

IF NECESSARY, RECOUP CLAIMS IN HX RESULTING IN OVERPAYMENTS
W/EOB 339/391.

IF AUTH # IS PRESENT - WORK CLAIM ACCORDING TO AUTHORIZATION FILE.

NOTE: DO NOT DENY IF OVERLAPPING MONTHS, FOR EXAMPLE: 6/21/00 - 7/18/00
HITTING AGAINST SPAN OF DATES 5/21/00 - 6/20/00.

ANY QUESTIONS SEE TRAINER/MMIS.

TEXT KEY	TEXT DESC
734	

TEXT KEY	TEXT DESC
735	USE THE OLDEST DATE OF SERVICE TO DETERMINE THE FIRST 12 MONTH PERIOD. THE SECOND 12 MONTH PERIOD BEGINS 1 YEAR FROM THE OLDEST DATE OF SERVICE. ALLOW 12 VISITS WITHIN EACH OF THE TWO 12 MONTH PERIODS. DENY ANY VISITS OVER THE LIMIT.

TEXT KEY	TEXT DESC
736	MAXIMUM LIMIT OF 42 PER YEAR. IF CUTTING BACK UNITS ON SUSPENDING CLAIM-USE INFO EOB 101. IF DENYING SUSPENDING CLAIM BECAUSE LIMIT HAS ALREADY BEEN REACHED- DENY W/EOBS 339/391. IF NECESSARY, RECOUP CLAIMS IN HX RESULTING IN OVERPAYMENTS W/EOB 339/391. IF AUTH# IS PRESENT-WORK CLAIM ACCORDING TO AUTHORIZATION FILE. ANY QUESTIONS SEE TRAINER/MMIS.

TEXT KEY 738

TEXT DESC

OB CARE (59400,59410,59610,59614) OR C-SECTION CARE (5947M,59510,59515, 59618,59622) BILLED IN COMBINATION W/TRIMESTER CARE(5944M,5945M,5946M, 5951M,5952M) OR TOTAL ANTEPARTUM (59420,5950M) OR POST PARTUM CARE (59430).

CHECK YOUR OB CODE TO IDENTIFY WHETHER OR NOT IT INCLUDES TRI OR POSTPARTUM CARE, SO THAT YOU WILL KNOW IF HISTORY IS APPLICABLE.

1. IF ITS NOT (I.E. 5946M/5951M VS 59515) - FORCE.

2. IF IT IS - DENY OR RECOUP & DENY THE TRIMESTER &/OR POSTPARTUM CARE W/EOB 303. FORCE AUDIT 738.

TEXT KEY 740 — TEXT DESC

OCCUPATIONAL THERAPY IS LIMITED TO 12 PROGRAM VISITS PER CALENDAR YEAR. READ ENTIRE TEXT BEFORE ADJUDICATING CLAIM.

CLAIM TYPE M (OUTPATIENT) - REV CODE IS 420/440 - FORCE.
IF PROVIDER BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY W/EOBS 968/365 AT HEADER.

ALL CLAIM TYPES:
DOS 070199 & AFTER: LIMIT IS CHANGED TO FAIL AT 12 UNITS DUE TO PROGRAM CHANGES. SEE THE FOLLOWING DEFINITIONS OF PROGRAM VISITS TO DETERMINE MAXIMUM ALLOWABLE UNDER THE OCCUPATIONAL THERAPY PROGRAM.

0701M-0702M, 97532-97533 & 97770: EACH UNIT EQUALS ONE PROGRAM VISIT.

TWO UNITS OF THE FOLLOWING PROCEDURE CODES IN ANY COMBINATION EQUAL ONE PROGRAM VISIT:

97110 THERAPEUTIC EXERCISES
97112 NEUROMUSCULAR REDUCTION
97113 AQUATIC THERAPY
97520 PROSTHETIC TRAINING
97530 THERAPEUTIC ACTIVITIES
97535 SELF CARE MNGMENT TRAINING
97537 COMMUNITY/WORK REINTEGRATION

IF AUTHORIZATION PRESENT, REVIEW FOR POSSIBLE PAYMENT:

EFFECTIVE DOS 070100 EXPEDITED AUTHORIZATION (AUTH BEGINS WITH 870000) IS ALLOWED FOR LIMITATION EXTENSIONS (LE) FOR THE FOLLOWING CODES:

644 - AN ADDITIONAL 12 OCCUPATIONAL THERAPY VISITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED VISITS FOR THE CURRENT YEAR AND HAS ONE OF THE FOLLOWING: HAND/UPPER EXTREMITY JOINT SURGERY OR CVA NOT REQUIRING ACUTE INPATIENT REHABILITATION.

645 - AN ADDITIONAL 24 OCCUPATIONAL THERAPY VISITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED VISITS FOR THE CURRENT YEAR AND HAS RECENTLY COMPLETED AN ACUTE INPATIENT REHABILITATION STAY.
LE ARE SUBJECT TO POST PAY REVIEW, AND EXAMINERS ARE NOT REQUIRED TO VERIFY THAT THE REQUIRED CONDITIONS HAVE BEEN MET.

IF OTHER THAN EXPEDITED, AND AUTHORIZATION COVERS THE PROCEDURE AND DATE OF SERVICE - FORCE. OTHERWISE DENY SERVICES OVER THE ESTABLISHED PROGRAM LIMITS FOR DATE OF SERVICE.

DO NOT DENY HISTORY CLAIMS WITH PRIMARY DIAGNOSIS ON LIST 1016 OR COUNT THEM TOWARDS THE LIMIT.

ALL ELSE CUT TO MAX ALLOWED W/INFO EOB 101, OR DENY IF OVER MAX.

OUTPATIENT ONLY:
IF PROVIDER BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY WITH EOBS 968/365.

ANY UNUSUAL SITUATIONS O'LOC TO 75.

TEXT KEY TEXT DESC

741 THE 741 & 746 EXCEPTIONS FAIL ON PROCEDURE CODES NOT ALLOWED IN COMBINATION. 741 POSTS ON THE LINE TO BE FORCED & 746 POSTS ON THE LINE TO BE DENIED. SOMETIMES EXC. 741 & 746 WILL POST ON SAME LINE REFER TO DIRECTIONS BELOW ALONG WITH LIST BEGINNING ON PAGE 2.

1. EXCEPTIONS HITTING SAME OR SUSPENDING CLAIM:
   A. 741 VS 746
      FORCE 741 & DENY 746.

   B. 746 VS 741 & 746
      DENY 746 & FORCE 741 & 746.

   C. 741 & 746 VS 741 & 746
      BY REFERRING TO LIST, DETERMINE WHICH LINE SHOULD BE PAID & WHICH SHOULD BE DENIED. IF PAYING LINE, FORCE BOTH 741 & 746.
      IF DETERMINATION IS TO DENY LINE THEN DENY 746 EXC.
      IF DETERMINATION IS TO PAY LINE THEN FORCE BOTH 741 & 746.

2. EXCEPTIONS HITTING PAID CLAIM IN HISTORY:
   DO NOT RECOUP PAID LINE(S) - DENY SUSPENDING LINE(S). IT WILL BE UP TO PROVIDER TO DO AN ADJUSTMENT ON PAID CLAIM IF NECESSARY.

3. PRIOR AUTH # ON CLAIM:
   FORCE 741 & 746 IF AUTHORIZED.
   (IF PROVIDER NEEDS MORE THAN IS INCLUDED IN KIT THEY MAY CALL AUTH UNIT & REQUEST ADDITIONAL SUPPLIES - EXCEPTION TO POLICY.)

4. FORCE 741/746 IF CLAIM IN HISTORY IS "O" - MEDICARE X-OVER.
   (CSR SUBMITTED SO EXC WON'T FAIL AGAINST CLAIM TYPE O - EXPECTED TO BE COMPLETED BY 10/25/00.)

5. IF 102 & 101 ALSO FAILING ON LINE - FORCE 101 & 102 IF P VS O.
   (CSR SUBMITTED TO STOP 100 EXC FROM AUTODENYING IN THESE CASES)

---------- PLEASE REFER TO LISTS ON PAGES 3-7 ----------

DENY CODES FROM 'B' LIST WHEN BILLED WITH CODE FROM 'A' LIST (CODES IN B LIST ARE INCLUDED OR PART OF KIT/TRAY CODES ON 'A' LIST).

LIST A	LIST B	LIST A	LIST B
A4310	A4311-A4316*	A4311	A4310
	A4354		A4338
	K0281		K0281

LIST A	LIST B	LIST A	LIST B
A4312	A4310	A4313	A4310
	A4344		A4346
			K0281

LIST A	LIST B	LIST A	LIST B
A4314	A4310 A4311 A4338 A4354 A4357 K0280 K0281	A4315	A4310 A4312 A4344 A4354 A4357 K0280 K0281

LIST A	LIST B	LIST A	LIST B
A4316	A4310 K0280 A4313 K0281 A4346 A4354 A4357	A4320*	A4322* A4355*

LIST A	LIST B	LIST A	LIST B
A4331*	A4358*	A4334*	A4358*

LIST A	LIST B	LIST A	LIST B
A4344*	A4312* A4315*	A4351*	A4352*

--NEXT--

LIST A	LIST B	LIST A	LIST B
A4352*	A4351*	A4353	A4310 A4351 A4352 4350A

(A4353 VS K0281 - FORCE.)
CSR SUBMITTED TO CORRECT TABLE 11/00

LIST A	LIST B	LIST A	LIST B
A4354	A4310 A4357 K0280 K0281	A4355	A4320 A4322

--NEXT--

LIST A	LIST B	LIST A	LIST B	LIST A	LIST B
A4357	A4314* A4315* A4316* A4354* K0280	A4358	A5113 A5114 K0280	A4359*	A5105*

LIST A	LIST B	LIST A	LIST B	LIST A	LIST B

A4361	A4375 A4376 A4379 A4380	A4375	A4377	A4376	A4378

LIST A	LIST B	LIST A	LIST B		
A5112	A5113 A5114	A5105	A4358 A4359	A5112 A5113	A5114 K0280

TEXT KEY	TEXT DESC
743	

LIMIT 1 PER CODE PER MONTH (A7003,A4622,A4623,A7010,E0431,E1390).

IF AUTHORIZATION #-REVIEW
IF UNITS AVAILABLE PAY UP TO UNITS ALLOWED & DENY ALL OTHERS.

A4622-4 OR LESS UNITS BILLED-FORCE
OVER 4 UNITS BILLED CUT BACK TO 4 WITH EOB 101

NOTE: IF DUPES POSTING & IT IS A REBILL DENY. ALL ELSE WORK 743 FIRST.

NOTE: IF MULTI UNITS ON ONE LINE AND AUTH # DOES NOT COVER, CUT BACK TO AUTH ALLOWANCE USING EOB 101.

NOTE: ADJUSTMENTS ONLY:IF AUTHORIZED SERVICES PAY CLAIM & E-MAIL DEE DEE HOWDEN/DMM MO TO USE UNITS FROM AUTH SCREEN

WHEN RECOUPING HX OVERPAYMENTS DENY W/EOBS 339/391.

ANY QUESTIONS SEE TRAINER/SUPERVISOR.

TEXT KEY	TEXT DESC
744	NON-DME/MSE MAXIMUM LIMIT 3 PER MONTH

1. MAXIMUM LIMIT OF 3 PER MONTH

2. IF ANY OF THE FOLLOWING COMMENTS ON CLAIM-FORCE:

   A. DOSE ADJUSTMENT REQUIRED
   B. MULTIPLE PRESCRIPTIONS/TYPES REQUIRED
   C. EMERGENCY FILL

3. IF PRIOR AUTHORIZATION ON CLAIM, REVIEW FOR LIMITATION EXTENSION AN PAY ACCORDINGLY.

4. ALL ELSE, CUT BACK UNITS TO MAXIMUM LIMIT WITH EOB'S 101/391 OR DENY IF MAXIMUM LIMITS HAVE BEEN REACHED.

TEXT KEY	TEXT DESC
746	THE 741 & 746 EXCEPTIONS FAIL ON PROCEDURE CODES NOT ALLOWED IN COMBINATION BECAUSE ONE CODE IS INCLUDED IN THE OTHER. WORK PER 741 TEXT FILE.

TEXT KEY TEXT DESC

747 ONE UPPER PARTIAL ALLOWED IN FIVE YEARS

DOS 11-1-02 TO 7-31-03:
1. IF DATES OF SERVICE ARE LESS THAN 1 YEAR APART:
   A. IF AUTHORIZED - FORCE
   B. IF NO AUTH - DENY WITH EOB 023 IN SECOND SLOT.

2. IF DATES OF SERVICE ARE MORE THAN 1 YEAR APART:
   A. IF AUTHORIZED - FORCE.
   B. IF NO JUSTIFICATION - DENY.
   C. IF JUSTIFICATION IS "NO LONGER SERVICEABLE" OR "DAMAGED BEYOND REPAIR"- FORCE.
   D. IF JUSTIFICATION SAYS "LOST" - ALLOW 1 REPLACEMENT WITHIN THE 5 YEAR PERIOD. IF MORE THAN 1 SET WITH THE JUSTIFICATION OF LOST - DENY WITH EOB 339.

DOS 8-1-03 OR AFTER:
1. AGE 21 AND OVER:
   A. IF AUTHORIZED - FORCE.
   B. IF NOT AUTHORIZED - DENY.
2. AGE 20 OR UNDER - FOLLOW DIRECTIONS UNDER DOS 11-2-02 TO 7-31-03.

0515D VS 05211, 5211D, D5211, 05213, 5213D OR D5213
1. DIFFERENT PROVIDERS - FORCE.
2. SAME PROVIDER:
   A. DATES OF SERVICE ARE MORE THAN A YEAR APART - FORCE.
   B. DATES OF SERVICE ARE WITHIN A YEAR OF EACH OTHER - STAGE TO DETERMINE IF THE 0515D IS FOR THE SAME SERVICE.
      1) IF THE SERVICES ARE THE SAME - DENY WITH EOB 189.
      2) IF THE SERVICES ARE DIFFERENT - FORCE.

TEXT KEY TEXT DESC

748 1 LOWER PARTIAL ALLOWED IN 5 YEARS

DOS 11-1-02 TO 7-31-03:
1. IF DATES OF SERVICE ARE LESS THAN 1 YEAR APART:
   A. IF AUTHORIZED - FORCE.
   B. IF NO AUTH - DENY WITH EOB 023 IN SECOND SLOT.
2. IF DATES OF SERVICE ARE MORE THAN 1 YEAR APART:
   A. IF AUTHORIZED - FORCE.
   B. IF NO JUSTIFICATION - DENY.
   C. IF JUSTIFICATION IS "NO LONGER SERVICEABLE" OR "DAMAGED BEYOND REPAIR" - FORCE.
   D. IF JUSTIFICATION SAYS "LOST" - ALLOW 1 REPLACEMENT WITHIN THE 5 YEAR PERIOD. IF MORE THAN 1 SET WITH THE JUSTIFICATION OF LOST - DENY WITH EOB 339.

DOS 8-1-03 OR AFTER:
1. AGE 21 OR OVER:
   A. IF AUTHORIZED - FORCE.
   B. IF NOT AUTHORIZED - DENY.
2. AGE 20 OR UNDER - FOLLOW DIRECTIONS UNDER DOS 11-1-02 TO 7-31-03.

0515D VS 05212, 5212D, D5212, 05214, 5214D OR D5214:
1. IF DIFFERENT PROVIDERS - FORCE.
2. IF THE SAME PROVIDER:
   A. DATES OF SERVICE ARE MORE THAN A YEAR APART - FORCE.
   B. DATES OF SERVICE ARE WITHIN A YEAR OF EACH OTHER - STAGE TO DETERMINE IF THE 0515D IS FOR THE SAME SERVICE.
      1) IF THE SERVICES ARE THE SAME - DENY WITH EOB 189.
      2) IF THE SERVICES ARE DIFFERENT - FORCE.

TEXT KEY	TEXT DESC
750	EXCEEDS MAX ALLOWABLE OF 1 EVERY 5 YEARS

HEARING AIDS - P CLAIM TYPE (MED VENDOR). DOS PRIOR TO 10/1/03.

1. IF EXPEDITED AUTH #870000601 AND DOS IS 7/01/00 OR AFTER, ALLOW 2 HEARING AIDS (5047V-5050V) WITHIN 5 YEARS.
2. IF AUTH # PRESENT, ADJUDICATE PER AUTH FILE.
3. IF MODIFIER "RP" OVERLOC TO 67.
4. ALL ELSE - DENY

DOS 10/1/03 & AFTER - NEW HEARING AID CODES WERE ADDED USING PARAMETER (1028).

TEMPORARILY OVERLOC ALL CLAIMS TO 67.

TEXT KEY 754

TEXT DESC

1 SPEECH EVALUATION 92506 PER CALENDAR YEAR PER PROVIDER. IF AUTH IS PRESENT REVIEW FOR POSSIBLE PAYMENT. FORCE PROVIDER TYPE 36. AUDIT DOES NOT APPLY TO AGE 20 & YOUNGER.

OUTPATIENT ONLY:
IF PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY W/EOBS 968/365 AT HEADER.

EFFECTIVE 070199 SPEECH/LANGUAGE PATHOLOGISTS (P.T. 37 SPECIALTY 76) AND M CLAIM TYPES ARE ALLOWED A SECOND MEDICAL EVALUATION AT THE TIME OF DISCHARGE FOR THE FOLLOWING DIAGNOSIS CODES ONLY:

348.1	ANOXIC BRAIN DAMAGE
436	ACUTE, ILL-DEFINED, CEREBROVASCULAR DISEASE
852-852.5	SUBARACHNOID, SUBDURAL, & EXTRADURAL HEMORRHAGE FOLLOWING INJ
854	INTRACRANIAL INJURY OF OTHER & UNSPECIFIED NATURE
854.1	" WITH OPEN INTRACRANIAL WOUND

IF BILLED BY AUDIOLOGISTS (P.T. 37 SPECIALTY 64) DENY SECOND EVALUATION.

ANY UNUSUAL SITUATIONS OVERLOC TO 83.

ALL ELSE DENY.

TEXT KEY TEXT DESC

755

TOTAL OF 52 UNITS SHOULD BE PAID FOR NURSE DELEGATION SERVICES.

1. COUNT UP THE UNITS IN HISTORY, NOT INCLUDING THE DUPES.
2. IF AUTH # NOT NECESSARY, FORCE THE 755 AUDIT.
3. IF NO AUTH # ON CLAIM - REVIEW THE 11 SCREEN FOR A VALID AUTH # FOR DOS AND IF ONE FOUND, KEY ON CLAIM.
4. CHECK AUTH # TO SEE HOW MANY UNITS ARE AVAILABLE.
5. IT MAY BE NECESSARY TO SPLIT THE LINES AND $, ALWAYS PUTTING THE PAYABLE UNITS ON THE UPPER LINES AND FORCE THE 755.
6. IF MORE UNITS ON THE CLAIM THAN THE AUTH # ALLOWS, MANUALLY DENY THOSE LINES W/EOB 760.
7. IF ANY PROBLEMS OR NOT ABLE TO RESOLVE THE CLAIM - RT TO MMIS/SANDY ASBACH W/DETAILED QUESTION.

NOTE: LISTED ARE A FEW ISSUES THAN MAY INDICATE NECESSITY OF ROUTING TO MMIS.
AUTH # USED ON 52 OR LESS UNITS, 600 EXCEPTION & CANNOT RESOLVE, OR ANY OTHER ISSUE THAT CANNOT BE RESOLVED.

TEXT KEY	TEXT DESC
756	INTERPRETER SIGN LANGUAGE OVER 6 UNITS

1. CONTRACTOR DOES NOT RESPOND TO EMAIL FOR CLAIM DATA OR HAS NOT SENT IN DSHS FORM 17-123 - DENY WITH 0224 EOB.
2. PERFORMING PROVIDER NUMBER ON CLAIM DOESN'T MATCH INTERPRETER FROM CONTRACTOR OR 17-123 FORM - DENY WITH EOB 429.
3. PREFORMING PROVIDER NUMBER NOT A VALID INDIVIDUAL MEDICAID ID NUMBER FOR DATE OF SERVICE ON CLAIM - DENY WITH EOB 080.
4. INTERPRETER SERVICE REQUESTED INAPPROPRIATELY - DENY WITH EOB 757.
5. INSUFFICIENT WRITTEN JUSTIFICATION ON 17-123 FORM OR INPATIENT HOSPITAL - DENY WITH EOB 348.
6. INTERPRETER SERVICE UNITS VERIFIED BY 17-123 FORM AND REDUCED PER TIME - REDUCE UNITS ON LINE WITH SECOND EOB 101 AND FORCE EXC. 094

BJS

TEXT KEY TEXT DESC
758

SYNVISC (J7320)
1/1/04 & AFTER = MAS OF 3 @ $606.00, EA UNIT = $202.00
7/1/03 - 12/31/03= MAX OF 3 @ $633.15, EA UNIT = $211.05
5/1/02 - 6/30/03 = MAX OF 3 @ $627.45, EA UNIT = $209.15
7/1/99 - 4/30/02 = MAX OF 3 @ $646.95, EA UNIT = $215.65

HYALGAN 5 MG (J7316)
1/1/02 - 4/30/02 = MAX OF 20 @ $661, EA UNIT = $33.05
5/1/02 - 6/30/02 = MAX OF 20 @ $640.80, EA UNIT =$32.04
7/1/02 - 12/31/02= MAX OF 20 @ $522.40, EA UNIT = $26.12
NOTE: IF J7315 & J7316 TOGETHER IN THE SAME SERIES - O'LOC TO 83.

HYALGAN 20-25 MG (J7317)
10/1/03 & AFTER = MAX OF 5 @ $627.85, EA UNIT = $125.57
7/1/03 - 9/30/03 = MAX OF 5 @ $643.95, EA UNIT = $128.79
1/1/03 - 6/30/03 = MAX OF 5 @ $666.40, EA UNIT = $133.28
NOTE: IF J7316 & J7317 TOGETHER IN THE SAME SERIES - O'LOC TO 83.

HYALGAN 20 MG (J7315)
7/7/99 - 12/31/01 = MAX OF 5 @ $661.00, EA UNIT = $132.20

THE PURPOSE OF THIS AUDIT IS TO PREVENT PAYING OVER THE MAX ALLOWED
$ AMOUNT FOR THE SERIES.

1. SEE EXCEPTION 348 FOR SPECIFICS.

2. PROCEDURE CODE 20610:
   A. WHEN PRICING DO NOT BE CONCERNED WITH 20610.
   B. IF DENYING SYNVISC(J7320) OR HYALGAN (J7315/J7316/J7315) DENY
      20610 W/EOBS 325/373.

3. DO NOT PAY MORE THAN THE MAX ALLOWED FOR EACH CODE, UNLESS PROVIDER
   IS BILLING FOR LEFT AND RIGHT KNEE, THEN YOU MAY PAY UP TO THE MAX
   FOR EACH SIDE.

4. DO NOT ALLOW MORE THAN THE # OF INJECTIONS LISTED ABOVE.

5. IF IT LOOKS LIKE THE PROVIDER IS BILLING THE MAX ON 1 LINE - MANUAL
   PRICE AT MAX.

6. IF IT LOOKS LIKE THE PROVIDER IS BILLING INDIVIDUAL LINES - MANUAL
   PRICE EA LINE, UP TO THE $ AMT MAX OF THE # OF INJECTIONS WE ALLOW.
   (IE J7317 - EA LINE WOULD GET $125.57)

7. DENY ANY INJECTIONS OVER 3/5 FOR EA KNEE W/EOB'S 339/373.
   NOTE: PER DR. BAUMGARTNER THERE SHOULD BE APPROXIMATELY A 12 WEEK
   INTERVAL BEFORE REPEATING THE SERIES OF INJECTIONS. THUS, IF HX
   INDICATES THIS INTERVAL, YOU MAY START OVER WITH THE PRICING.
   IF LESS THAN A 12 WK INTERVAL BETWEEN SERIES - DENY W/EOB 339.
   ANY QUESTIONS SHOULD BE DIRECTED TO SANDY A/MMIS.

TEXT KEY TEXT DESC
767

NOTE: DO NOT COUNT ANY HISTORY FOR DATES OF SERVICE 10/01/03 AND AFTER.

IF MATERNITY SUPPORT SERVICES ATTACHMENT (LETTER OR E-MAIL COPY) REQUESTING ADDITIONAL SERVICES OR COMMENT "ROUTE TO DIANE TIFFANY, MS 45530, PER SHELLEY MCDERMOTT": ROUTE TO DIANE TIFFANY MS 45530. USE INFORMATIONAL EOB 103 IN SECOND SLOT AT HEADER.

UPON RETURN FROM INTERNAL REVIEW, FINALIZE CLAIM ACCORDING TO DIRECTION FROM PROGRAM MANAGER. KEY EOB 373 OVER EOB 103. USE OVERCODE 998.

TEXT KEY	TEXT DESC
769	

TEXT KEY TEXT DESC

772 CONTRAST MATERIAL IS INCLUDED IN MRI/CAT ALLOWANCE.

MRI:

1. IF BILLING CONTRAST MATERIAL WITH PROCEDURE CODES:
   70541, 70552, 70553, 71555, 72142, 72147, 72149, 72156, 72157, 72158, 72193, 72194, 72198, 73201, 73225, 73725, 74185, 75553, 75554, 75555, 76093, 76094 - DENY W/EOB 800.

2. IF BILLING CONTRAST MATERIAL WITH ANY OTHER MRI PROCEDURE CODE - DENY WITH EOB 365.

3. IF 90782 OR 90784 FOR INJECTION OF CONTRAST MATERIAL ON SAME CLAIM DENY WITH EOB 365.

4. IF 79999 AND BILLING FOR CONTRAST MATERIAL -DENY.

CAT & CT SCANS:

1. IF BILLING CONTRAST MATERIAL WITH PROCEDURE CODES:
   70460, 70470, 70481, 70482, 70487, 70488, 70491, 70492, 71260, 71270, 72126, 72127, 72129, 72130, 72132, 72133, 73701, 70702, 74160, 74170 - DENY W/EOB 800.

2. IF BILLING CONTRAST MATERIAL WITH ANY OTHER CAT OR CT PROCEDURE DENY WITH EOB 365.

3. IF 90782 OR 90784 FOR INJECTION OF CONTRAST MATERIAL ON SAME CLAIM - DENY WITH EOB 365.

4. IF 79999 AND BILLING FOR CONTRAST MATERIAL - DENY.

TEXT KEY 773

TEXT DESC

NOTE: DO NOT COUNT ANY HISTORY FOR DATES OF SERVICE ON OR BEFORE 10/15/03.

1. IF UNITS APPEAR OVERLY EXCESSIVE FOR THE BILLED AMOUNT, DENY WITH EOB 452.

2. IF MATERNITY SUP SERVICES ATTACHMENT (LETTER OR E-MAIL COPY) REQUESTING ADDITIONAL SERVICES OR COMMENT "ROUTE TO DIANE TIFFANY, MS 45530" : ROUTE TO DIANE TIFFANY/MS 45530 & USE INFORMATIONAL EOB 103 IN THE SECOND SLOT AT HEADER.

UPON RETURN FROM INTERNAL REVIEW, FINALIZE CLAIM ACCORDING TO DIRECTION FROM PROGRAM MANAGER. KEY EOB 373 OVER EOB 103. USE OVERCODE 998.

TEXT KEY	TEXT DESC
774	

TEXT KEY
779

TEXT DESC

1. 0115M (HOME BLOOD MONITORING) ALLOW 1 PER CALENDAR YEAR, DENY ALL OTHERS.

2. 0075M (SHORT TERM CASE MGMT) ALLOW 1PER CALENDAR YEAR, DENY ALL OTHERS.

3. 0116M (INSULINIZATION) ALLOW 1 PER CALENDAR YEAR, DENY ALL OTHERS.

4. 0117M (INTENSIFIED INSULIN THERAPY) ALLOW 1 PER CALENDAR YEAR, DENY ALL OTHERS.

TEXT KEY TEXT DESC
780

NOTE: IF CLAIM OR COMMENT INDICATES "CLIENT MOVED, TRANSFERRED CARE TO NEW DR":
A. DIFFERENT PROVIDER AND NO PERFORMING PROVIDER # - FORCE AND OVERCODE 617.
B. DIFFERENT PROVIDER AND DIFFERENT PERFORMING PROVIDER - FORCE AND OVERCODE 617.
C. DIFFERENT PROVIDER AND SAME PERFORMING PROVIDER# - APPLY POLICY BELOW.
D. ALL ELSE - APPLY POLICY BELOW.
ANY QUESTIONS SEE YOUR SUPV/TRAINER/MMIS

1. ALLOW 1 ROUTINE ANTEPARTUM CARE CODE PER MONTH
A. 5951M - 1ST AND 2ND TRI CARE
B. 5952M - 3RD TRI CARE

2. ALLOW 1 HIGH RISK MANAGEMENT CODE PER MONTH
A. 5953M - 1ST TRI, HIGH RISK ADD ON
B. 5954M - 2ND TRI, HIGH RISK ADD ON
C. 5955M - 3RD TRI, HIGH RISK ADD ON

ALLOW ONLY 1 OF THE CODES IN 1.A/B & 1 OF THE CODES IN 1.A/B/C PER MO, DENY OTHERS. PAY THE EARLIEST DOS IN THE MO IF BOTH ARE LIVE, OTHERWISE - DENY THE CURRENT.

IF THE MAX ALLOWED FOR THE PROCEDURE HAS NOT BEEN MET - DO NOT PAY ADDITIONAL MONIES, AN ADJ WILL HAVE TO BE DONE BY PROVIDER.

BE ALERT TO DUPES. >>>>>>>>

NOTE: IF YOU SEE 2 DIFFERENT BILLING #'S PAID IN HX & THE ICN IS PRIOR TO (02032) - DO NOT RECOUP, IF AFTER ICN(02032) -APPLY AUDIT.

3. FQHC'S (SPECIALTY 90)
IF NOT PAYING ANY MONTHLY TRIMESTER/HIGH RISK MANAGEMENT CODES, MANUALLY DENY ENCOUNTER 9001M OR 5900M ON SAME CLAIM FOR SAME DAY/MONTH WITH EOB'S 757/189 WHEN BLOOD DRAWS, LAB, X-RAYS, J CODES &/OR 59000 SERIES CODES(NON-DELIVERY) PAY ON SAME DOS. THESE LAST CODES DO NOT GET AN ENCOUNTER W/O A PAID PRE-NATAL ASSESSMENT, TRIMESTER, HIGH-RISK OR DELIVERY CODE.
MULTIPLE 9001M'S MUST BE BILLED ON OR ADJUSTED ONTO THE SAME CLAIM AS THE PAID GLOBAL PROCEDURE.

TEXT KEY TEXT DESC
781 5951M (1ST AND 2ND) TRIMESTER CARE

NOTE: IF DIFFERENT PREGNANCY,NEW PREGNANCY,2ND PREGNANCY,ETC OR COMMENT "CLIENT MOVED, TRANSFERRED CARE TO NEW DR":

A. DIFFERENT PROVIDER AND NO PERFORMING PROVIDER# - FORCE AND OVERCODE 617.
B. DIFFERENT PROVIDER AND DIFFERENT PERFORMING PROVIDER - FORCE AND OVERCODE 617.
C. DIFFERENT PROVIDER AND SAME PERFORMING PROVIDER - APPLY POLICY BELOW.
D. DIFFERENT PREGNANCY,NEW PREGNANCY, 2ND PREGNANCY, ETC - FORCE AND OVERCODE 555.
E. ALL ELSE - APPLY POLICY BELOW.
ANY QUESTIONS ASK YOUR SUPV/TRAINER/MMIS

1. PAY UP TO 6, 6 MO IN A ROW IF POSSIBLE.

2. DO NOT ALLOW MULTIPLES IN A MONTH OR ON 1 LINE.

3. DO NOT ALLOW 1ST OR 2ND TRIMESTER TO BE BILLED THE SAME MONTH AS 3RD HIGH RISK TRIMESTER, IF POSSIBLE.

4. PAY TRI CARE CODES IN BEST ORDER POSSIBLE, & ONLY ADJ WHEN VERY CLEAR PROBLEM. EOB(S) 917/189 MAY BE NECESSARY.

5. IF YOU SEE 2 DIFFERENT BILLING #'S PAID IN HX & THE ICN IS PRIOR TO (02032) - DO NOT RECOUP, IF AFTER (02032) - APPLY AUDIT.

ANY UNUSUAL CIRCUMSTANCES,QUESTIONS OR POSSIBLE ADJ - SEE YOUR SUP.

6. FQHC'S (SPECIALTY 90)

IF NOT PAYING ANY MONTHLY TRIMESTER/HIGH RISK MANAGEMENT CODES, MANUALLY DENY ENCOUNTER 9001M OR 5900M ON SAME CLAIM FOR SAME DAY/MONTH WITH EOB'S 757/189 WHEN BLOOD DRAWS, LAB, X-RAYS, J CODES &/OR 59000 SERIES CODES(NON-DELIVERY) PAY ON SAME DOS. THESE LAST CODES DO NOT GET AN ENCOUNTER W/O A PAID PRE-NATAL ASSESSMENT, TRIMESTER, HIGH-RISK OR DELIVERY CODE.
MULTIPLE 9001M'S MUST BE BILLED ON OR ADJUSTED ONTO THE SAME CLAIM AS THE PAID GLOBAL PROCEDURE.

TEXT KEY TEXT DESC

782 IF AUDIT 780 OR 781 IS ALSO POSTING - WORK IT FIRST.

NOTE: IF DIFFERENT PREGNANCY,NEW PREGNANCY,2ND PREGNANCY, ETC OR COMMENT "CLIENT MOVED, TRANSFERRED CARE TO NEW DR":

A. DIFFERENT PROVIDER WITH NO PERFORMING PROVIDER # - FORCE AND OVERCODE 617.
B. DIFFERENT PROVIDER AND DIFFERENT PERFORMING PROVIDER - FORCE AND OVERCODE 617.
C. DIFFERENT PROVIDER AND SAME PERFORMING PROVIDER - APPLY POLICY BELOW.
D. DIFFERENT PREGNANCY, NEW PREGNANCY, 2ND PREGNANCY, ETC - FORCE AND OVERCODE 555.
E. ALL ELSE - FOLLOW TEXT BELOW.
ANY QUESTIONS SEE SUPV/TRAINER/MMIS

1. ALLOW 3 ROUTINE ANTEPARTUM CARE CODES (5952M) FOR 3RD TRIMESTER. (3 CONSECUTIVE MO). PAY IN ORDER IF POSSIBLE.

2. ALLOW 3 EACH HIGH RISK ADD ON CODES (LISTED BELOW) FOR EACH TRIMESTER
   1. 5953M - 1ST TRI, HIGH RISK ADD ON
   2. 5954M - 2ND TRI, HIGH RISK ADD ON
   3. 5955M - 3RD TRI, HIGH RISK ADD ON

3. DO NOT PAY 3RD TRIMESTER IN SAME MONTH AS 1ST OR 2ND HIGH RISK, DENY W/EOB 917.

4. DO NOT ALLOW ALTERNATE TRIMESTER/HIGH RISK CARE, THEY SHOULD BE BILLED IN ORDER IF POSSIBLE. YOU MAY NEED TO DENY W/EOB 917 OR 302.

5. BE AWARE OF DUPES.

6. IF YOU SEE DIFFERENT BILLING #'S PAID IN HX & THE ICN IS PRIOR TO (02032) - DO NOT RECOUP OR COUNT AGAINST ANOTHER PROVIDER #, OTHERWISE, IF AFTER ICN (02032) APPLY AUDIT.

7. IF MORE THAN THE ABOVE LIMITS FOR EACH CODE ARE BILLED - DENY. QUESTIONS OR UNUSUAL CIRCUMSTANCES OR POSSIBLE ADJ - SEE TRAINER/ SUP.

8. FQHC'S (SPECIALTY 90) SEE NEXT PAGE.

IF NOT PAYING ANY MONTHLY TRIMESTER/HIGH RISK MANAGEMENT CODES, MANUALLY DENY ENCOUNTER 9001M OR 5900M ON SAME CLAIM FOR SAME DAY/ MONTH WITH EOB'S 757/189 WHEN BLOOD DRAWS, LAB, X-RAYS, J CODES &/OR 59000 SERIES CODES(NON-DELIVERY) PAY ON SAME DOS. THESE LAST CODES DO NOT GET AN ENCOUNTER W/O A PAID PRE-NATAL ASSESSMENT, TRIMESTER, HIGH-RISK OR DELIVERY CODE.

MULTIPLE 9001M'S MUST BE BILLED ON OR ADJUSTED ONTO THE SAME CLAIM AS THE PAID GLOBAL PROCEDURE.

TEXT KEY TEXT DESC
783

NEW ANTEPARTUM CODES (59425, 4-6 VISITS OR 59426 7 OR MORE VISITS) VS OLD TRI CARE CODES (5951M,5952M) OR NEW VS NEW TRI CODES.

THIS AUDIT IS DESIGNED TO CATCH NEW ANTEPARTUM VS NEW ANTEPARTUM CODES AND THIS AUDIT IS DESIGNED TO CATCH NEW ANTEPARTUM VS OLD ANTEPARTUM CODES. THIS COULD COVER A TIME PERIOD OF THE PAST 8 MO. OR THE NEXT 8 MO. PROVIDERS HAVE BEEN BILLING THE MONTHLY TRI CODES & THOSE CODES END ON 07/31/03 DOS. THE NEW ANTEPARTUM CODES ARE EFFECTIVE W/DOS 07/01/03 & WILL REPLACE BILLING PRACTICES.

NOTE: IF CLAIM OR COMMENTS INDICATES "CLIENT MOVED, TRANSFERRED CARE TO NEW DR, ETC"
A. DIFFERENT PROV & NO PP # - FORCE & O'CODE 617.
B. DIFFERENT PROV & DIFFERENT PP # - FORCE & O'CODE 617.
C. DIFFERENT PROV & SAME PP # - APPLY POLICY BELOW.
D. ALL ELSE - APPLY POLICY BELOW.

NOTE: NEW ANTEPARTUM CODES VS TOTAL OB WILL BE ADJUDICATED IN AUDIT 099.

MAA MUST BE ABLE TO IDENTIFY THE OLD CODES PAID, WHEN THE NEW CODES ARE BILLED TO ADJUST THE MONIES. WHEN THIS AUDIT POSTS YOU WILL HAVE ONE OF 2 ISSUES.

1. NEW CODES VS NEW CODES: (ONLY 1 ALLOWED PER PREGNANCY)
   A. IF 59425 &/OR 59426 ARE SUSPENDING - PAY THE HIGHER & DENY ALL ELSE.
   B. IF 1 OF THE CODES PAID IN HX - DENY CURRENT. IF DENYING 59426- USE INFO EOB 189 FOR SAME PROVIDER OR 2 DIFF PROVIDERS IN SAME CLINIC, IF 2 DIFF BILLING PROVIDERS - DENY & USE INFO EOB 280.
2. NEW CODES VS OLD CODES: (59425/59426)BILLED & POSTING AGAINST 1 OR MORE OLD CODES IN HX. (THIS TEXT APPLIES TO NON FACILITY PRICE ONLY. IF FACILITY POS (1,2,5,21,22,23) ON CODES, O'LOC TO 75 FOR REVIEW.

   MANUAL PRICE):
   A. REVIEW HX FOR OLD CODES (5951M/5952M) & ADD UP $ PAID, USE $ AMT BELOW TO DECIPHER HOW MUCH WE HAVE PD & SUBTRACT FROM ALLOWED ON NEW CODE (59425 OR 59426), MANUAL PRICE NEW CODE AT:
      1. $ OWED W/INFO EOB 001.
      2. IF NO BALANCE LEFT - DENY W/EOB 561.
   B. IF NEW & OLD CODES BOTH IN SUSPENSE:
      1. ALL OF THE OLD CODES IN SUSPENSE - DENY THE OLD CODES W/EOB 905 & PAY THE HIGHER OF THE NEW CODES. DENY THE LOWER OF THE NEW CODES IF BOTH BILLED W/EOB 825.
      2. OLD CODES PART PD & PART IN SUSPENSE - DENY SUSPENDED OLD CODES, FOLLOW 2.A ABOVE TO MANUAL PRICE NEW CODE.
3. 59425 ALLOWED AMT = $453.16
   59426 ALLOWED AMT - $797.37
4. 5951M: 5952M: SOME ALREADY COMPUTED COMBOS:
   1 = $ 74.31 1 = $126.28 5 5951M + 1 5952M = $497.83
   2 = 148.62 2 = 252.56 5 5951M + 2 5952M = $624.11

3 = 222.93	3 = 378.84	5 5951M + 3 5952M = $750.39
4 = 297.24		6 5951M + 1 5952M = $572.14
5 = 371.55		6 5951M + 2 5952M = $698.42
6 = 445.86		6 5951M + 3 5952M = $824.70

5. EXAMPLE:
   59426 BILLED & ALLOWED IS $797.37.
   3 5951M'S @ $222.93 AND 2 5952M'S @ $252.56 ARE PD = TOTAL PAID OF $475.49. SUBTRACT FROM $797.37 = MANUAL PRICE OF $321.88.
NOTE: IF ANY INDICATION OF DIFFERENT PREGNANCY - FORCE.

6. LOC 34: ANY QUESTIONS - SEE SUP/MMIS/SANDY A-TRINA (O'LOC 83 IF NOT AVAILABLE).

TEXT KEY	TEXT DESC
784	PANTS & PANT LINERS 150 MAX LIMIT PER MONTH.

IF PRIOR AUTH# ON CLAIM OR IN HX.

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1. REVIEW AUTH FILE FOR "ADDITIONAL" AMOUNT THAT HAS BEEN APPROVED.
2. IF CODE ON CLAIM DOES NOT MATCH CODE AUTH'D DENY 353 EXC W/EOB 251 & PA2 784 EXC.
3. IF 608/353 IS POSTING AND ADDITIONAL AMOUNT IS APPROVED, FORCE 608/353/784 & SEND W/S TO AUTH UNIT TO "USE" UNITS.

TEXT KEY TEXT DESC
785

EXCEEDS MAX OF 48 PHYSICAL THERAPY PROGRAM UNITS PER CALENDAR YEAR, PER DIAGNOSIS, ANY PROVIDER. FORCE PROVIDER TYPES 37 AND 40. DOS 060100 AND AFTER FORCE 97504 AND 97703 & DO NOT COUNT TOWARDS LIMIT. DOES NOT APPLY TO AGE 20 & YOUNGER. READ ENTIRE TEXT BEFORE ADJUDICATION.

CLAIM TYPE M (OUTPATIENT) - REV CODE 430/440 - FORCE. *SR
NOTE: IF PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY ON THE SAME CLAIM - DENY W/EOBS 968/365 AT HEADER.

CLAIM TYPES J/P:
DO NOT COUNT HISTORY OF PROVIDER TYPE 37 & 40 TOWARDS LIMIT.

ALL CLAIM TYPES:
DIFFERENT DIAGNOSIS ALLOWS ANOTHER 48 UNITS. DIAGNOSIS MUST BE FOR A NEW OR UNRELATED INJURY. WATCH FOR RELATED DIAGNOSIS & ADJUDICATE ACCORDINGLY. E.G.: 723.1 CERVICALGIA (NECK PAIN) VS 847.0 NECK SPRAIN WOULD BE DENIED AS RELATED UNLESS AUTHORIZATION APPLIED.

DO NOT COUNT HISTORY CLAIMS WITH PRIMARY DIAGNOSIS FROM LIST 1018 OR COUNT THEM TOWARD LIMIT. WHEN CALCULATING HISTORY CLAIMS, DO NOT COUNT CLAIMS WITH SPECIAL DIAGNOSIS TOWARD LIMITATION. SEE DIAGNOSIS LIST 1018 ON THE 10 SCREEN. OUTPATIENT (M): CHECK HISTORY CLAIMS IN THE 04 SCREEN FOR SECONDARY DIAGNOSIS FROM LIST 1018 & ADJUDICATE ACCORDINGLY.

IF YOU CORRECT THE DX AND THE DX IS ON THE 1018 LIST, CYCLE THE CLAIM FOR THE SYSTEM TO CHECK THE DX AND POST THE APPROPRIATE AUDIT.

DOS PRIOR TO 060100 THE SYSTEM WAS SET AT A DOLLAR LIMIT AS FOLLOWS:
070198-053000 LIMIT OF $695.00 WITHOUT SPECIAL DIAGNOSIS OR AUTH.

DOS PRIOR TO 060100 - SYSTEM LOOKED AT SAME PROVIDER. ONLY COUNT CLAIMS FROM THE SAME PROVIDER TOWARDS LIMIT, FORCE VS DIFFERENT PROVIDER.

IT MAY BE NECESSARY TO VERIFY CLAIM FIELDS ON CURRENT AND/OR HISTORY FOR ACCURACY. ADJUDICATE ACCORDINGLY. SPECIAL HANDLE ADJUST HISTORY IF NECESSARY. IF YOU CHANGE ANYTHING ON CURRENT CLAIM IT MAY NEED TO BE CYCLED. IF YOU ADJUST HISTORY THE CURRENT AUDIT MAY NOT APPLY. DO NOT DENY 785 IF THE CORRECTED DIAGNOSIS IS ON THE SPECIAL DIAGNOSIS LIST 1018. SYSTEM CHECKS DIAGNOSIS AND POSTS APPROPRIATE AUDIT.

IF AUTHORIZATION PRESENT, REVIEW FOR POSSIBLE PAYMENT:

EFFECTIVE DOS 070100 EXPEDITED AUTHORIZATION (AUTH BEGINS WITH 870000) IS ALLOWED FOR LIMITATION EXTENSIONS (LE) FOR THE FOLLOWING CODES:

640 - 48 ADDITIONAL PHYSICAL THERAPY PROGRAM UNITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED PROGRAM UNITS FOR THE CURRENT YEAR AND HAS ONE OF THE FOLLOWING SURGERIES OR INJURIES: LOWER EXTREMITY JOINT SURGERY, CVA NOT REQUIRING ACUTE INPATIENT REHABILITATION OR SPINE SURGERY.

641 - 96 ADDITIONAL PHYSICAL THERAPY PROGRAM UNITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED PROGRAM UNITS FOR THE CURRENT YEAR AND HAS RECENTLY COMPLETED AND ACUTE INPATIENT REHABILITATION STAY.

LE ARE SUBJECT TO POST PAY REVIEW, & EXAMINERS ARE NOT REQUIRED TO VERIFY THAT THE REQUIRED CONDITIONS HAVE BEEN MET.

IF OTHER THAN EXPEDITED, AND AUTHORIZATION COVERS THE PROCEDURE AND DATE OF SERVICE - FORCE. ALL ELSE DENY SERVICES OVER THE ESTABLISHED PROGRAM LIMITS FOR DATE OF SERVICE.

IF SUSPENDED LINE EXCEEDS LIMITATION - DENY. EXCEPTION: IF YOU ARE ABLE TO ESTABLISH THAT ITS FOR AN UNRELATED DX OR NEW INJURY (E.G.: CARPAL TUNNEL VS BACK INJURY) THEN EACH DIAGNOSIS COUNTS SEPARATELY TOWARD THE LIMIT. RECOUP HISTORY CLAIMS OVER THE LIMIT IF APPROPRIATE. IF EXCESSIVE RECOUPMENTS ARE INDICATED, SEE MMIS SERVICES BEFORE RECOUPING.

HISTORY CONTAINING DATES OF SERVICE BEFORE AND AFTER 060100: IF THE MAX OF 695.00 IS ALREADY PAID IN HISTORY DENY DOS AFTER 6/1. IF MAX $ WAS NOT PAID BEFORE 6/1, BUT CALCULATING THE NEW UNIT LIMIT THE UNIT MAX IS EXCEEDED - DENY THE DATES AFTER 6/1.

NOTE: THE MAY 2000 BILLING INSTRUCTIONS STATE THE SPECIAL DIAGNOSIS MUST BE BILLED PRIMARY, THEREFORE YOU DO NOT HAVE TO CHECK HISTORY FOR ANY SECONDARY DIAGNOSIS.

CLAIMS WITH X IN LMC & OL 37, REVIEW FOR COMMENT OF NEW INJURY.

ANY UNUSUAL SITUATIONS OL 75 WITH COMMENTS OF PF7 SCREEN.

TEXT KEY TEXT DESC
786

EXCEEDS MAX OF 96 ADDITIONAL (144 TOTAL) PHYSICAL THERAPY PROGRAM UNITS PER CALENDAR YEAR, PER DIAGNOSIS, ANY PROVIDER. FORCE PROVIDER TYPES 37 AND 40. DOS 060100 & AFTER FORCE 97504 & 97703 AND DO NOT APPLY TOWARDS LIMIT. AUDIT DOESN'T APPLY TO CLIENTS AGE 20 & YOUNGER. READ ENTIRE TEXT BEFORE ADJUDICATION.

CLAIM TYPE M (OUTPATIENT) - REV CODE 430/440 - FORCE. *SR
NOTE: IF PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY ON SAME CLAIM - DENY W/EOBS 968/365 AT HEADER.

CLAIM TYPES J/P:
DO NOT COUNT HISTORY OF PROVIDER TYPE 37 & 40 TOWARDS LIMIT.

ALL CLAIM TYPES:
DIFFERENT DIAGNOSIS ALLOWS ANOTHER 96 UNITS. DIAGNOSIS MUST BE FOR A NEW OR UNRELATED INJURY. WATCH FOR RELATED DIAGNOSIS & ADJUDICATE ACCORDINGLY. E.G.: 343 CEREBRAL PALSY VS 343.9 UNSPECIFIED CEREBRAL PALSY WOULD BE DENIED AS RELATED UNLESS AUTHORIZATION APPLIED.

DOS PRIOR TO 060100 THEY SYSTEM WAS SET AT A DOLLAR LIMIT AS FOLLOWS:
070198-053000 LIMIT OF $2,085.00 WITHOUT SPECIAL DIAGNOSIS OR AUTH.

DOS PRIOR TO 060100 - SYSTEM LOOKED AT SAME PROVIDER. ONLY COUNT CLAIMS FROM THE SAME PROVIDER TOWARDS LIMIT, FORCE VS DIFFERENT PROVIDER.

IT MAY BE NECESSARY TO VERIFY CLAIM FIELDS ON CURRENT AND/OR HISTORY FOR ACCURACY. ADJUDICATE ACCORDINGLY. SPECIAL HANDLE ADJUST HISTORY IF NECESSARY. IF YOU CHANGE ANYTHING ON CURRENT CLAIM IT MAY NEED TO BE CYCLED. IF YOU ADJUST HISTORY THE CURRENT AUDIT MAY NOT APPLY. DO NOT DENY 786 IF THE CORRECTED DIAGNOSIS IS NOT ON THE SPECIAL DIAGNOSIS LIST 1018. CYCLE THE CLAIM AND LET THE SYSTEM CHECK THE DIAGNOSIS AND POST THE APPROPRIATE AUDIT.

IF AUTHORIZATION PRESENT, REVIEW FOR POSSIBLE PAYMENT:

EFFECTIVE DOS 070100 EXPEDITED AUTHORIZATION (AUTH BEGINS WITH 870000) IS ALLOWED FOR LIMITATION EXTENSIONS (LE) FOR THE FOLLOWING CODES:

640 - 48 ADDITIONAL PHYSICAL THERAPY PROGRAM UNITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED PROGRAM UNITS FOR THE CURRENT YEAR AND HAS ONE OF THE FOLLOWING SURGERIES OR INJURIES: LOWER EXTREMITY JOINT SURGERY, CVA NOT REQUIRING ACUTE INPATIENT REHABILITATION OR SPINE SURGERY.

641 - 96 ADDITIONLA PHYSICAL THERAPY PROGRAM UNITS WHEN THE CLIENT HAS ALREADY USED THE ALLOWED PROGRAM UNITS FOR THE CURRENT YEAR AND HAS RECENTLY COMPLETED AN ACUTE INPATIENT REHAB STAY. LE ARE SUBJECT TO POST PAY REVIEW AND EXAMINERS ARE NOT REQUIRED TO VERIFY THAT THE REQUIRED CONDITIONS HAVE BEEN MET.

IF OTHER THAN EXPEDITED, AND AUTHORIZATION COVERS THE PROCEDURE AND DATE

OF SERVICE - FORCE. ALL ELSE DENY SERVICES OVER THE ESTABLISHED PROGRAM LIMITS FOR DATE OF SERVICE.

IF SUSPENDED LINE EXCEEDS LIMITATION - DENY. EXCEPTION: IF YOU ARE ABLE TO ESTABLISH THAT ITS FOR AN UNRELATED DX OR NEW INJURY (E.G.: BRAIN INJURY VS WOUND OF LOWER LIMB) EACH DIAGNOSIS COUNTS SEPARATELY TOWARD THE LIMIT. RECOUP HISTORY CLAIMS OVER THE LIMIT IF APPROPRIATE. IF EXCESSIVE RECOUPMENTS ARE INDICATED, SEE MMIS SERVICES BEFORE RECOUPING.

HISTORY CONTAINING DATES OF SERVICE BEFORE AND AFTER 060100: IF THE MAX OF 695.00 IS ALREADY PAID IN HISTORY DENY DOS AFTER 6/1. IF MAX WAS NOT PAID BEFORE 6/1, BUT CALCULATING THE NEW UNIT LIMIT THE UNIT MAX IS EXCEEDED - DENY THE DATES AFTER 6/1.

NOTE: THE MAY 2000 BILLING INSTRUCTIONS STATE THE SPECIAL DIAGNOSIS MUST BE BILLED PRIMARY, THEREFORE YOU DO NOT HAVE TO CHECK HISTORY FOR ANY SECONDARY DIAGNOSIS.

CLAIMS WITH X IN LMC & OL 37, REVIEW FOR COMMENT OF NEW INJURY.

ANY UNUSUAL SITUATIONS OL 75 WITH COMMENTS IN PF7 SCREEN.

TEXT KEY TEXT DESC

787

ONE HIV/AIDS CASE MGMT PER MONTH

ONLY ONE CASE MANAGEMENT CODE (0470M) IS ALLOWED. THIS CODE IS FOR AN ENTIRE MONTHS SERVICES. IF THE SAME PROVIDER IS BILLING A SECOND TIME - DENY. IF A DIFFERENT PROVIDER IS BILLING - DENY WITH EOB 791.

IF A PARTIAL CASE MANAGEMENT CODE (0471M) IS POSTING AGAINST ANOTHER PARTIAL (0471M) OR AGAINST A FULL (0470M) BEING BILLED BY A DIFFERENT PROVIDER AN OVERLAPPING OF UP TO 5 DAYS IS ACCEPTABLE. IF THE THE OVERLAP IS 6 DAYS OR MORE - DENY WITH EOB 791.

IF THE SAME PROVIDER BILLES BOTH 0470M AND 0471M FOR THE SAME MONTH - DENY. A PROVIDER IS ALLOWED A 0472M IN COMBINATION WITH OTHER SERVICES HOWEVER THEY ARE ONLY ALLOWED ONE 0472M PER PATIENT. TWO PARTIALS (0471M) ARE ALLOWED BY THE SAME PROVIDER IN THE SAME MONTH, IF MORE DENY.

IF THERE ARE SITUATIONS THAT ARISE THAT ARE NOT COVERED PLEASE OVERLOC TO ALLON PETERMAN, LOCATION 83.

TEXT KEY	TEXT DESC
788	

TEXT KEY	TEXT DESC
790	

TEXT KEY TEXT DESC

791

LAB PROCEDURE INCLUDED IN PRENATAL PANEL I OR II.

1. IF PROVIDER # 7038359 (OLY MEDICAL LAB) OR 7010937 (PATHOLOGY ASSOC OF SPOKANE) - FORCE.

2. IF 86317, 86280 OR 86762 BILLED WITH PANEL I, PAY -
   A. $16.95 FOR DOS 1/1/93-4/30/95
   B. $16.94 FOR DOS 5/1/95-6/30/95
   C. $17.29 FOR DOS 7/1/95-6/30/96
   D. $18.14 FOR DOS 7/1/96 AND AFTER

3. ALL ELSE - DENY

TEXT KEY TEXT DESC

792 PANT/PANT LINER CODES NOT ALLOWED IN COMBINATION

PANT/PANT LINER CODES MAY ONLY BE BILLED IN COMBINATION IF "DY" OR "59" MODIFIER ON CLAIM. ALLOW UP TO MAXIMUM OF 240 FOR ADULTS OR 300 FOR CHILDREN AGES 19 AND UNDER. IF CLAIM EXCEEDS LIMIT, CUT BACK TO ALLOWED AMOUNT USING INFO EOB 0101. IF THE MAXIMUM LIMIT HAS BEEN PAID DENY USING EOB'S 0309/0339.

IF PRIOR AUTHORIZATION # ON CLAIM OR IN HISTORY:

1. REVIEW AUTH FILE TO SEE IF ADDITIONAL HAS BEEN ALLOWED OVER THE MAXIMUM OF 240/300(SEE AUTH SCREEN AND AUTH NOTES).

   A. IF CODE ON CLAIM DOES NOT MATCH CODE AUTHORIZED DENY 353 EXCEPTION WITH EOB 0251 AND PA2 784 EXCEPTION.

   B. IF 608/353 IS POSTING AND ADDITIONAL AMOUNT IS APPROVED FORCE 608/353/792 AND SEND WORKSHEET TO AUTH UNIT(QUS) TO "USE UNITS". FORCING 608 EXCEPTION BYPASSES AUTH FILE AND THE UNITS WILL NOT BE USED AUTOMATICALLY, THEREFORE,QUS MUST UPDATE FILE MANUALLY.

   C. IF 608/353 IS NOT POSTING AND ADDITIONAL AMOUNT IS APPROVED FORCE 792.

BE SURE TO TAKE INTO CONSIDERATION HISTORY CLAIMS WITH PRIOR AUTH#'S.

NOTE: IF 353 POSTING ON ANOTHER CODE NOT NEEDING AUTHORIZATION-FORCE.

TEXT KEY	TEXT DESC
798	SERVICES APPEAR TO BE FOR LATE CHARGES AND ARE INCLUDED IN DRG REIMBURSEMENT AMOUNT. IF DRG HAS NOT BEEN PAID AND CHARGES ARE FOR OUTPATIENT SERVICERS, CORRECT BILL TYPE AND RESUBMIT.

TEXT KEY	TEXT DESC
799	RESOLUTIONS AND ADJUSTMENTS:

NOTE: IF PA# ON CLAIM - REVIEW FOR EXTENSION TO LIMIT AND PAY
IF ADDITIONAL AMOUNT IS APPROVED (IF 608/353 EXCEPTIONS, FORCE
AND SEND DEAD CLAIM TO QRS FOR AUTH FILE UPDATE).

TEXT KEY TEXT DESC
856 X-OVER CLAIM OUT OF BALANCE.

MEDICARE NON-INST. X-OVERS (O)

1. HARD COPY CLAIMS
   A. PSYCHIATRIC CLAIMS FOR TREATMENT (90841-90899) OR (G0071-G0094)
      IF YOU HAVE ADDED THE REDUCTION (RC-AMOUNT) FROM THE RIGHT HAND SIDE OF THE REMITTANCE ADVICE TO THE COINSURANCE AND/OR DEDUCTIBLE AND KEYED IN THE ALLOWED AMOUNT ON THE SCREEN AND EXCEPTION 856 IS STILL POSTING - ALSO ADD THE REDUCTION (RC-AMOUNT'S) TO THE MEDICARE ALLOWED FOR EACH DETAIL LINE WITH THE ABOVE PROCEDURES AND KEY IN THE ALLOWED FIELD ON THE SCREEN AND ENTER. IF 856 DOES NOT GO AWAY - O'LOC THE CLAIM TO 35.
      (THE ABOVE DOES NOT APPLY TO DATES OF SERVICE 1/1/98 AND AFTER)

   B. MEDICARE RA OR EOMB IS ATTACHED:

      1) AND SHOWS MONEY PAID TO BENEFICIARY AND/OR INDICATES MEDICARE ACTION CODE MA-28 IN UPPER RIGHT CORNER OF CLIENT INFORMATION, DENY WITH EOB 988. (PROVIDER DID NOT ACCEPT ASSIGNMENT.)

      2) NUMBER OF LINES, UNITS AND/OR BILLED AMOUNT DOESN'T MATCH:
      EE - PUT "X" IN LMC AND PA-2 TO RES, UNLESS DENYING ENTIRE CLAIM FOR ANOTHER REASON (I.E. ELIGIBILITY OR MEDICARE DENIED ENTIRE CLAIM)
      RES - SEE YOUR SUPERVISOR/TRAINER/MMIS.

      3) IF CLAIM APPEARS TO BE A HOSPITAL BILLING:(NO CONTRACT ADJ)
      EE: X - LMC, PA-2 TO RES FOR REVIEW.
      RES: IF IN DOUBT - SEE MMIS.
      EXCEPTION:
      IF PROVIDER NUMBER 7036502 AND MEDICARE RA INDICATES HIGHLINE COMMUNITY HOSPITAL(OUTPT) AND DOS AND CLIENT MATCH-ACCEPT RA AS VALID AND CONTINUE PROCESSING.

      4) THERE IS MONEY IN THE CONTRACT ADJUST COLUMN:
      A) TOS 3 (J) - KEY ALL INFO FROM THE BACKUP INTO THE APPROPRIATE FIELDS ON THE SCREEN. IGNORE THE CONTRACT ADJ INFO. IF CLAIM BALANCES - PROCESS. IF CLAIM DOES NOT BALANCE - CHECK KEYING. IF KEYED CORRECT & BACKUP INDICATES ONE OF THE FOLLOWING, DENY WITH EOB 565:
      1. PROV # (6 DIGIT) AT TOP OF RA/EOMB BEGINS WITH A (5).
      2. 1 LINE ON THE RA AND MULTIPLE LINES ON THE CLAIM.
      3. RURAL HLTH, COMMUNITY HLTH OR HOSPITAL IS INDICATED IN PROVIDER NAME FIELD ON RA/EOMB.
      4. BILL TYPE ON RA/EOMB BEGINS WITH A (1). IE (141).
      5. BACKUP STATES PART A.

      B) TOS 9 (P) - "CONTRACT ADJUST"
      PHYSICAL THERAPY (PROV TYPE 34) - IF SIX DIGIT PROVIDER

NUMBER AT TOP OF RA/EOMB, DENY WITH EOB 565.

GROUND OR AIR AMBULANCE (PT 51 OR 53) -
EE - PA2

RES - USE THE FOLLOWING FORMULA TO ADJUDICATE CLAIM WHEN MEDICARE'S BACKUP HAS 1 LINE AND CLAIM HAS MULTIPLE LINES. (IF THERE IS A DEDUCTIBLE AMOUNT ON MCARE BACKUP - DO NOT WORK - OVERLOC TO 83)
FROM THE BACKUP -

PERCENTAGE PAID FOR EACH LINE BILLED =
"NET REIMBURS" DIVIDED BY "COVD CHGS" (SEE MCARE BACKUP)
EXAMPLE: $730.86 DIVIDED BY 1874.00 = .39 (% OF TOTAL PD ON EACH LINE)

MCARE PAID = CHARGED AMT DIVIDED BY PERCENTAGE
EXAMPLE:
LINE 1. 02/09/01 9 3 0001A SH V900 714.00 1
LINE 2. 02/09/01 9 3 0007A SH V900 1160.00 80

LINE 1. $ 714.00 X .39 = $278.46 (MCARE PAID)
LINE 2. 1160.00 X .39 = 452.40 (MCARE PAID)

MCARE ALLOWED = MCARE PAID DIVIDED BY .80 (80%):

EXAMPLE: $278.46 DIVIDED BY .80 = 348.08 (MCARE ALLOWED)
452.40 DIVIDED BY .80 = 565.50 (MCARE ALLOWED)
MPI = 3

C. MEDICARE EOMB ATTACHED WITH ACTION CODE CO29 - DENY W/EOB 334.

D. MEDICARE'S RA OR EOMB IS NOT ATTACHED - DENY 224.

E. IF UNABLE TO KEY FROM CLAIM, KEY MEDICARE ALLOWED, MEDICARE PAID, AND/OR COINSURANCE/DEDUCTIBLE AMOUNTS AND MEDICARE PAID DATE FROM THE MEDICARE RA/EOMB.

F. ANY SITUATIONS NOT ADDRESSED - OVERLOC TO 83.

2. TAPE CLAIMS OVERLOC TO 83.

3. ANY QUESTIONS REGARDING RURAL HEALTH/SPEECH & HEARING BRING TO MMIS SERVICES.

TEXT KEY	TEXT DESC
897	PROCEDURE CODE NC FOR ADULTS AGE 21 & OVER DOS 8-1-03 AND AFTER.

IF AUTHORIZATION, LOOK AT AUTH FILE NOTES SCREEN PAGE 2:

A. IF NOTHING IN NOTES INDICATING A REQUEST FOR AN EXTENSION - DENY.
B. IF NOTES SAY "EXTENSION HAS BEEN APPROVED" - FORCE.
C. IF NOTES SAY "EXTENSION PENDING" - DENY.
D. IF NOTES SAY "EXTENSION DENIED" - DENY.

TEXT KEY TEXT DESC
899 TOO MANY EXCEPTIONS POSTING.

1. COMBINE CONSECUTIVE MULTIPLE PROCEDURES ON ONE LINE WHEN POSSIBLE, SUCH AS HOME HEALTH VISITS, CHIROPRACTIC VISITS, HOSPITAL VISITS, ETC.

2. TOTALLY DENYING CLAIMS:
CLAIMS THAT FAIL 899 & NEED TO BE TOTALLY DENIED AT HEADER OR ON EACH DETAIL LINE I.E., ELIGIBILITY, TIMELINESS, MISSING POS, ETC--- DENY THE 899 WITH THE SYSTEM EOB FOR THE APPROPRIATE EXCEPTION I.E., ELIGIBILITY, TIMELINESS, ETC. IF MORE THAN 6 DETAIL LINES ON THE CLAIM USE 899 AS A SECONDARY EOB. NOTE: ADJUDICATE AS MANY EXCEPTIONS AS POSSIBLE, REMEMBERING TO ADDRESS ANY/ALL SUPERSUSPENDS.

3. IF YOU CANNOT ELIMINATE ANY OF THE CRITERIA BY COMBINING LINES IT WILL BE NECESSARY TO SPLIT THE CLAIM.
A. DENY 899 WITH EOB 333 AND 387
B. TAKE A COPY OF THE CLAIM.
C. ON BOTH CLAIM COPIES DELETE OPPOSITE HALVES OF THE LINE ITEMS.
1) CHANGE THE TOTAL CHARGE
2) PUT YOUR EXAMINER NUMBER IN UPPER LEFT CORNER.
3) CROSS OUT ICN.
4) PUT "FORCE 125" IF NEEDED IN BOX 23 A.
5) IF THERE IS INSURANCE MONEY ON ORIGINAL CLAIM OR BACKUP - PUT A "Y" IN TPL FIELD ON BOTH NEW DAY CLAIMS TO ASSURE THAT TPL WILL STAGE. ON BOTH NEW DAY CLAIMS REFERENCE THE ORIGINAL ICN AND STATE THAT THE CLAIM IS AN 899 SPLIT.
6) PLACE BOTH COPIES IN APPROPRIATE RE-ICN SLOT
7) MARK BATCH 333

3. FOR RESOLUTIONS USE ONLY

HARD COPY & EMC CLAIMS (EXCLUDING MEDICARE X-OVERS) THAT FAIL 899 AND THERE IS NO POSSIBLE WAY TO DENY ENTIRE CLAIM (AS DUPE, ETC.) YOU MAY DENY WITH EOB 899. GIVE THE PROVIDER AS MANY OTHER EOB'S ON LINES AS POSSIBLE.

THE END

TEXT KEY TEXT DESC

900 EXTRA! EXTRA! EXTRA! PUBLISHED BY MMISS PRESS, INC.
MAY 28, 2004

D P S H E A D L I N E N E W S

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PAGE 003 TEXT FILE & 4-LINE UPDATES

BULLETIN BOARD: (PLEASE DATE & INITIAL EACH ENTRY)

05/26/04-CP WILL RECYLCE THE SUSPENSE FILE ON 05/29/04. *C

EOB	NEW	DELETED	REVISED	DATE UPDATED	UPDATED BY	TIED TO

NEW/ON TEST EXC	PARAMETER	DATE ADDED	CLAIM TYPES	DATE RELEASED	BY
0007	(1031)	10/08/03	P	ON TEST	CC
1016		04/30/04	K	ON TEST	JH
1017		04/30/04	K	ON TEST	JH

CLAIM TYPE IND	DEL-ETE	TEXT FILE	I N D	PAGE	REQUESTED BY	DATE	UPDATED BY
W		0379	4-LINE		MMIS	05/04/04	GERALD
J,P,L		0999	E	9,10	MMIS	05/04/04	BJS
J		0365	E	6	MMIS	05/04/04	BJS
R,S		0422	E	4-LINE	MMIS	05/04/04	SUE
M,R,S		0324	E	4-LINE	CP/MMIS	05/05/04	SUE
M		0991	I	8	CP/MMIS	05/05/04	CC
D		0992	I	10	MMIS	05/05/04	PATTY
M		0353	E	4	MMIS	05/05/04	SUE
R,S		0583	E	1	MMIS	05/05/04	SUE
J,P,L		0101	E	27	MMIS	05/05/04	BJS
J,P,L		0102	E	35,50	MMIS	05/05/04	BJS
J,P,L		0343	E	20	MMIS	05/05/04	BJS
J,P,L		0377	E	10	MMIS	05/05/04	BJS
J,P,L		0756	E	1	MMIS	05/05/04	BJS
J,P,L		0094	E	1	MMIS	05/05/04	BJS
M,R,S		0345	E	1	MMIS	05/06/04	SUE
J		0053	A	12,41	MMIS	05/07/04	SR
J		0331	E	8	MMIS	05/07/04	SANDY
J		0088	A	2	MMIS	05/07/04	SANDY
S		0109	E	4-LINE	MMIS	05/10/04	SUE

P	0792	4-LINE	CP/MMIS 05/11/04 DEBBIE
P	0792	E 1,2	CP/MMIS 05/11/04 DEBBIE
M	0261	E 12	MMIS 05/11/04 SUE
J,P	0999	I 13	CP/MMIS 05/11/04 GERALD
R,S	0588	E 4-LINE	MMIS 05/11/04 SUE
J	0105	A 12	MMIS 05/12/04 SANDY
P	0261	E 20	MMIS 05/12/04 DEBBIE
M	0301	E 6	MMIS 05/12/04 SR
J	0105	E 5	MMIS 05/13/04 SANDY
J,M,R,S	0345	E 17,25	MMIS 05/13/04 SANDY
P	0328	E 13	MMIS 05/14/04 CC
J	0331	E 15	CP/MMIS 05/14/04 SR
J	0993	E 10	CP/MMIS 05/14/04 BJS
ALL	0999	I 12,13,14	CP/MMIS 05/14/04 GERALD
J	0177	E 14	CP/MMIS 05/14/04 BJS
J	0169	E 1,6	CP/MMIS 05/14/04 BJS
J,P,L	0261	E 36	CP/MMIS 05/14/04 BJS
J	0105	E 4	CP/MMIS 05/15/04 SANDY
ALL	0988	I ALL	CP/MMIS 05/15/04 GERALD
J,P,L	0328	E 7	CP/MMIS 05/17/04 BJS
J,P,L	0261	E 36	CP/MMIS 05/17/04 BJS
J	0993	E 7	MMIS 05/17/04 BJS
J	0053	I 41,42	MMIS 05/17/04 BJS
J	0365	E 6	MMIS 05/18/04 BJS
M	0991	E 10	MMIS 05/18/04 SUE
J	0088	E 1	MMIS 05/18/04 BJS
M	0103	A 4	MMIS 05/18/04 SR
M	0065	A 1	MMIS 05/18/04 SR
M	0068	A 1	MMIS 05/18/04 SR
M	0785	A 1	MMIS 05/18/04 SR
M	0786	A 1	MMIS 05/18/04 SR
J	0353	E 13	MMIS 05/19/04 BJS
P	0996	I 14	CP/MMIS 05/20/04 DC
J	0611	E 11	MMIS 05/20/04 BJS
M,R,S	0190	E 1	MMIS 05/21/04 SUE
M,R,S	0343	E 2	MMIS 05/21/04 SUE
M,R,S	0586	E 4-LINE	MMIS 05/21/04 SUE
S	0109	E 1	MMIS 05/21/04 SUE
M,R,S	0603	E 4-LINE	MMIS 05/21/04 SUE
J	0184	E 1	MMIS 05/24/04 SR
P	0102	E 17	MMIS 05/24/04 DC
O	0996	I 15	CP/MMIS 05/24/04 GERALD
P	0261	E 13	CP/MMIS 05/24/04 DC
J	0287	E 4-LINE	MMIS 05/26/04 BJS
O	0996	I 11,16	CP/MMIS 05/26/04 GERALD
P	0331	E 24	CP/MMIS 05/27/04 DC
ALL	0999	I 2	CP/MMIS 05/27/04 GERALD
W	0310	E 1,2	MMIS 05/27/04 SR
J	0281	E 3	MMIS 05/27/04 SR
M	0388	A 1	MMIS 05/28/04 CC
P	0127	E 4-LINE	MPMU/MMIS 05/28/04 KB
J	0331	E 12	MMIS 06/01/04 SR

TEXT KEY TEXT DESC
970

EXCEPTION CODE PRINT LOCATIONS:

LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
001	N	PAY & REPORT		
002	N	TABLE OVERFLOW		898
003	Y	TPR PREMIUMS		
004	N	CASH CONTROL	CASH CONTROL	
005	Y	TPL 166 165		165 166
006	Y	TPL CASULTY		320 325
007	Y	197 COMM		
		PRINTS FOR CLAIM TYPE "P" ONLY		
008	N	AVAILABLE		331
009	Y	MANUAL PRICE		
		DOES NOT PRINT FOR CLAIM TYPES: J, L, O, P		
010	Y	DRG REVIEW EXCEPT		
011	Y	LAB PANAL HISTORY		013
012	Y	DENTAL SURG/ANES		
013	N	AVAILABLE		
LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
014	Y	SMC REV		
015	N	SURGERY REVIEW		
016	Y	MEDICAL REVIEW		
017	Y	HYSTERECTOMY		
018	Y	STERILIZATION		
019	N	NON-CONTRACT		
020	N	AVAILABLE		
021	N	MEDICARE REVIEW		
022	Y	PRIOR AUTHORIZ		
		DOES NOT PRINT FOR CLAIM TYPES: J, P		
023	Y	AUTH PROBLEM		
		DOES NOT PRINT FOR CLAIM TYPES: J, P		
024	N	DENTAL		
025	Y	DENTAL AUTH		
026	Y	AVAILABLE		
027	Y	COMPL RES		
		DOES NOT PRINT FOR CLAIM TYPES: L, P		
028	N	AVAILABLE		
LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
029	Y	TPL HEALTH		
030	Y	TPL CASULTY		
031	N	HOME HEALTH		
032	N	MEDICARE		
033	N	COMPL RES		
034	Y	POSSIBLE DUPS		100 101
		DOES NOT PRINT FOR CLAIM TYPES: K, L, M, R, S, W, Y		
035	Y	SURGERY CL		
036	Y	UTIL REVIEW		

DOES NOT PRINT FOR CLAIM TYPES: L

037 Y RES THERAPY
038 Y CLAIMS SUSPEND
039 N MEDICARE ELIG
040 N RE-ADMIT
041 N AVAILABLE
042 Y HMO
043 N AVAILABLE
044 N OVER 25 EXCEPT

LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
045	N	MARY FRY		
046	N	GEN HOSP "S"		
047	Y	QFFS NURSE		
048	N	GEN SUSPENCE		
049	Y	RES AGED		
050	N	HOSPITAL BASIC		
051	N	AVAILABLE		
052	N	BASIC EXCEPTIONS		
053	N	AVAILABLE		
054	N	GEN PHARMACY		
055	Y	MANAGED MDCR		

DOES NOT PRINT FOR CLAIM TYPES: J, P

LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
056	N	HOSPITAL PROC		
057	N	HMO REVIEW		
058	N	PROC/DIAGNOSIS		
059	Y	SA REVIEW		
060	N	EXCEPTION 361		361

LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
061	N	EXCEPTION 261, 552		261 552
062	N	CLIENT OTHER		
063	N	AVAILABLE		
064	N	TIMELY FILE		
065	N	CLIENT DEATH		
066	Y	CLIENT ELIGIBLE		
067	Y	SH REVIEW		
068	N	HOSP DOS		
069	N	DATE OF SVS		
070	N	ELIGIBILITY UNIT		
071	N	HOSPITAL # ERROR		
072	N	D. KINGERY REV		
073	N	PROVIDER OTHER		
074	N	PROV # ERROR		
075	Y	MMIS TESTING		
076	N	CLIENT REVIEW		
077	N	PENDING PROV		

LOC	PR	DESCRIPTION	UNIT	EXCEPTION(S)
078	Y	PROV ON REVIEW		
079	N	197 COMM		
080	N	INVALID LOCATION		

081	Y	PROV RELATIONS
082	N	PIP/QRS
083	Y	MMIS UNIT
084	Y	QC
085	Y	SPHAND/116
086	N	GROSS ADJUSTMENT
087	Y	MASS ADJUSTMENT
088	N	SCANNER
089	Y	ADJUSTMENTS

TEXT KEY TEXT DESC
985

OLD	X	NEW	DATE	DESCRIPTION	BY
		088	5/07/02	DIABETES/ASTHMA COUNSELING	S
		099	5/22/02	99078 INCL IN E&M	S
776	X	088	5/23/02	MAX 15 HLA TYPING	S
738	X	099	5/24/02	DELIVERY INCL TRI CARE	S
050	X	099	5/24/02	TRI CARE INCL IN DELIVERY	S
		088	6/01/02	10 SMOKING CESSATION PER PREG	S
		064	6/07/02	0998M NOT ALLOWED W/0997M	A
720	X	720	7/31/02	1 PRENATAL ASSESS ALWD PER PREG	SR
		720	7/31/02	1 LABOR MNGMNT ALLWD PER PREG	SR
711	X	711	7/31/02	PSYCH VS E&M	S
		711	7/31/02	E&M VS PSYCH	S
		088	8/01/02	12 NEUROPSYCH IN A LIFETIME.	S
		725	9/25/02	ORTHOTIC LIMITS/COMBINATIONS, CALENDAR YR	S
		088	11/12/02	1 PALLIATIVE TREATMENT PER DAY	JH
		012	12/03/02	3 FLUORIDES IN 12 MONTHS	JH
		720	01/28/03	1 DOH NB SCREEN PER CLIENT	SR

OLD	X	NEW	DATE	DESCRIPTION	BY
		720	01/28/03	1 NORMAL NB CARE PER CLIENT	SR
		088	08/14/03	2 NEUROPSYCH(96100) IN LIFETIME W/O AUTH	SA
783	X	783	09/12/03	NEW VS NEW/OLD TRI & OLD VS NEW TRI/ANTEP	SA
750	X	750	09/23/03	HEARING AIDS 1 IN 5 YEARS FOR ADULTS	DK
		007	10/08/03	1 BOX SYRINGE (A4232) PER 2 MONTHS	CC
		388	10/08/03	1 BATTERY KIT (4883B) PER 6 MONTHS	CC
		012	10/08/03	5 GASTRO/JEJUNO (B4086) PER MONTH	CC
075	X	075	02/04/04	CRIT CARE INCL SERVICES	SA
		075	02/04/04	PEDIATRIC/NEONATE INCL SERVICES	SA
008	X	1036	02/10/04	CLOZARIL (0857J) 1 PER WK	SA
008	X	1037	02/10/04	CLOZARIL (90862) 1 PER WK	SA

TEXT KEY TEXT DESC
986

CLAIMS PROCESSING PERFORMANCE REPORT USER NUMBERS

007 014 017 022 024 025 041 059 060 061 063 065 068 073 094 103 105 107
108 109 115 116 119 123 126 128 130 132 134 141 142 143 145 167 173 180
183 191 193 194 195 196 199 202 204 209 210 216 219 226 238 249 250 255
265 271 277 284 287 288 290 293 294 297 302 310 312 316 328 336 349 351
360 361 367 368 369 370 376 377 384 385 386 391 396 401 405 419 440 443
446 448 451 457 462 463 470 493 495 514 517 519 524 528 530 534 552 560
562 570 572 579 588 605 610 616 621 626 632 635 644 649 650 653 672 679

TEXT KEY TEXT DESC
987
CLAIMS/DENIED/PAID/REVIEW
REPORT # BWMC9420-ROO1

111	AUDREY FINNIGAN,REVIEW MDCR PD/DENIED	BIN 14
112	DIANNE BAUM,REVIEW-SAME CLIENT,SAME DAY,SAME PROV(103)	BIN 12
999	SANDY ASBACH TEST REVIEW	BIN 12

TEXT KEY TEXT DESC
988 LOCATION 55 - MM (MANAGED MEDICARE)

CONTENTS

1. INTRODUCTION - DEFINITIONS.....002

2. GENERAL INFORMATION.....004

3. PRICING.....006

INTRODUCTIONS-DEFINITIONS

MEDICARE IS A HEALTH INSURANCE PROGRAM FOR:

PEOPLE AGE 65 OR OLDER.
PEOPLE UNDER 65 WITH CERTAIN DISABILITIES.
PEOPLE WITH END-STAGE RENAL DISEASE (PERMANENT KIDNEY FAILURE REQUIRING DIALYSIS OR A KIDNEY TRANSPLANT).

MEDICARE HAS TWO PARTS:

PART A - HOSPITAL INSURANCE
PART B - MEDICAL INSURANCE

MEDICARE HEALTH PLAN CHOICES INCLUDE:

THE ORIGINAL MEDICARE PLAN (CROSSOVERS).

MANAGED MEDICARE PLANS.MEDICARE USES THE TERMS "MEDICARE ADVANTAGE" AND "MEDICARE + CHOICE."
MANAGED MEDICARE PLANS CONT.

MANAGED MEDICARE PLANS INCLUDE: (WASH. STATE 2004).

MEDICARE MANAGED CARE PLANS.

MEDICARE PRIVATE FEE FOR SERVICE PLANS (STERLING OPTION 1).

THIS TEXT IS FOR CLAIMS BILLED SECONDARY TO A MANAGED MEDICARE PLAN.

COPAY: IN SOME MEDICARE HEALTH PLANS, THE AMOUNT THE PATIENT PAYS FOR EACH MEDICAL SERVICE THEY RECEIVE, LIKE A DOCTOR VISIT. A COPAYMENT IS USUALLY A SET AMOUNT SUCH AS $10.00 OR $20.00.

COINSURANCE: A PERCENTAGE OF THE MEDICARE APPROVED AMOUNT OR COST OF SERVICE.

CAPITATION: A PAYMENT METHOD IN WHICH THE PROVIDER IS PAID A PREDETERMINED RATE BY THE MEDICARE HEALTH PLAN RATHER THAN REIMBURSED FEE FOR SERVICE.

1. CLAIM TYPE O/M/R/S - IF CLAIM/COMMENTS/BACKUP INDICATE MANAGED MDCR:

A. CLAIM TYPE "O" - DENY W/EOB 333 AND RESUBMIT AS A "J/P" CLAIM.
B. CLAIM TYPE "M" - DENY W/EOB 333 AND RESUBMIT AS A "W"CLAIM.
C. CLAIM TYPE "S" - DENY W/EOB 333 AND RESUBMIT AS A "V" CLAIM.
ANY QUESTIONS SEE TRAINER/SUPERVISOR.

2. CLAIMS PAID BY MANAGED MEDICARE MUST BE BILLED TO MAA WITHIN 6 MOS.
A. IF THE ORIGINAL ICN IS MORE THAN 6 MOS. PAST THE MANAGED MEDICARE PAID DATE - DENY W/EOB 546.

B. THE ICN IS MORE THAN 6 MOS. PAST THE DATE OF SERVICE ON CLAIM AND NO MANAGED MEDICARE PAID DATE - DENY W/EOB 364.

3. OVERCODES:
434 - CLAIM ADJUDICATED PER MANAGED MEDICARE BACKUP.
436 - CLAIM ADJUDICATED WITHOUT BACKUP.

4. IF NECESSARY, FORCE EXCEPTIONS, MANUAL PRICE OR BALANCE THE CLAIM IN ORDER TO PAY PER THE PRICING SECTION OF THIS TEXT.
QUESTIONS - SEE TRAINER/SUPERVISOR.
5. CLAIMS PROCESSING/COB AGREEMENT:
CLAIMS PROCESSING WILL WORK TPL EXCEPTION 263 IF POSTING ON CLAIM WITH CAPITATED COPAY OR COINSURANCE. LOCATION 55 WILL PROCESS CLAIM THEN SEND IT TO COB HEALTH NORTH SUPERVISOR FOR REVIEW. IF NECESSARY, COB WILL RETURN CLAIM TO LOC 55 FOR FOLLOW UP.

6. IF 247 POSTING (QMB MEDICARE ONLY).
A. PLAN PAYS - FORCE 247.
B. PLAN DENIES - DENY.

7. IF 326 POSTING AND NO 247 OR 276 ON CLAIM - DENY 326 EXCEPTION.

PRICING MANAGED MEDICARE

1. PRICING POLICY (J AND P CLAIMS)
A. MEDICARE MANAGED CARE PLANS:
(1) IF CLAIM OR BACKUP GIVES COPAY AMOUNT - PAY THE COPAY.
(A) MANUAL PRICE/BALANCE CLAIM IF NECESSARY.
(B) QUESTIONS - SEE TRAINER/SUPERVISOR
(2) IF CLAIM OR BACKUP GIVES COINSURANCE AMOUNT - PAY THE COINS.
(A)(B) - SAME AS ABOVE.

B. PRIVATE FEE FOR SERVICE PLANS (STERLING OPTION 1)
(1) IF CLAIM OR BACKUP GIVES COPAY AMOUNT - PAY THE COPAY.
(A) MANUAL PRICE/BALANCE CLAIM IF NECESSARY.
(B) QUESTIONS - SEE TRAINER/SUPERVISOR.
(2) IF THE CLAIM OR BACKUP GIVES COINSURANCE AMOUNT - PAY THE DIFFERENCE BETWEEN THE PLAN PAID AMOUNT AND THE LESSER OF MAA ALLOWED OR MEDICARE ALLOWED.

NOTE: STERLING OPTION 1 MAY HAVE COPAY AND COINSURANCE ON THE SAME CLAIM.

MANAGED MEDICARE PRICING CONT.

2. PRICING HOSPITAL CLAIMS

*THE MAA MANAGED MEDICARE WORKGROUP IS WORKING TO RESOLVE ISSUES FOR HOSPITAL MANAGED MEDICARE CLAIMS. ANY QUESTIONS - SEE TRAINER/SUPE.

NOTE: PATIENT RESPONSIBILITY = $0.00 - O/LOC 64.

NOTE: THIS TEXT, BY DESIGN, DOES NOT ADRRESS EVERY POSSIBLE MANAGED MEDICARE CLAIM SITUATION. IF UNSURE, THE DECISION MAKING ORDER IS: TRAINER > SUPERVISOR > GERALD H.(MMISS) > THE MAA MANAGED MEDICARE WORKGROUP.

NOTE: A CAPITATED AMOUNT CAN REPRESENT "COPAY" OR 'COINSURANCE".

*G

B. DENIAL IS "NO REFERRAL/UNAUTHORIZED DOCTOR" OR SIMILAR STATEMENT - DENY W/EOBS 334/169.

C. DENIAL REASON IS "NON-COVERED BENEFIT" & NOT FORCEABLE PER 261 - DENY W/EOB 918.

D. DENIAL REASON IS "NO COVERAGE FOR CLIENT" OR CLIENT NOT ELIGIBLE & 261 EXC POSTING - DENY W/EOB 918.

E. DENIAL REASON INDICATES MORE INFO REQUIRED FOR POSSIBLE PAYMENT - DENY W/EOB 211/334.

F. ADDITIONAL COVERED SERVICES FOR MANAGED MDCR PLAN WITH ANY DENIAL REASON OTHER THAN ABOVE - O'LOC TO 75.

G. ALL ELSE - SEE 261 TEXT & ADJUDICATE ACCORDINGLY.

MEDICARE X-OVERS (O) - OVERLOC TO 64.

MANAGED MDCR PLANS AND PRIVATE FEE FOR SERVICE PLAN EFF W/DOS 1/1/03

HEALTH NET OF OREGON PPO - PPO - ADDTL SERVICES COVERED:
1. PHYSICIANS - ROUTINE EYE EXAM, ROUTINE PHYSICALS
2. DENTAL - ROUTINE DENTAL EXAMS, CLEANINGS, DENTAL X-RAYS
3. MED VENDOR - EYE GLASSES FOR ROUTINE PURPOSES

GHC MEDICARE A&B HIGH OPTION PLAN - HMO/POS - ADDTL SVCS COVERED:
A. PHYSICIAN - ROUTINE VISION EXAMS, ROUTINE PHYSICIALS EXAMS SMOKING CESSATION SVCS, ROUTINE HEARING TESTS AND FITTING.
2. MED VENDOR - HEARING AIDS, ROUTINE TRANSPORTATION.
3. PHARMACY - OUTPATIENT PRESCRIPTIONS DRUGS

GHC MEDICARE PLAN - HMO/POS - ADDTL SVCS COVERED:
1. PHYSICIANS - ROUTINE EYE EXAMS, ROUTINE PHYSICIAL EXAMS, SMOKING CESSATION SVCS, ROUTINE HEARING TESTS AND FITTING.
2. MED VENDOR - HEARING AIDS, ROUTINE TRANSPORTATION.

KAISER FOUNDATION HEALTH PLAN OF THE NW (SENIOR ADVANTAGE) - HMO

ADDITIONAL SERVICES COVERED:
1. PHYSICIAN - ROUTINE EAR TESTS, ROUTINE EYE EXAMS, ROUTINE PHYSICAL EXAM,SMOKING CESSATION SVCS,DISEASE MANAGEMENT SVCS.
2. MED VENDOR - EYE GLASSES OUTSIDE OF MEDICARE COVERED ISSUES.
3. PHARMACY - OUTPATIENT PRESCRIPTION DRUGS

KAISER FOUNDATION HEALTH PLAN OF THE NW (SENIOR ADVANTAGE II) - HMO
ADDITIONAL COVERED SERVICES:
1. PHYSICIAN - ROUTINE EAR TESTS, ROUTINE EYE EXAMS, ROUTINE PHYSICIAL EXAMS, SMOKING CESSATION SVCS, DISEASE MANAGE SVCS.
2. MED VENDOR - HEARING AIDS, EYE GLASSES OTHER THAN MEDICARE COVERED ISSUES, ROUTINE TRANSPORTATION
3. PHARMACY - OUTPATIENT PRESCRIPTION DRUGS

REGENCY HMO OREGON(FIRST CHOICE SIXTY FIVE) - HMO - ADDTL SVCS COVERED:
1. PHYSICIAN - ROUTINE EYE EXAMS, ROUTINE PHYSICAL EXAMS, DISEASE MANAGEMENT SVCS.
2. MED VENDOR - GLASSES OTHER THAN MEDICARE COVERED ISSUES.

SECURE HORIZONS MEDICARE+CHOICE PLAN(LAKEWOOD PLAN) - HMO
ADDITIONAL SERVICES COVERED:
1. PHYSICIAN - ROUTINE EAR TESTS, ROUTINE EYE EXAMS, ROUTINE PHYSICAL EXAM.
2. MED VENDOR - HEARING AIDS, EYE GLASSES OTHER THAN MEDICARE COVERED ISSUES.

SECURE HORIZONS MEDICARE+CHOICE PLAN(STANDARD PLAN) - HMO
ADDITIONAL SERVICES COVERED:
1. PHYSICIAN - ROUTINE EAR TESTS, ROUTINE EYE EXAMS, ROUTINE PHYSICAL EXAMS.
2. MED VENDOR - HEARING AIDS, EYE GLASSES OTHER THAN MEDICARE COVERED ISSUES.

STERLING LIFE INSURANCE COMPANY(STERLING OPTIONS 1) - PFFS
ADDITIONAL SERVICES COVERED: PHYSICIAN - ROUTINE HEARING TESTS, ROUTINE EYE EXAMS, ROUTINE PHYSICAL EXAMS, DISEASE MANAGEMENT SVCS.

MANAGED MDCR PLANS AND PRIVATE FEE FOR SERVICE PLAN EFF W/DOS 1/1/02

FIRST CHOICE SIXTY-FIVE (REGENCE HMO OREGON) MMC - ADDITIONAL SERVICES COVERED:
1. PHYSICIANS - ROUTINE EYE EXAMS.
2. MED VENDOR - HEARING AIDS.

GHC MEDICARE PLAN (GROUP HEALTH) MMC - ADDITIONAL SERVICES COVERED:
1. PHYSICIANS - ROUTINE EYE EXAMS.
2. MED VENDOR - HEARING AIDS.

GHC MEDICARE PLAN HIGH OPTION (GROUP HEALTH) MMC - ADDITIONAL SERVICES COVERED:
1. PHYSICIANS - ROUTINE EYE EXAMS
2. MED VENDOR - HEARING AIDS.

SECURE HORIZONS STANDARD PLAN (SECURE HORIZONS) MMC - ADDITIONAL SERVICES COVERED:
1. PHYSICIANS - ROUTINE EYE EXAMS

2. MED VENDOR - HEARING AIDS.
SECURE HORIZONS LAKEWOOD PLAN (SECURE HORIZONS) MMC - ADDITIONAL SERVICES COVERED:
1. PHYSICIANS - ROUTINE EYE EXAMS.
2. MED VENDOR - HEARING AIDS.
SENIOR ADVANTAGE (KAISER FOUNDATION HEALTH PLAN NW) MMC - ADDITIONAL SERVICES COVERED: PHYSICIANS - ROUTINE EYE EXAMS.

SENIOR ADVANTAGE II (KAISER FOUNDATION HEALTH PLAN NW) MMC - ADDITIONAL COVERED SERVICES: PHYSICIANS - ROUTINE EYE EXAMS.

STERLING OPTION I (STERLING LIFE INS CO) PFFS - ADDITIONAL COVERED SERVICES: PHYSICIANS - ROUTINE EYE EXAMS.

MANAGED MEDICARE PLANS EFFECTIVE W/DOS 1/1/01

CLASSIC CARE	(PREMERA)
FIRST CHOICE SIXTY-FIVE	(REGENCE HMO OREGON)
GHC MEDICARE PLAN	(GROUP HEALTH)
OPTIONS MEDICARE	(OPTIONS HEALTH CARE)
PROVIDENCE MEDICARE EXTRA	(PROVIDENCE HEALTH PLAN)
SENIOR ADVANTAGE	(KAISER)
SENIOR ADVANTAGE II	(KAISER)
SECURE HORIZONS	(PACIFICARE)
TRICARE SENIOR PRIME	(TRICARE SENIOR PRIME MILITARY RETIREES)

MANAGED MEDICARE PLANS PRIOR TO DOS 01/01/00

AVMED
COST PLUS PLAN
FIRST CHOICE SIXTY-FIVE
GOLDEN MEDICARE (AETNA)
GROUP HEALTH MEDICARE
HEALTH SENSE
MANAGED MEDICARE
MEDICARE CARRIER
MEDICARE CHOICE
MEDICARE EXTRA
MEDICARE HMO
MEDICARE PLUS
MORE THAN MEDICARE
MSC CLASSIC CARE
OPTIONS HEALTH CARE MEDICARE
OPTIONS MEDICARE
PROVIDENCE MEDICARE EXTRA
RISK PLUS PLAN
SECURE HORIZONS
SECURE HORIZONS/PACIFIC CARE
SENIOR ADVANTAGE
SENIORS FIRST
SENIOR PARTNERS
SENIOR PRIME (TRICARE)

NOTE: SEE 999 TEXT FOR EE PROCESSING GUIDELINES.

TEXT KEY 989

TEXT DESC

ITA INFORMATIONAL TEXT

DEFINITION OF TERMS

1. DATE OF INITIAL DETENTION: CAN BE FOUND IN SECTION IV OF THE ITA FORM (DSHS 13-628). THIS IS THE DATE THE PATIENT WAS ORIGINALY DETAINED.

2. REVOCATION DATE: CAN BE FOUND IN SECTION IV OF THE ITA FORM (DSHS 13-628). THE DATE A CONDITIONALLY RELEASED PATIENT IS READMITTED FOR EVALUATION. THIS TAKES THE PLACE OF INITIAL DETENTION DATE IF ON FORM.

3. DATE OF RELEASE/TRANSFER/DISCHARGE: CAN BE FOUND IN SECTION IV OF THE ITA FORM (DSHS 13-628). THIS IS THE DATE THE PATIENT LEAVES THE COMMUNITY HOSPITAL.

4. DENTENTION PERIOD: THE TIME SPAN A PERSON WAS INVOLUNTARILY DETAINED, AS INDICATED BY THE INITIAL DETENTION DATE/REVOCATION DATE AND DISCHARGE DATE ON THE ITA FORM. ALSO 30 CALENDAR DAYS FROM THE INITIAL DETENTION DATE/REVOCATION DATE IF NO DISCHARGE DATE IS GIVEN.

INFORMATION

---IMPORTANT NOTE - ALWAYS PUT "I" IN ITA FIELD---

1. ITA CLAIMS ARE ENTERED INTO THE SYSTEM LIKE ANY OTHER HCFA 1500 PHYSICIAN OR MEDICAL VENDOR CLAIM. TIMELINESS, MEDICARE AND TPR ARE WORKED THE SAME. THE ONLY DIFFERENCE IS THAT WE WILL NEVER DENY AN ITA CLAIM FOR ELIGIBILITY. IF AN ELIGIBILITY EDIT IS UNRESOLVABLE IN CP - O'LOC CLAIM TO 65 W/ AN X IN THE LMC FIELD.

2. IF PROVIDER NUMBER MISSING OR INVALID DO SEARCH FOR THE CORRECT PROVIDER NUMBER. IF FOUND, ENTER AND USE 510 INFORMATIONAL EOB. IF NOT FOUND OR NOT ABSOLUTELY SURE THAT NUMBER FOUND IS CORRECT NUMBER, DENY FOR INVALID OR MISSING PROVIDER NUMBER. ALSO, IF DENYING FOR INVALID OR MISSING PROVIDER NUMBER, YOU CAN ALSO DENY ANY SUPER-SUSPEND EXCEPTIONS.

3. IF TWO PIC'S FOUND IN SEARCH, ONE WITH TIEBREAKER "Q" AND THE OTHER WITH AN "A-E", USE THE NON "Q" PIC, SEND NOTE WITH BOTH PIC'S TO ELIGIBILITY SECTION.

4. IF NO PIC ON CLAIM AND NOT ABLE TO LOCATE AFTER PIC SEARCH,"DO NOT" LEAVE BLANK. CREATE PIC BY USING INFO IN BOX 2 AND 3. USE "Q" TIE BREAKER, THEN ADJUDICATE ACCORDINGLY.

5. RESOLUTIONS/ELECTRONIC SUBMITTALS, AFTER STAGING CLAIM FOR FORM 13-628, IF ELIGIBILITY NEEDS TO BUILD "Q" SEGMENT, ROUTE THE

WORKSHEET AND BACKUP TO ELIGIBILITY.

TEXT KEY TEXT DESC
990 GENERAL TEXT FILE--NURSING HOMES--T/I
SCREEN, KEY, NEW DAY
RESOLUTIONS, ADJUSTMENTS

CONTENTS PAGE
SCREENING.....1
KEYING.....1
NEW DAY.....2
RESOLUTIONS....2
ADJUSTMENTS....2
EOB'S.....2,3,4
ELIGIBILITY....4
MID-MO MCARE...4,5
MCARE COINS....5,6

1. SCREENING
--SEE TAD SCREENING INSTRUCTIONS.

2. KEYING
--SEE TAD KEYING INSTRUCTIONS.

3. NEW DAY
NOTE: NURSING HOME NEW DAY CLAIMS ARE IN-HOUSE BILLINGS CREATED BY THE NURSING HOME UNIT. THEY ARE GENERATED FROM EITHER A PROVIDER REQUEST (I.E. COMMENT OR CLAIM), OR TO CORRECT AN ERROR.
A. WHEN WRITING A NEW DAY BILLING, BE SURE TO:
1) FILL OUT THE NEW DAY FORM, INCLUDING CHARGES AND EOB'S.
2) MAXIMUM OF 12 LINES PER FORM.
3) UPDATE THE NURSING HOME ELIGIBILITY SCREEN (PAGE 3 OF RECIPIENT FILE) BEFORE SUBMITTING TO THE NEW DAY KEYER.
4) WRITE YOUR INITIALS/USER # AND DATE ON THE NEW DAY CLAIM.
B. NEW DAY KEYER--SEE NURSING HOMES NEW DAY INSTRUCTIONS.

4. RESOLUTIONS
--WORK POSTED 4-LINES AND TEXT FILES.

5. ADJUSTMENTS
--SEE NURSING HOME ADJUSTMENT INSTRUCTIONS.

6. EOB LIST
NOTE: THIS IS A REFERENCE--IF YOU KNOW THE MESSAGE DESIRED, THIS LIST WILL INDICATE THE EOB TO USE.
075--DEATH DATE PRIOR TO DATE OF SERVICE
142--CLAIM SPLIT/DATES OF SERVICE CHANGED BECAUSE SAME OR SIMILAR SERVICES PAID TO A DIFFERENT PROVIDER
181--ADMIT PREVIOUSLY PAID TO DIFFERENT PROVIDER
189--PROVIDER NEEDS TO ADJUST SERVICES, NOT REBILL
234--ALTERED/RETOUCHED AWARD LETTERS ARE NOT ACCEPTABLE
280--SAME/SIMILAR SERVICES PAID TO DIFFERENT PROVIDER
283--CLAIM/BACKUP ILLEGIBLE
387--CLAIM IS SPLIT

397--ORIGINIAL CLAIM PAID CORRECTLY
398--DATES OF SERVICE CHANGED TO MATCH ELIGIBILITY
491--EXCEPTIONAL CARE SERVICES REQUIRE EXCEPTIONAL CARE LETTER
492--PATIENT PAY/CHANGE OF ELIGIBILITY REQUIRE AWARD LETTER
506--PER PHONE CALL TO PROVIDER
749--PROVIDER NEEDS TO BILL NURSING FACILITY SERVICES ON A TAD
907--CHANGE IN PATIENT PARTICIPATION
913--CHANGE TO A PREVIOUSLY PAID/DENIED CLAIM
937--MEDICARE PAID IN FULL
952--CLIENT NOT IN NURSING HOME THIS DATE OF SERVICE
969--CLAIM RETURNED SEPERATELY W/ LETTER
978--RECOUP AT PROVIDER REQUEST
992--NURSING HOME RATE CHANGED PER AASA.(NOTE) NOT A VALID EOB
AFTER 10/15/03.
989--PATIENT PAY NEEDS TO BE SPLIT BY PROVIDER
921--DAYS CHANGED
922--CLASS CHANGED

7. BUILDING ELIGIBILITY
FROM AWARD LETTERS:
IF BOX 1 EARLIER THAN BOX 2, BUILD ELIGIBILITY FOR 6 MONTHS USING BOX 2 AS BEGIN DATE.

IF BOX 2 IS EARLIER THAN BOX 1, BUILD TWO ELIGIBILITY SEGMENTS
- FIRST FROM BOX 2 DATE TO BOX 1 DATE, ELIGIBILITY 6.
- SECOND FROM BOX 1 DATE FOR 6 MONTHS, ELIGIBILITY 1.

8. MID-MONTH MEDICARE RATE CHANGE

IF MEDICARE'S RATE CHANGED IN THE MIDDLE OF THE MONTH, THE CLAIM MAY BE SPLIT.
A. UPDATE THE SYSTEM'S FULL MEDICARE RATE FOR THE FACILITY IF APPROPRIATE. PLACE DOCUMENTATION IN THE PROVIDER RATE FILE.
B. SPLIT THE CLAIM, INCLUDING PATIENT PAY IF ANY.
C. FOR THE SPLIT CLAIM (USUALLY THE FIRST) THAT HAS THE CORRECT PER DIEM MEDICARE RATE IN THE SYSTEM, ALLOW THE SYSTEM TO PRICE THAT CLAIM.
D. FOR THE OTHER SPLIT CLAIM, MANUALLY PRICE AT THE APPROPRIATE MEDICARE RATE, USING INFORMATIONAL EOB 864.

9. MEDICARE COINSURANCE (READ ENTIRE SECTION)
A. MEDICARE COINSURANCE CLAIMS ARE PRICED AS FOLLOWS:
1) CALCULATE PAID-BY-MEDICARE:= (MODE 99 RATE) - (COINSURANCE)
2) CALCULATE MEDICAID-ALLOWED:= (PAID-BY-MCARE) - (MODE 20 RATE)
(USE MODE 26 IF BEGIN-DATE ON RATE FILE IS MORE RECENT)
3) CALCULATE AMOUNT PAID:= (MCAID-ALLOWED) - (TPR$) - (PATPAY$)
- IF THIS RESULTS IN A NEGATIVE OR $0.00, PAYMENT IS $0.00 -
B. THE TOTAL OF AMOUNT PAID, TPR$, AND PATIENT-PAY $ CANNOT EXCEED THE MEDICAID-ALLOWED. THE PATIENT-PAY$ MUST BE REDUCED (AND IF POSSIBLE, SHIFTED TO OTHER NURSING HOME CLAIMS FOR THAT PROVIDER-PATIENT-MONTH) FIRST, IF REDUCTION IS NECESSARY. CHANGES IN TPR $ MUST BE REFERRED TO: TPR, NURSING HOMES DESK

---NOTE: NURSING HOME MEDICARE COINSURANCE RATES ARE LISTED BELOW---

C. MEDICARE COINSURANCE NURSING HOME RATES, BY YEAR:

1990	74.00	2002	101.50
1991	78.50	2003	105.00
1992	81.50	2004	109.50
1993	84.50		
1994	87.00		
1995	89.50		
1996	92.00		
1997	95.00		
1998	95.50		
1999	96.00		
2000	97.00		
2001	99.00		

TEXT KEY TEXT DESC
991 TABLE OF CONTENTS:

OVERCODES
EXAM ENTRY- ALL CLAIM TYPES
OUTPATIENT (M)
DRG (R) AND INPATIENT (S)
CROSSOVER (W/V)
RESOLUTIONS
HOSPITAL ADJUSTMENTS

1. OVERCODES:

014 INDICATES REPORTS ARE ATTACHED, I.E. OP REPORT, HISTORY, PHYSICALS, DISCHARGE SUMMARIES, PAS, CONSENT FORMS, ETC.
024 REMOVED AUTHORIZATION NUMBER AND CYCLED (RES).
111 MDCR COB REVIEW OF PAID/DENIED CLAIMS.
303 IDENTIFIES CLAIMS SUBMITTED FOR DONOR.
444 INDICATES THE CLAIM OR A SINGLE LINE INDICATED THE STATEMENT, "ADDITIONAL SERVICES" OR "NOT A DUP", OR "SEEN TWICE IN THE SAME DAY", OR LATE CHARGES (DRG "R" CLAIMS SEE PAGE 10).
991 NOT DONE AS A PANEL, MODIFIERS LP OR 2N,OR QP OR STATEMENT "LAB DONE STAT".
777 TRIPLET A
778 TRIPLET B
779 TRIPLET C
886 TWIN OR TRIPLET, UNIDENTIFIED:
THERE IS A MULTIPLE BIRTH DX CODE V31-V37.2 (PRIMARY OR ADMITTING) OR OTHER INDICATION ON CLAIM - DENY W/EOB 779.
888 TWIN A, BABY #1, FIRST, ETC.
889 TWIN B, BABY #2, SECOND, ETC.
998 APPROVED FOR EXCEPTION TO POLICY BY PRU/ASU/MHCRA

ITA INDICATORS: B = BABY ON PARENTS PIC
I = INVOLUNTARY
V = VOLUNTARY

--NOTE: ALL INFO ON THE FRONT OF THE CLAIM SHOULD BE KEYED WHETHER THE CLAIM IS PAID OR DENIED. EXCEPTION: IF PROV IS BILLING W/DUMMY PROV #8999500 IN THE ATTENDING PROV FIELD - DO NOT KEY UNLESS INSTRUCTED TO BY EXC 139 OR THE DOCTOR'S NAME IS PRESENT.

2. EXAM ENTRY - ALL CLAIM TYPES

A. D333 - CHANGING CLAIM TYPES. IN THE UPPER RIGHT HAND CORNER OF THE UB-92 INDICATE THE CORRECT CLAIM TYPE. X-OVERS (W/V) SHOULD BE PUT IN THE X-OVER PRESORT BOX. M,R,S SHOULD BE PUT IN RE-ICN SLOT. FYI: 111 BILL TYPE IS INPATIENT - 131 BILL TYPE IS OUTPATIENT.

B. FOR CLAIMS DETERMINED TO BE REPROCESSED AS MEDICARE X-OVERS (W/V) WHEN D333'ING A CLAIM THAT IS POSTING AS NOT TIMELY (EXCEPTION 125); IF NOT TIMELY, PUT EOB 546 IN 2ND SLOT.

C. WHEN DETERMINING THAT A CLAIM NEEDS TO BE RESUBMITTED AS A DIFFERENT CLAIM TYPE, IF POSTING FOR ELIGIBILITY OR TIMELINESS AND JUSTIFICATION NOT GIVEN, DENY WITH APPROPRIATE EOB. THIS APPLIES TO R, S, AND M CLAIM TYPES.

D. PATIENT PAY AMTS (M,R,S) - IF THERE IS ANY INDICATION OF PATIENT PARTICIPATION (I.E. SPEND DOWN, ER CO-PAY, EMER, KIDNEY DISEASE PROGRAM, KDP) ON THE CLAIM, IN THE COMMENTS, OR BACKUP - ENTER AMT IN THE PATIENT PAY FIELD W/EOB 046 IN THE 2ND EOB FIELD. KEY NET CLAIM CHARGE AS SHOWN ON THE CLAIM.
IF EXCEPTION 134 POSTS DO THE FOLLOWING:
--NOTE: BE SURE YOU HAVE KEYED THE NONCOVERED CHARGES, PATIENT PAY AND INSURANCE AMOUNTS.
1. IF THE AMTS LISTED ABOVE DO NOT EXCEED THE BILLED AMOUNT - CORRECT THE NET CLAIM CHARGES.
2. IF THE AMTS LISTED ABOVE EXCEED THE BILLED AMOUNT - KEY 0.00 IN THE NET CLAIM CHARGE.
3. IF EXCEPTION 134 STILL POSTS - OVERLOC TO 72.

E. WHEN DENYING ENTIRE CLAIM FOR TWO EXCEPTIONS, MANUALLY PUT IN BOTH EOB'S IN THE FOLLOWING ORDER: ELIGIBILITY, TIMELINESS, MEDICARE, AND THEN ANY OTHER.

F. IF STERILIZATION/TUBAL LIGATION/HYSTERECTOMY/VASECTOMY INDICATED ON CLAIM OR BACKUP, OVER-LOC TO LOCATION 18 EVEN IF EXCEPTION 343 IS NOT POSTING. PUT AN X IN THE LMC FIELD AND PA-2 EXEPTION 116.

G. MAXIMUM NUMBER OF LINES THAT CAN BE KEYED PER CLAIM = 150. KEY FIRST 150 LINES, THEN PUT AN "X" IN THE LMC FIELD & O'LOC TO 72.
--ROUTE THE HARD-COPY CLAIM TO: SUE HILTON/MMIS SVS/MS: 45564.
--KEY THE TOTAL CLAIM CHARGE EXACTLY AS SHOWN ON THE CLAIM.

H. MEDICARE DEDUCTIBLES BY YEAR ARE:
01/01/04 - $876.00 01/01/03 - $840.00 01/01/02 - $812.00
01/01/01 - $792.00 01/01/00 - $776.00 01/01/99 - $768.00
01/01/98 - $764.00 01/01/97 - $760.00 01/01/96 - $736.00

I. UNITS SHOULD BE KEYED AS THEY APPEAR ON THE CLAIM FOR ALL REVENUE AND CPT/HCPCS CODES. WHEN UNITS EXCEED THE FIELD SIZE DO THE FOLLOWING:
EE: 1. ACCOMODATION (ROOM) REVENUE CODES:
A. LEAVE THE UNIT FIELD BLANK.
B. KEY AN "X" IN THE LMC FIELD.
C. PF7 & ENTER A COMMENT INDICATING WHICH LINE & HOW MANY UNITS WERE BILLED.
D. OVERLOC THE CLAIM TO 72.
2. ALL OTHER REVENUE CODES - FILL THE FIELD WITH 9'S.

J. PATIENT-CONTROL NUMBER - KEY PRECEDING ZEROS, ALPHA & NUMBERIC, DO NOT KEY PERIODS, DASHES, ETC.

K. OUTPATIENT (M), INPATIENT (S), DRG (R) - THE FOLLOWING INFORMATION IS TO BE ENTERED ON THE SECOND SCREEN (PF6):

1. OCCURRENCE CODES (FORM LOCATOR 32) AND CONDITION CODES (FORM LOCATORS 24-30). OCCURRENCE CODESREQUIRE A DATE - ENTER THE DATE (IF PRESENT) IN THE "OCD:" FIELD. NOTE: ENTER THE OCCURRENCE CODE EVEN IF THERE IS NO DATE IN THE "OCD:" FIELD.

2. INSURANCE DOLLAR AMOUNT THAT APPEARS ON THE CLAIM. IF THE AMT IS ENTERED, AN ENTRY MUST BE MADE IN THE PRIOR PAY FIELD. VALID ENTRIES ARE: INSURANCE COMPANY NAME (MAY BE ABBREVIATED) OR IF NAME IS UNCLEAR OR MISSING A "." (PERIOD) MAY BE ENTERED. IF ONLY THE NAME IS ON THE CLAIM, DO NOT ENTER INFO IN SECOND SCREEN.

3. EXAM ENTRY OUTPATIENTS (M) CLAIMS:

A. KEY BOTH THE CPT CODE AND THE REVENUE CODE ON OUTPATIENT CLAIMS. FYI: IF THE CPT CODE IS VALID FOR OUTPATIENT SERVICES, THE SYSTEM WILL PAY OFF THE PDD FILE. IF THE CPT CODE IS NOT VALID, THE SYSTEM WILL PAY THE PERCENT OF CHARGES PER THE PROVIDERS CHARGE MODE.

B. KIDNEY CENTERS (PT 62) - EFFECTIVE WITH DATES OF SERVICE 10/01/03 AND AFTER: CHECK REMARKS, DESCRIPTION FIELD AND/OR BACK UP FOR NDC'S. KEY THE NDC ON THE APPROPRIATE LINE AS INDICATED BY THE PROVIDER.

C. HOME HEALTH CLAIMS (PROVIDER TYPE 44) - EFFECTIVE 12/1/03
HOME HEALTH CLAIMS WILL BE PROCESSED AS M CLAIM TYPE:
NOTE: DO NOT COMBINE DIFFERENT MONTHS.
   1. HOME HEALTH CLAIMS BILLED ON ANY CLAIM FORM OTHER THAN UB-92 DENY WITH EOB 817.
   2. CONSECUTIVE DAYS MAY BE KEYED ON ONE LINE. *C
   3. NON-CONSECUTIVE DAYS, ONLY KEY 2 DAYS/SAME SVC ON 1 LINE
   4. DUPLICATE SERVICES FOR THE SAME DAY MUST BE BILLED ON SEPARATE LINES. IF NOT, DENY W/EOB 305. (NOTE) DO NOT COMBINE LINES FOR DUPLICATE SERVICES BILLED ON THE SAME DAY.
   5. IF ACTUAL DATES OF SERVICE ARE NOT LISTED ON CLAIM, DENY W/ EOB 177.
   6. IF DATES AND UNITS DO NOT MATCH, DENY W/EOB 305.
   7. IF MONEY CANNOT BE DIVIDED EVENLY BY DATES/UNITS LISTED, OVERLOC TO 67.
   8. CLAIMS W/MEDICARE B/U- OVERLOC TO 67.

D. HOSPICE CLAIMS (PT 63) - IF BILLING REV CODES 651 &/OR 653 AND DOS ARE CONSECUTIVE, COMBINE LINES. NOTE: DO NOT COMBINE LINES FOR DIFFERENT MONTHS.

E. WHEN A PHYSICIAN MEDICARE BACKUP IS ATTACHED, DENY THE CLAIM WITH EOB 335. IF MEDICARE RA/EOMB SHOWS PAYMENT - DENY WITH EOB 934 IF NO PAYMENT/DEDUCTIBLE ON MEDICARE RA/EOMB.

F. IF STATEMENT ON CLAIM INDICATES "ADDITIONAL SERVICES" OR "NOT A DUP", OR "SEEN TWICE IN THE SAME DAY", OR LATE CHARGES, ENTER OVERCODE 444, AND "X" IN LMC FIELD & OVERLOC TO LOCATION 35.

G. ELECTRONIC OUTPATIENT BILLINGS IDENTIFIED AS MEDICARE X-OVERS- IF HARD COPY CLAIM ATTACHED, DENY WITH EOB 333 AND RESUBMIT AS A X-OVER (W). IF CLAIM NOT ATTACHED, DENY WITH EOB 226. MEDICARE X-OVERS CANNOT BE BILLED ELECTRONICALLY.

H. IF CLAIM HAS APPROVED CSHCN (CHILDREN WITH SPECIAL HEALTH CARE NEEDS) STAMP WITH SIGNATURE ON IT OR ATTACHED FORM/BACKUP - KEY "H" IN THE ITA FIELD.

I. MEDICARE BACKUP (RA/EOMB) ATTACHED SHOWING PAYMENT AND 259/261 IS NOT POSTING:

1. EXCEPTION 271, ETC. BLOCK MEDICARE - CHECK ELIGIBILITY FILE, PAGE 2, COLUMN E:

A. IF THERE IS NO 1 OR 7 IN COLUMN E - ENTER 111 IN THE OVERCODE FIELD. IF HARD COPY CLAIM - DENY WITH EOB 333 AND RESUBMIT AS A X-OVER CLAIM. IF ELECTRONIC CLAIM AND NO UB-92 ATTACHED AS BACKUP - DENY WITH EOB 226.
B. IF THERE IS A 1 OR 7 IN COLUMN E - FOLLOW THE SAME INSTRUCTIONS IN A - EXCEPT DO NOT ENTER OVERCODE 111.

2. IF THERE IS NO ELIGIBILITY EXCEPTION BLOCKING 259/261 - ENTER 111 IN THE OVERCODE FIELD. IF HARD COPY CLAIM - DENY WITH EOB 333 AND RESUBMIT AS A X-OVER CLAIM. IF ELECTRONIC CLAIM - DENY WITH EOB 226.

*SH

J. IF THE PROVIDER IS BILLING MORE THAN 1 TYPE OF THERAPY REV CODE (42X/43X/44X/47X) ON THE SAME CLAIM - DENY AT HEADER W/EOB 365. EXCEPTION: ALLOW REV CODES 44X & 47X IN COMBINATION ON THE SAME CLAIM.
EXCEPTION: HOME HEALTH PT(44) - ALLOW MULTIPLE THERAPY CODES.

4. EXAM ENTRY - DRG (R) AND/OR INPATIENT (S) CLAIMS:

A. DRG (R) AND INPATIENT (S) - EXCEPTIONS 602 AND 620 POSTING. CHECK KEYING OF AUTHORIZATION NUMBER - IF CORRECT, DO NOT WORK EITHER EXCEPTION - PA2.

B. DRG (R) AND INPATIENT (S) - EXCEPTION 195 (MISSING ADMITTING DIAGNOSIS) POSTING, EXCEPTIONS 620 OR 621 WILL ALSO POST. WORK THE 195, PA2 THE 620/621 - SYSTEM CANNOT DETERMINE IF SERVICE REQUIRES AUTHORIZATION WITHOUT THE ADMITTING DIAGNOSIS.

C. INPATIENT (S) - PAS EXTENSION ATTACHED - IF ACUTE DAYS ARE APPROVED, ENTER THE NUMBER OF DAYS IN EXTENSION DAY FIELD AND A "Y" IN THE LMC FIELD. NEVER KEY ADMINISTRATIVE DAYS. IF MULTIPLE ACUTE EXTENSIONS ARE ATTACHED, TOTAL ALL PAS EXTENSION DAYS. THE ADMIT DATE MUST CORRESPOND TO THE ADMIT DATE ON THE CLAIM.

D. DRG (R) - IF SVS BILLED ARE FOR LATE AND/OR ADDITIONAL CHARGES (MUST BE STATED ON THE CLAIM OR IN THE COMMENT FIELD).

EE: ENTER 444 IN THE OVERCODE, KEY AN "X" IN THE LMC FIELD,

AND PA2.
RES: IF THE CLAIM IS NOT SUSPENDING AS A POSSIBLE DUPE AGAINST ANOTHER INPATIENT CLAIM (R OR S) - DENY W/EOB 798. OTHERWISE WORK PER DUPE AUDIT INSTRUCTIONS.

E. INPATIENT (S) - MEDICARCE PAYMENT INDICATED AND EXCEPTION 259 IS NOT POSTING:

1. IF THE CLAIM INDICATES PART B (*MMEDICARE PAYMENT EITHER ON THE CLAIM OR IN THE COMMENTS) - ENTER THE PAYMENT IN THE *MED-AMT: FIELD ON THE P6 SCREEN (PAYER 001). NOTE: THIS WILL CAUSE EXCEPTION 556 TO POST - DO THE FOLLOWING:

A. IF THERE ARE NO PART B CHARGES (SEE 259 TEXT) - FORCE EXCEPTION 556 AND KEY 111 IN THE OVERCODE FIELD.

B. IF THERE ARE PART B CHARGES (SEE 259 TEXT) - DENY EXCEPTION 556 WITH EOB 292. KEY 111 IN THE OVERCODE FIELD.

2. IF THE CLAIM INDICATES MEDICARE PAYMENT, BUT DOES NOT SPECIFY PART A OR PART B AND THERE IS NOT BACKUP - ENTER THE PAYMENT AMT IN THE *MED-AMT: FIELD ON THE F6 SCREEN (PAYER 001). NOTE: THIS WILL CAUSE EXCEPTION 556 TO POST - DO THE FOLLOWING:

A. IF THERE ARE NO PART B CHARGES ON THE CLAIM (SEE 259 TEXT) FORCE EXCEPTION 556. KEY 111 IN THE OVERCODE FIELD.

B. IF THERE ARE PART B CHARGES ON THE CLAIM (SEE 259 TEXT) - DENY EXCEPTION 556 WITH EOB 292. KEY 111 IN THE OVERCODE FIELD.

3. IF THE CLAIM INDICATES A MEDICARE PART A PAYMENT AND SHOULD BE PROCESSED AS A X-OVER CLAIM - DO THE FOLLOWING:
A. HARD COPY CLAIMS - DENY W/EOB 333 & REPROCESS AS A X-OVER.
B. ELECTRONIC CLAIMS - DENY W/EOB 226.

4. ANY QUESTIONS SEE YOUR SUPERVISOR/TRAINIER.

F. DRG (R) - MEDICARE PAYMENT INDICATED AND EXCEPTION 259 IS NOT POSTING:

1. IF THE CLAIM INDICATES PART B MEDICARE (*MMEDICARE PAYMENT EITHER ON THE CLAIM OR IN THE COMMENTS) - ENTER THE PYMT AMOUNT IN THE *MED-AMT: FIELD ON THE F6 SCREEN (PAYER 001).

2. IF THE CLAIM INDICATES MEDICARE PAYMENT, BUT DOES NOT SPECIFY PART A OR PART B AND THERE IS NOT BACKUP - ENTER THE PYMT AMT IN THE *MED-AMT: FIELD ON THE F6 SCREEN (PAYER 001). ENTER 111 IN THE OVERCODE FIELD.

3. IF THE CLAIM INDICATES MEDICARE PART A PAYMENT AND SHOULD BE BE PROCESSED AS A X-OVER CLAIM - DO THE FOLLOWING:

A. HARD COPY CLAIMS - DENY W/EOB 333 & REPROCESS AS A X-OVER.

B. ELECTRONIC CLAIMS - DENY WITH EOB 226.

4. ANY QUESTIONS - SEE YOU SUPERVISOR/TRAINER.

G. IF MEDICARE EMOB/RA INDICATES BENEFITS EXHAUSTED, CLAIM FOR NON COVERED SERVICES - CHARGES ARE TO BE PROCESSED AS A DRG. THE CLAIM MUST MEET OUTLIER STATUS. IF NOT, DENY WITH EOB'S 030/520. IF MEDICARE EOMB IS NOT ATTACHED - DENY EXCEPTION 259.

5. EXAM ENTRY (PRESORT) - CROSSOVER (W/V).

OVERCODES: 444 - STATEMENT ON CLAIM - "ADDITIONAL SERVICE", "NOT A DUP" OR "SEEN TWICE IN THE SAME DAY"
998 - APPROVED FROM EXCEPTION TO POLICY BY PRU/ASU/DUS (MHCRA).

A. SPENDDOWN AMOUNT SHOULD BE DEDUCTED FIRST FROM CO-INSURANCE AND THEN FROM THE DEDUCTIBLE AMOUNT. THE AMOUNT CAN BE TAKEN FROM THE CLAIM OR AN ATTACHED AWARD LETTER THAT COVERS THE DOS. ENTER 046 IN THE SECOND EOB SLOT. (NOTE) TREAT KDP (KIDNEY DISEASE PROGRAM) MONEY AS SPENDDOWN.

B. TYPE OF BILL
1. 110-115, 117 (INPATIENT CLAIM) OR MEDICARE EOMB INDICATES INPATIENT, KEY V IN THE INPUT-FORM-IND FIELD.
A. IF PROV NUMBER 3200318 OR 3200326 - SHOULD BE V CLAIMS.
2. ALL ELSE SHOULD BE OUTPATIENT - LEAVE BLANK & THE SYSTEM WILL INSERT W INTO THE INPUT-FORM-IND FIELD.

C. STATUS CODE ENTER FROM THE CLAIM. IF NOT PRESENT - LEAVE BLANK.

D. DAYS COVERED
1. W CLAIM TYPE - ENTER NUMBER OF DAYS AS INDICATED ON CLAIM. IF DAYS NOT GIVEN - ENTER 01.
OTHERWISE ENTER 01.

--NOTE--IF DAYS/UNITS ARE GREATER THAN 99 - ENTER 99.

E. ADMIT DATE
1. V CLAIM TYPE - ENTER ADMIT DATE, IF NOT GIVEN USE "FROM" DATE.
2. W CLAIM TYPE - NOT REQUIRED, LEAVE BLANK.

F. WHEN TOTAL CHARGES ON CLAIM EXCEEDS THE FIELD - KEY IN 99,999.00. PUT AN X IN LMC AND PA-2 EXCEP 116. FIELD HAS BEEN EXPANDED 11/00

G. WHEN THERE IS NO DEDUCTIBLE AND/OR CO-INSURANCE ON MEDICARE RA/EOMB WITH A MEDICARE PAYMENT - DENY WITH EOB 157.

H. PAT-CNL NUMBER - KEY PRECEDING ZERO(S), ALPHA AND NUMERIC, DO NOT KEY DOTS, DASHES, ETC.

I. DIAGNOSIS - ENTER FROM CLAIM. IF NOT GIVEN, LEAVE BLANK.

J. WHEN THERE IS A MINUS PAYMENT FROM MEDICARE - LEAVE MEDICARE PAID

FIELD BLANK.

K. MEDICARE EOMB/RA MUST MATCH CLAIM INFORMATION. IF DATES DO NOT MATCH - DENY WITH EOB 105. IF TOTAL BILLED AMOUNT ON UB-92 MINUS TOTAL NON-COVERED CHARGES (INDICATED IN NON-COVERED FIELD) EQUALS TOTAL BILLED TO MEDICARE ON RA/EOMB CONSIDER IT A MATCH. OTHERWISE - DENY WITH EOB 105.

L. IF PROVIDER HAS COMBINED MULTIPLE MEDICARE PAYMENTS & IS BILLING ON ONE UB-92 - DENY WITH EOB 105. EACH SERVICE/PAYMENT MUST BE BILLED SEPARATELY.

M. PHYSICIAN MEDICARE BACKUP ATTACHED
1. IF MEDICARE RA SHOWS MEDICARE PAYMENT - DENY WITH EOB 335.
2. IF NO PAYMENT/DEDUCTIBLE ON MEDICARE RA/EOMB -DENY W/ EOB 934.

N. IF MEDICARE RA/EOMB INDICATES SERVICES ARE FOR SWING BED OR SKILLED NURSING AND/OR IF PER DIEM RATE ENTERED ON MEDICARE RA/EOMB, DENY WITH EOB 749. SERVICES MUST BE BILLED ON THE NURSING HOME TURN AROUND (TAD) DOCUMENT.

O. IF A MEDICARE HMO REMITTANCE IS ATTACHED - ENTER A "Y" IN TPL AND OVER-LOC TO LOCATION 55, UNLESS DENYING THE CLAIM.

P. AMBULANCE CHARGES FOR IN-STATE PROVIDERS SHOULD BE BILLED BY THE PROVIDER OF SERVICE (AMBULANCE), USING THE HCFA 1500 CLAIM FORM. DENY WITH EOB 318/335.

Q. LIFETIME RESERVE DAYS ARE PAYABLE. IF THE EOMB FROM MEDICARE INDICATES LIFETIME RESERVE DAYS (LTR), ADD THIS AMOUNT TO THE CO-INSURANCE AMOUNT IF ANY. ENTER TOTAL IN CO-INSURANCE FIELD.

6. RESOLUTIONS - ALL CLAIM TYPES
A. WHEN DENYING CLAIM AND BACKUP INDICATED BUT NOT RECEIVED, USE 224 IN SECOND EOB SLOT. IF BACKUP RECEIVED BUT INAPPROPRIATE, USE EOB 281 IN SECOND SLOT.

B. IF TRANSPLANT AND ONE OF THE CLAIMS IS FOR DONOR - FORCE. (WE PAY FOR DONOR UNDER CLIENT'S PIC.)

7. HOSPITAL ADJUSTMENTS (ALL CLAIM TYPES) - WHENEVER KEYING ADJUSTMENTS, ALWAYS CLEAR DUP AUDITS (I.E. 102, 103) AND CYCLE.

TEXT KEY TEXT DESC
992

PHARMACY CLAIM TYPE "D" EXAM ENTRY AND ADJUSTMENT INSTRUCTIONS.

NOTE: THE 999 GENERAL INFORMATION TEXT DOES NOT ALWAYS APPLY TO THE POS SYSTEM. ANY INFORMATION IN THIS TEXT FILE, SUPERSEDES ANY LIKE INFORMATION IN THE 999. NO OTHER TEXT FILES IN THE MMIS SYSTEM APPLY TO POINT OF SALE CLAIMS. ANY QUESTIONS, SEE YOUR TRAINER OR PATTY ORTH.

PHARMACY CLAIMS ARE PROCESSED ON THE POINT OF SALE (POS) SYSTEM. IT IS AN ON-LINE REAL TIME PRODUCTION SYSTEM, AND DETERMINES PAYMENT OR DENIAL OF PRESCRIPTION DRUG CLAIMS. IT IS A COMPLETELY SEPARATE SYSTEM FROM THE MMIS SYSTEM. THE CLIENT AND PROVIDER INFORMATION TRANSFERS FROM MMIS TO POS. (NOTE: AUTHORIZATION INFO TRANSFERRED FROM MMIS FEB 2002 & BEFORE. EFFECTIVE FEB 2002, PRIOR AUTHORIZATION IS NOW BUILT IN POS.) THE CLAIMS INFORMATION FROM POS IS SENT BACK TO THE MMIS SYSTEM FOR HISTORY PURPOSES, & PAYMENT/RA TO PROVIDER. THE INSTRUCTIONS FOR POS ARE LOCATED HERE, NO TEXT FILES EXIST IN POS.

NOT ALL ELIGIBLE MEDICAID CLIENTS TRANSFER ELIGIBILITY TO THE POINT OF SALE CLIENT HISTORY FILE. THE FOLLOWING MATCH OR MATCH/PROGRAM COMBINATIONS DO NOT TRANSFER TO POS:

MATCH CODE D (MEDICARE QMB ONLY)
MATCH CODE W (NOT ELIG FOR MEDICAL CARE - ONLY MEDICARE COVERAGE)
MATCH CODE E (ESLMB) IF THE PROGRAM CODE IS EQUAL TO A, B, P, OR T.
MATCH CODE K (SLMB)

IF CLAIM OR BACKUP INDICATES MEDICARE MADE PAYMENT BACK OUT & ROUTE TO SANDY MITCHELL, PRU, MAIL STOP 45562.

IF CLAIM/ADJ IS KEYED WRONG, SEE YOUR TRAINER FOR INSTRUCTIONS ON ADJUSTING. NOTE: IF ORIGINAL CLAIM/ADJ HAS A CROSS REFERENCED PIC, YOU CAN NOT CHANGE PIC, SEE TRAINER FOR INSTRUCTIONS.

POS HAS THE CAPABILITY OF HISTORY ONLY ADJUDICATION. IF A BATCH COVER INDICATES HISTORY ONLY A "1" MUST BE ENTERED IN THE ACCOUNT CODE ON THE CLAIMS EXAM ENTRY KEY PANEL. IF A BATCH IS KEYED IN ERROR AS HISTORY ONLY, IT MUST THEN BE KEYED AS HISTORY ONLY CREDIT TO CORRECT THE MISTAKE. THEN THE ORIGINAL BATCH CAN BE REICN'D AND KEYED AS NORMAL PAY (ACCOUNT CODE 0).

ADJUSTMENTS: IF BATCH COVER INDICATES ONE OF THE FOLLOWING, KEY THE TWO DIGIT INDICATOR IN THE REASON FOR ADJUSTMENT FIELD:
PIP (PAYMENT INTEGRITY PROGRAM) = PP
QRS (QUALITY REVIEW SECTION) = QQ

KEYING INSTRUCTIONS:
1. OTHER INSURANCE: ALWAYS SKIP. ADDRESS THIS FIELD AFTER ENTERING CLAIM IF INSTRUCTED TO DO SO IN THE ALERT 41 SECTION OF THIS TEXT.

2. PHARMACY NUMBER: KEY FROM UPPER LEFT HAND BOX ON CLAIM. IF MULTIPLE

NUMBERS KEY THE ONE BEGINNING WITH (4) OR INDICATING NABP NUMBER.
(NOTE: NABP NUMBERS CAN BEGIN WITH ZERO THRU FIVE.)
IF NO 7 DIGIT NUMBER, LEAVE FIELD BLANK.

3. DATE WRITTEN & DATE FILLED:
   A. DO NOT USE DATES FROM ONE PRESCRIPTION TO ANOTHER ON CLAIM FORM.
   B. DO NOT TRANSFER FILL OR WRITTEN DATE IF ONE IS MISSING.
   C. IF INVALID DATE, LEAVE FIELD BLANK.

4. PRESCRIPTION NUMBER: KEY NUMERIC. DO NOT KEY PRECEEDING ALPHA, ZERO(S), DOTS, DASHES, ETC. CONVERT ALPHA CHARACTERS WITHIN THE PRESCRIPTION NUMBER TO ZERO(S).

5. REFILL CODE: KEY ONLY 1 THRU 99, OTHERWISE LEAVE BLANK. NOTE: IF DECIMAL INDICATED DO NOT ROUND, LEAVE BLANK.

6. SUBMITTED QUANTITY:
   A. KEY QUANTITY FROM "FILLED" FIELD ONLY.
   B. FIELD ACCEPTS 5 DIGITS (PLUS 3 DECIMAL PLACES) IF PROVIDER BILLS OVER 99,999.999 BACK OUT OF CLAIM AND ROUTE TO PATTY ORTH IN MMIS SERVICES FOR REVIEW.
   C. METRIC DECIMAL QUANTITIES MUST BE KEYED TO THE THIRD (THOUSANDTH) DIGIT. E.G. 0.25 IS KEYED AS 0.250, OR 3.5 IS KEYED AS 3.500.

7. SUBMITTED DAYS SUPPLY: IF SPAN OF DAYS INDICATED KEY THE FIRST AMOUNT, IE: 15-30 KEY 15. DECIMALS ARE ALWAYS ROUNDED DOWN.

8. NATIONAL DRUG CODE (NDC): COMPOSED OF 3 FIELDS. FIRST IS 5 DIGIT LABELER (MANUFACTURER) CODE, SECOND IS 4 DIGIT PRODUCT CODE, & THIRD IS 2 DIGIT PACKAGE SIZE. PRECEEDING ZERO'S FOR EACH FIELD MAY BE KEYED OR LEFT OFF & SKIP TO THE NEXT FIELD.

9. PRESCRIBER ID:

   FILL DATE PRIOR TO 1/1/03:
   KEY AS IS UNLESS PROVIDER BILLS WITH 8999500 WITH NO NAME INDICATED, THEN LEAVE BLANK AND DENY. IF NAME INDICATED ON CLAIM, KEY IT IN. NOTE: DEA IDENTIFIER IS A VALID VALUE FOR THIS FIELD AND MUST BE KEYED. IT IS TWO ALPHA FOLLOWED BY SEVEN NUMERIC (9 DIGITS TOTAL).

   FILL DATE 1/1/03 AND AFTER:
   KEY AS IS UNLESS PROVIDER BILLS WITH 8999500 THEN LEAVE BLANK & LET CLAIM DENY.

10. DUR (DRUG USE REVIEW): CONSISTS OF 3 FIELDS AND ARE USUALLY FOUND IN THE COMMENTS FIELD. CONFLICT CODE IS 2 DIGIT ALPHA, INTERVENTION CODE IS 1 ALPHA FOLLOWED BY 1 NUMERIC, AND OUTCOME CODE IS 1 NUMERIC FOLLOWED BY 1 ALPHA. ENTER CODES IF INDICATED ON CLAIM. EXAMPLE: TD, R0, 1B.

11. SUBMITTED INGREDIENT COST & TOTAL CHARGE: KEY SAME AMOUNT IN BOTH FIELDS INCLUDING DECIMAL. IF ONE AMOUNT PRESENT IN THE TOTAL CHARGE, PATIENT PAY &/OR BALANCE DUE-KEY THAT AMOUNT. IF 2 DIFFERENT AMOUNTS & NOTHING IN THE INSURANCE PAID AMOUNT, KEY THE SMALLER AMOUNT. IF

2 DIFFERENT AMOUNTS & INSURANCE PAID AMOUNT IS INDICATED, KEY THE LARGER AMOUNT. IF AMOUNT BILLED IS GREATER THAN $99,999.99 BACK OUT AND ROUTE CLAIM TO PATTY ORTH IN MMIS SERVICES FOR REVIEW.

12. TAX: DO NOT ADD ON OR KEY IN TAX.

13. OTHER AMOUNT: KEY FROM INSURANCE PAID AMOUNT INCLUDING DECIMAL.

14. PRIOR AUTHORIZATION: KEY NUMBER AS IS EXCEPT IF ATTEMPTING EXPEDITED AUTH YOU MAY ADD ZERO(S) TO MIDDLE OF AUTH TO EQUAL 9 DIGITS. NOTE: VALID AUTH NUMBERS ARE 9 DIGIT (ASSIGNED OR EXPEDITED) OR 11 DIGIT (POS SYSTEM GENERATED). EFFECTIVE 02-02 SYSTEM READS THE ELIGIBILITY PROFILE AND IF CLAIM QUALIFIES FOR THE APPROVED AUTH IT WILL SYSTEM PLUG THE AUTH NUMBER. (IT WILL OVERLAY WHAT IS KEYED IN THIS FIELD.)

15. SPECIAL HANDLING BATCHES: KEY CLAIM & ENTER. IF CLAIM WILL DENY FOR ANY REASON NOT ADDRESSED ON THE CLAIM, BACK OUT OF CLAIM & SEE THE BATCH ORIGINATOR.

16. IF PROVIDER IS INQUIRING ABOUT NON-PAYMENT PROCESS CLAIM AS NORMAL. IF CLAIM DENIES FOR ANY REASON, SEND PRU REFERRAL.

17. IF CLAIM NEEDS TO BE REMOVED FROM BATCH (EG: DUPLICATE ICN, L&I, PRU, TPR, ETC) BACK OUT & DO NOT PROCESS CLAIM. INDICATE TIMELINESS ON CLAIM, & INDICATE ACTION ON BATCH COVER (EG: L&I, RE-ICN, ETC).

COMMENTS ON CLAIMS - THE FOLLOWING COMMENTS MAY APPEAR ON CLAIMS & THE APPROPRIATE INDICATORS TO KEY, AS YOU ARE ENTERING THE CLAIM, ARE NOTED. IF COMMENT NOT INDICATED HERE, DO NOT KEY UNLESS THE SPECIFIC ALERT INSTRUCTIONS DIRECT YOU TO DO SO.

HOSPICE = 11 IN CUSTOMER LOCATION IF CLAIM ALSO STATES NOT RELATED TO TERMINAL ILLNESS, OR NOT COVERED BY HOSPICE

K = 11 IN CUSTOMER LOCATION

ITA = 2 IN CUSTOMER LOCATION

DAW OR DISPENSE AS WRITTEN = 1 IN DAW FIELD.

COMPOUND = 2 IN COMPOUND FIELD
EXCEPTION: IF YOU CAN CLEARLY SEE THAT CLAIM IS A CARBON COPY OF PREVIOUS CLAIM IN BATCH AND THE PREVIOUS CLAIM WENT TO PAY, DO NOT KEY 2 IN COMPOUND FIELD OR THE DUPLICATE CLAIM WILL PAY IN ERROR.

PRESCRIBED BY:
COMMUNITY MENTAL HEALTH
DENTIST
FAMILY PLANNING
HEALTH DEPARTMENT
OR IF CLAIM INDICATES ABORTION RELATED

ANY OF THE ABOVE = 2 IN MEDICAL CERTIFICATION CODE (CERT CD)

LOST/STOLEN DRUG REPLACEMENT = 5 IN CERT CD

TAKE HOME, EMERGENCY BOX, CAMP MEDS, SCHOOL MEDS, WEEKEND PASS, WORKSHOP, CHEMOTHERAPY, PRESCRIBER MONITORING PATIENT, SUICIDE RISK, SR, OR POTENTIAL FOR ABUSE = 8 CERT CODE

BABY ON PARENT'S PIC = 2 IN ELIGIBILITY OVERRIDE

UNIT DOSE = Y IN UNIT DOSE INDICATOR

IF PROVIDER INDICATES FIELD & CODE, KEY IN ACCORDINGLY. NOTE: HIPAA CHANGED MANY FIELD NAMES, BUT THEY DID NOT CHANGE ON THE SCREEN. YOU MAY NEED TO CHECK THE PAYER SHEET IN THE BILLING INSTRUCTIONS.

BIRTH CONTROL PILLS FOR MALE OR BCP FOR MALE SEE 88 SX INSTRUCTIONS.

SYSTEM ALERTS & INSTRUCTIONS:

ERROR STATUS CODES:
1 = INFORMATIONAL
2 = DENIAL
3 = INFORMATIONAL, ECEPTION: ON ALERT 76 A 3 IS DENIAL

EDIT SPECIFIC ERROR STATUS CODES:

25 - D = MISSING OR INVALID DEA NUMBER IN THE PRESCRIBER ID FIELD

70 - D = DESI DRUG
70 - N = NOT COVERED PER COVERAGE INDICATOR
70 - P = NOT COVERED ON THE PLAN FILE
70 - R = NON-SIGNED REBATE AGREEMENT
70 - S = NO PRICING SEGMENT FOR DATE FILLED
70 - X = NON-PREFERRED DRUG *P

75 - A = REGULAR PA
75 - C = PA SET BY THE PLAN FILE
75 - M = AUTHORIZED UNITS OR DAYS EXCEEDED ON THE MEDICAL PROFILE
75 - O = OXYCONTIN 2 PER DAY EXCEEDED

76 - 3 = 3RD FILL OF THE MONTH
76 - 5 = 5TH FILL OF THE MONTH
76 - C = EXCEEDED LIMITS ON THE PLAN FILE
76 - T = FOUR BRAND LIMIT EXCEEDED (TCS)

M1 - THIS EDIT ALSO POSTS IF 70 FAILS FOR A CLIENT IN PLAN 252. YOU MAY SEE THE SAME REASON CODES THAT POST FOR EDIT 70 WITH EDIT M1.

--DO NOT APPLY MANAGEMENT OVERRIDE UNLESS ALL DENIAL ALERT CAN BE OVERRIDDEN. REMEMBER ALERT 88 NOT IN (2) STATUS IS NOT DENYING CLAIM. FYI: ONLY THE FOLLOWING ALERTS CAN BE OVERRIDDEN BY E/E WITH A "Y" KEYED IN THE MANAGEMENT OVERRIDE FIELD: 41, 70, 81, 83, 88, M1 & M2.

--CLAIMS SHOULD NOT BE ADJUDICATED AS ITA UNLESS VALID ITA FORM IS

ATTACHED COVERING FILL DATE. IF ITA STATEMENT ON CLAIM, KEY 2 IN CUSTOMER LOCATION FIELD, BUT DO NOT APPLY MANAGEMENT OVERRIDES, ETC. UNLESS VALID ITA FORM IS ATTACHED COVERING FILL DATE.

05 LOOK UP NABP NUMBER ON THE MMIS SYSTEM IF OUT OF STATE PROVIDER.

07 WITH COUPON STATING OTHER THAN SLMB OR QMB ONLY, CORRECT PER COUPON. IF THAT DOESN'T WORK TRY TIEBREAKER A OR B. PF-4 TO VERIFY CLIENT. IF OK, LET CLAIM GO. IF NOT, BACK OUT & SEND TO ELIGIBILITY.

18 THIS APPLIES TO SUBMITTED QUANTITY. IF QUANTITY FILLED IS BLANK F12 TO DENY. IF THERE IS A QUANTITY & POSTING ALERT 41, OR CLAIM/BACKUP INDICATES TPR, SEE ALERT 41 INSTRUCTIONS. ALL ELSE DENY.

19 THIS APPLIES TO DAYS SUPPLY. IF DAYS SUPPLY IS BLANK F12 TO DENY. IF THERE IS A DAYS SUPPLY & ALERT 41 IS POSTING OR CLAIM/BACKUP INDICATES TPR, SEE ALERT 41 INSTRUCTIONS. IF CLAIM INDICATES DELAYED CERT TAKE CLAIM TO PATTY ORTH IN MMIS SERVICES FOR REVIEW. ALL ELSE DENY.

41 IGNORE IF ALERT OTHER THAN 18 OR 19 WILL DENY THE CLAIM, OTHERWISE IF CLAIM STATES ANY OF THE FOLLOWING KEY THE CODE INDICATED IN THE OTHER INSURANCE FIELD:
LESS THAN CO-PAY = 3
COPAYMENT COVERS COST = 3
INSURANCE PAID ZERO = 3
NOT COVERED = 3

COPAYS:
CLAIMS SUBMITTED BY GROUP HEALTH STATING CAPITATED CO-PAY = 8. NOTE: THIS IS FOR GROUP HEALTH SUBMISSIONS ONLY, INDICATED BY A RED STAMP. ALL OTHER CO-PAYS FORWARD TO TPR UNLESS NO INSURANCE COMPANY NAME OR INITIALS ARE PRESENT.

ANY CLAIM WITH NO INSURANCE PAID AMOUNT, NO INSURANCE STATEMENT INDICATING INSURANCE COMPANY (NAME OR INITIALS), OR NO INSURANCE RELATED BACK-UP LET THE ALERT 41 DENY.

IF CLAIM STATES MVA, E-COLI, ETC. OR ANYTHING ELSE NOT ADDRESSED ABOVE AND CLAIM IN ONLY POSTING 41 OR COMBINATION OF 41 WITH 18 AND/OR 19, BACK OUT AND RE-ICN PRIORITY IN A TPR BATCH.

50 LOOK UP NABP NUMBER ON THE MMIS SYSTEM IF OUT OF STATE PROVIDER. IF IN STATE PROVIDER - DENY.

52 WITHOUT COUPON CORRECT PER INFO ON CLAIM/BACKUP. IF STILL POSTING CHANGE BACK TO ORIGINAL PIC & DENY. WITH COUPON STATING OTHER THAN SLMB OR QMB ONLY, CORRECT PER COUPON. IF THAT DOESN'T WORK TRY TIEBREAKER A OR B. PF-4 TO VERIFY CLIENT. IF OK LET CLAIM GO, IF NOT BACK OUT & SEND CLAIM TO ELIGIBILITY. IF OUT OF STATE PROVIDER LOOK UP PIC. IF PROPERLY COMPLETED ITA FORM IS ATTACHED COVERING THE FILL DATE, BACK OUT AND FORWARD TO THE ELIG UNIT.

63 IF STATEMENT ON CLAIM "CLIENT RESIDES IN OWN HOME" OR "CLIENT NOT

IN NURSING HOME" OR SIMILAR STATEMENT KEY 01 IN CUSTOMER LOCATION.

65 IF NO COUPON COVERING DATE OF SERVICE OR COUPON IS FOR SLMB OR QMB ONLY, DENY. IF DATE OF SERVICE IS BEFORE THE FIFTH ELIGIBILITY SEGMENT, BACK OUT AND ROUTE CLAIM TO ELIGIBILITY UNIT NOTING "CLIENT ELIGIBLE BUT BEYOND 5 SEGMENTS IN POS." ALL ELSE BACK OUT AND ROUTE TO ELIGIBILITY UNIT. EXCEPTION: IF CLAIM DENYING FOR EDIT 50, DO NOT HAVE ELIG UPDATED. IF PROPERLY COMPLETED ITA FORM IS ATTACHED COVERING THE FILL DATE, BACK OUT AND ROUTE TO THE ELIG UNIT.

65 & 67 POSTING TOGETHER:
WITH COUPON STATING OTHER THAN SLMB OR QMB ONLY, PF-4 TO CHECK ELIG FILE. IF BEFORE BEGIN DATE ON PAGE 2, OR IF BEFORE THE 5 ELIGIBILITY SEGMENTS ON PAGE 3, ROUTE TO ELIG UNIT NOTING "CLIENT ELIGIBLE BUT BEYOND 5 SEGMENTS IN POS". ALL ELSE ROUTE TO ELIG UNIT. EXCEPTION: IF CLAIM DENYING FOR EDIT 50, DO NOT HAVE ELIG UPDATED.

70 NDC NOT COVERED.

ERROR STATUS DENIAL REASONS:
- D = DESI DRUG
- N = NOT COVERED PER COVERAGE INDICATOR
- P = NOT COVERED ON THE PLAN FILE
- R = NON-SIGNED REBATE AGREEMENT
- S = NO PRICING SEGMENT FOR DATE FILLED
- X = NON-PREFERRED DRUG (TCS)

IF ERROR STATUS D, N, R, S OR X - DENY, ALL ELSE CONTINUE THRU TEXT.

VERIFY PLAN ON CLAIM (AT "PLAN" LOCATED ABOVE THE DATE FILLED):

PLAN 250, 252, 257 - DENY.

PLAN 251 - IF COMMENT ON CLAIM "PATIENT RESIDES AT HOME" OR CUSTOMER LOCATION 01 IS INDICATED - KEY "Y" IN MANAGEMENT OVERRIDE.

PLAN 253 - HOSPICE. IF COUPON ATTACHED FOR DATE OF SERVICE WITH NO X IN HOSPICE BOX, OR IF ITA, OR IF FILL DATE MATCHES THE END DATE OF THE PLAN 253 SPAN ON PAGE 3 OF THE POS ELIG FILE - KEY "Y" IN THE MANAGEMENT OVERRIDE.

PLAN 254 - IF COUPON ATTACHED FOR DATE OF SERVICE INDICATING PROGRAM OTHER THAN FAMILY PLANNING, OR STATMENT ON CLAIM "PAIN MED FOLLOWING STERILIZATION, TUBAL, VASECTOMY OR IUD INSERTION"; OR IF ITA - KEY "Y" IN MANAGEMENT OVERRIDE.

PLAN 255:
MEDICARE BACKUP ATTACHED WITH DENIAL REASON:
- CO-18 F12 & LET CLAIM DENY.
- CO-50 KEY 1B OUTCOME CODE.
- CO-57 KEY 1B OUTCOME CODE.
- PR-28 KEY 1B OUTCOME CODE, ROUTE CLAIM/BACKUP TO AUDREY FINNIGAN
- PR-31 KEY 1B OUTCOME CODE, ROUTE CLAIM/BACKUP TO AUDREY FINNIGAN
- PR-46 KEY 1B OUTCOME CODE.

PR-96 KEY 1B OUTCOME CODE.
PR-B11 F12 & LET CLAIM DENY.

ALL OTHER MEDICARE DENIAL REASONS SEE YOUR TRAINER.

IF NO MEDICARE BACKUP ATTACHED - DENY. EXCEPTION ADJUSTMENTS: IF MRS ADJUSTMENT STATES TO FORCE 261 - KEY 1B IN OUTCOME CODE.

PLAN 256 - IF COUPON ATTACHED FOR DATE OF SERVICE INDICATING PROGRAM OTHER THAN GAU, MI, EMERGENCY HOSPITAL & AMBULANCE, OR IF ITA - KEY "Y" IN MANAGEMENT OVERRIDE. ALL ELSE DENY.

81 IF PREVIOUS ICN, RA, OR DELAYED/RETRO COUPON VERIFY THIS IS A TIMELY SUBMISSION, KEY "Y" IN THE MANAGEMENT OVERRIDE UNLESS CLAIM IS OVER 15 MONTHS FROM FILL/DELAYED/RETRO DATE, DENY. EXCEPTION: INHOUSE CLAIM WITH INSTRUCTIONS TO FORCE TIMELINESS - KEY "Y" IN THE MANAGEMENT OVERRIDE.

83 IF CLAIM INDICATES BABY ON PARENT'S PIC, TWINS, TRIPLETS, ETC. REVIEW RELATED CLAIMS HISTORY FOR POSSIBLE PAYMENT. IF APPROPRIATE, KEY "Y" IN MANAGEMENT OVERRIDE.

88 SX ONLY: IF COMMENT ON CLAIM "BIRTH CONTROL PILLS FOR MALE" OR "BCP FOR MALE" AND THERE IS ALSO AN AUTHORIZATION NUMBER PRESENT ON THE CLAIM - KEY "Y" IN MANAGEMENT OVERRIDE. IF FIRST NAME DOES NOT MATCH SEX CODE ON ELIGIBILITY FILE, KEY "Y" IN MANAGEMENT OVERRIDE, AND COMPLETE ELIG SEX CHANGE FORM & ROUTE TO ELIG UNIT.

M1 IF COUPON COVERING FILL DATE AND DOESN'T INDICATE MANAGED CARE OR IF ITA - KEY "Y" IN THE MANAGEMENT OVERRIDE.

M2 IF COUPON COVERING DATE OF SERVICE DOESN'T STATE RESTRICTED OR IF ITA - KEY "Y" IN THE MANAGEMENT OVERRIDE.

IF AN ALERT IS POSTING AND WAS NOT ADDRESSED ABOVE, CHECK KEYING. IF ALERT STILL FAILING, DENY.

PHARMACY PRESORT:
A. IN-HOUSE POS SCREEN PRINTS, ALWAYS PROCESS AS SPECIAL HANDLING:
   1. IF PREVIOUSLY DENIED AND AN AUTHORIZATION NUMBER IS PRESENT OR TO BE ADDED, PROCESS AS NEW DAY CLAIM. OTHERWISE AS AN ADJUSTMENT.
   2. IF PREVIOUSLY PAID, PROCESS AS AN ADJUSTMENT.
B. ADJUSTMENT REQUESTS ARE SORTED TO:
   ADJUSTMENT BATCH (CHANGES TO CLAIM) OR
   CREDIT BATCH (RECOUP REQUESTS WITH NO CHANGES TO CLAIMS)
C. IN-HOUSE ADJUSTMENT REQUESTS BEYOND 15 MONTHS WITH NO NOTATION TO FORCE TIMELINESS - RETURN TO ORIGINATOR WITH EXPLANTATION. (THE ORIGINATOR CAN GROSS ADJUST.) COMMON IN-HOUSE MAILSTOPS:
   DRUG REBATE - 45503
   QFFS - 45506
   QRS - 45506
   TPL CASUALTY - 45561
D. PROVIDER SUBMITTED CREDITS BEYOND 15 MONTHS FORWARD TO CASH CONTROL MS 45566 FOR GROSS ADJUSTMENT.

E. PROVIDER SUBMITTED ADJUSTMENT REQUESTS BEYOND 15 MONTHS REFER TO PRU ON PURPLE SHEET.

ADDITIONAL ADJUSTMENT INFORMATION:

IF YOU RECEIVE A PROVIDER SUBMITTED ADJUSTMENT REQUEST TO A CLAIM PREVIOUSLY PROCESSED AS A CREDIT, REFER TO PRU ON PURPLE SHEET. CREDITS CANNOT BE ADJUSTED. A NEW DAY CLAIM MUST BE SUBMITTED IF WITHIN THE REBILLING TIME LIMIT. IF REQUEST IS IN-HOUSE, RETURN TO THE ORIGINATOR WITH EXPLANATION.

ADJUSTMENT BATCH IS ACTIVATED AS CLAIM TYPE A WITH ADJUSTMENT REASON 03. CREDIT BATCH IS ACTIVATED AS CLAIM TYPE C WITH ADJUSTMENT REASON 01.

IF TCN IS NOT VALID, SEARCH HISTORY FOR VALID TCN. IF TCN HAS ALREADY BEEN ADJUSTED, SEARCH FOR MOST RECENT TCN. IF UNABLE TO LOCATE CORRECT CLAIM OR ALREADY PROCESSED AS REQUESTED, REFER PROVIDER SUBMITTED TO PRU ON A PURPLE SHEET, IN-HOUSE SUBMITTED RETURN TO ORIGINATOR WITH EXPLANATION.

WHEN KEYING ADJUSTMENTS, IF DIAGNOSIS (DIAG) FIELD HIGHLIGHTS RED, ERASE END OF FIELD.

DO NOT ADJUST A CLAIM THAT WAS ORIGINALLY BILLED WITH NO PIC, PROCESS AS A NEW DAY CLAIM. (INVALID PIC CAN BE ADJUSTED, BUT NOT BLANK PIC.)

TEXT KEY TEXT DESC
993 PHYSICIANS CLAIM TYPE (J)

1. OVERCODING: NOTE; IF KEYING THE MOD ON THE DETAIL LINE, IT IS NOT NECESSARY TO USE THE CORRESPONDING OVERCODE.

002 - INDICATES 2ND VISIT ON SAME DAY WHEN TIMES ARE STATED FOR EMERGENCY/OFFICE/CONSULTATION (E&M) PROCEDURES, ETC.
NOTE: X IN LMC TO SUSPEND THE CLAIM FOR RES REVIEW.
014 - OP REPORTS, HISTORY, PHYSICALS OR DISCHARGE SUMMARIES ATTACHED. (DO NOT O'CODE FOR CONSENT FORMS)
017 - PROCESSED ACCORDING TO 017/053 AUDITS.
024 - MULTIPLE VALID MODIFIERS ON LINE AND 24 IS YOUR MODIFIER OF SECONDARY IMPORTANCE, KEY OTHER MOD IN 1ST POSITION.
025 - MULTIPLE VALID MODIFIERS ON LINE AND 25 IS YOUR MODIFIER OF SECONDARY IMPORTANCE, KEY OTHER MOD IN FIRST POSITION.
031 - LT MODIFIER OR LEFT INDICATED ON CLAIM OR IN COMMENTS FOR THIS LINE.
032 - RT MODIFIER OR RIGHT INDICATED ON CLAIM OR IN COMMENTS FOR THIS LINE.
040 - CLAIM DECISION/ADJUDICATION BY MMIS
111 - MDCR COB REVIEW OF PAID/DENIED CLAIMS.
175 - CLAIM DECISION/ADJUDICATION BY MCCM.
221 - USE ON LINE IF YOU CHANGE MOD QR/91 TO ANOTHER MOD PER TEXT.
NOTE: RES - MOD QR/91 IN COMBO W/OTHER VALID MODS ON SAME DETAIL LINE, KEY OTHER MOD IN 1ST POSITION.
NOTE: X IN LMC TO SUSPEND CLAIM FOR RES REVIEW.
222 - MOD 76 IN COMBO W/OTHER VALID MODS ON SAME DETAIL LINE, KEY OTHER MOD IN 1ST POSITION.
NOTE: X IN LMC TO SUSPEND CLAIM FOR RES REVIEW.
223 - MOD 77 IN COMBO W/OTHER VALID MODS ON SAME DETAIL LINE, KEY OTHER MOD IN 1ST POSITION.
318 - CLAIM STATES "PROVIDER OF SERVICES".
434 - <RES> CLAIM ADJUDICATED PER MEDICARE MANAGED CARE BACKUP OR COMMENT/STATEMENT
436 - <RES> MEDICARE/MANAGED CARE COPAY PAID WITHOUT BACKUP
444 - CLAIM OR A SINGLE LINE INDICATED THE STATEMENT (ADDITIONAL SERVICES, SECOND SERVICE, MULTIPLE SERVICE, MULTIPLE AUTH UNITS OR NOT A DUP)
NOTE: IF PROCEDURE 99201-99291,99295-99350,99361-99456 - DO NOT KEY 444.
NOTE: IF COMMENTS INDICATE (NEVER PAID, NO RECORD OF PAYMENT, UNPAID, RESUBMIT) - DO NOT KEY 444. SEE SUP/TRAINER IF UNSURE. OTHERWISE, KEY AN "X" IN LMC TO HOLD CLAIM FOR RES REVIEW.
555 - 2ND/3RD/DIFFERENT PREGNANCY OR NEW DUE DATE
617 - E&M CODES (99201-99215,99281-99288,5941M-5955M,59425,59426) & COMMENTS OR BACKUP INDICATE (PATIENT MOVED, TRANSFERRED, BILLING PROV. REFFERED OR SENT TO ANOTHER DR, SAW PATIENT ONLY ONCE, PATIENT ABORTED OR TOP "TERMINATION OF PREGNANCY" OR CHANGED HEALTH CARE DURING OB CARE. 99201-99215 AND 99281-99285 ONLY AND DETAIL LINE DX IS 650 OR V22-V24.2 AND THERE IS ANOTHER DX FOR THAT LINE OR THERE IS ANOTHER DX FOR THE

SAME DOS.
618 - EXAM ENTRY - IF PROCEDURES 5940M-5943M, 5949M, 5953M-5959M & DETAIL LINE DX IS 650 OR V22-V22.2 AND THERE IS ANOTHER DX FOR THE SAME DOS. RES-FORCE EXCEPTION 105.
619 - EXAM ENTRY - IF PROCEDURES 9913M OR J1055 AND DX V25-V25.9 OR V99.9 IS NOT THE PRIMARY DX BUT IS REFERENCED ON THE DETAIL LINE, OR ON ANOTHER LINE FOR SAME DOS. RES FORCE 105.
625 - MMIS - IF MANUAL PRICING DETAIL LINE FOR DISEASE ORGAN PANEL/ MULTICHANNEL LAB CODES PER CSR # 2868. THIS IS USED FOR CLAIMS WITH MULTI DAYS. SYSTEM CANNOT CHECK DIFFERENT DAYS.
680 - MEDICARE BACKUP ATTACHED.
690 - NO MEDICARE BACKUP BUT DISCLAIMER FROM PROVIDER ON CLAIM, BACKUP OR COMMENTS STATING "NO MEDICARE" "ALIEN" "REFUGEE" "NEMB" "NOT ELIGIBLE" "NO PART B", ETC.
801 - <RES> MOD 51 (THIS O'CODE DOES NOT OVERIDE OTHER PERTINENT O'CODES.
802 - MOD 2R
803 - MOD 1C/HA (DO NOT USE O'CODE FOR PT 75/CHEMICAL DEPENDENCY)
804 - MOD 1R
805 - MOD 57
806 - MOD 55
807 - MOD 26
808 - MOD TC
809 - CLAIM SUBMITTED W/MOD 53.
810 - CLAIM SUBMITTED W/MOD GB/59
811 - PRICED @ INTRA-OP FEE (MOD 54) PER CLAIM OR HISTORY
812 - CLAIM SUBMITTED W/MOD 79
813 - PRICED @ INTRA-OP FEE (MOD 78) PER CLAIM OR HISTORY
814 - <RES> RETURNED TO "OP" ROOM OR DIFFERENT "OP" SESSION
815 - <RES> PRICED BILATERALLY AT "A"
816 - (RES> PRICED BILATERALLY AT "B"
817 - (RES> PRICED AS ASSIST.
818 - (RES> (EE> PRICED PER BI-LATERAL POLICY
819 - (RES> PRICED AT "A"
820 - (RES> PRICED AT "B"
821 - (RES> PRICED AT CO-SURGEON/TEAM.
822 - (RES> PRICED AT CO-SURGEON/TEAM - 5A/U1
823 - (RES> PRICED AT CO-SURGEON/TEAM - 5B/U2
824 - (RES> PRICED AT CO-SURGEON/TEAM - BILAT/5A/U1
825 - (RES> PRICED AT CO-SURGEON/TEAM - BILAT/5B/U2
826 - (RES> PRICED AT ASSIST - 5A/U1
827 - (RES> PRICED AT ASSIST - 5B/U2
828 - (RES> PRICED AT ASSIST - BILAT/5A/U1
829 - (RES> PRICED AT ASSIST - BILAT/5B/U2
830 - (RES> PRICED AT ANESTHESIA/100%
831 - (RES> PRICED AT ANESTHESIA/50%
998 - APPROVED FOR EXCEPTION TO POLICY/FAIR HEARING BY FSU/PRU/DMM/ INTERNAL REVIEW.

2. BABY INFO AND OVERCODING

777 - BABY UNDER PARENT'S PIC - TRIPLET A
778 - " " " " - TRIPLET B
779 - " " " " - TRIPLET C
886 - " " " " - TWIN OR TRIPLET - UNIDENTIFIED

888 - " " " " - TWIN A,BABY #1,FIRST, ETC.
889 - " " " " - TWIN B,BABY #2,SECOND, ETC.
NOTE: ALSO KEY "X" IN LMC

-- MULTIPLE BIRTHS - UNIDENTIFIED AND DIAGNOSIS V31 - V37.2 OR UNIDENTIFIED (ANYWHERE ON CLAIM) O'CODE 886 & DENY W/EOB 779.

-- MODIFIER 1C/HA ON CLAIM & CLAIM IS FOR BABY ON PARENTS PIC OR PIC AGE 10 & UNDER - DO NOT REMOVE.
NOTE: MODIFIER HA WILL BE USED FOR HIPAA XWALKING AS OF 10/01/03 FOR PT 75 (CHEM DEPENDENCY) YOUTH & CHILD CARE CODES.

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3. EXAM ENTRY - IF THE CLAIM INDICATES ONE OF THE FOLLOWING OR A COMMENT THAT IS SIMILAR, PUT AN X IN THE LMC FIELD TO SUSPEND THE CLAIM AND PA-2 EXCEPTION CODE 116.
   -- EXCEPTION: IF DENYING THE ENTIRE CLAIM OR DENYING THE DETAIL LINE THAT RELATES TO PUTING THE "X" IN LMC - DO NOT USE X IN LMC.

   A. DIFFERENT TESTS FOR LAB AND DIFFERENT TIMES (TIME MUST BE STATED)
   B. CLAIM INDICATES (IE) NEW PREGNANCY,SECOND PREGNANCY OR MULTIPLE PREGNANCIES.
   C. CLAIM STATES PATIENT ON A VENTILATOR OR PAIN MANAGEMENT.
   D. IF STATEMENT ON CLAIM SAYS "TUMOR BEHIND EYE" OR "RULING OUT TUMOR".
   E. CLAIM INDICATES (IE) DIFFERENT OPERATIVE (OP) SESSION, SEPARATE SURGERIES, ANY PROCEDURE DONE AT DIFFERENT TIMES, OR PRE/POST OP OR PRE/POST SURGERY.
   F. IF CLAIM STATES "RUNNING MULTIPLE GLUCOSE TESTS"
   G. MEGAVOLTAGE (77401-77416 OR 77420-77430) AND STATEMENT ON CLAIM YOUNG CHILD, FAST GROWING TUMOR, PATIENT TERMINAL, HYPERFRACTION-ATION OR PATIENT'S CONDITION WARRANTS SMALL DOSES TWICE A DAY INSTEAD OF LARGE DOSE ONCE A DAY.
   H. IF CLAIM STATES PREVIOUS TUBAL, PREVIOUS BTL, STERILE, OR POST-MENOPAUSE. ((NOTE): IF EXCEPTION 345 FAILING, O'LOC TO APPROPRIATE LOCATION PER 345 4-LINE).
   I. CLAIMS THAT ARE SUBMITTED IN NEW DAY BATCHES AND HAVE SPECIFIC DIRECTION PERTAINING TO AUDITS (IE DUPE RELATED OR STATEMENTS SUCH AS "DO NOT DENY AGAINST ICN----------)
   J. SUPPLIES USED FOR PERMANENT CONDITION.
   K. DX (V59.0 - V59.9) OR CLAIM/COMMENTS/BACKUP INDICATES (DONOR/ RECIPIENT FOR TRANSPLANT)
   L. PERMANENT CONDITION

4. WRITTEN DESCRIPTION OF SERVICE ON THE CLAIM DOES NOT MATCH THE PRO-CEDURE CODE, MANUALLY DENY DETAIL LINE W/EOB 340. IF USING UNLISTED OR INAPPROPRIATE CODE WHEN THERE IS A MORE DESCRIPTIVE CODE IN THE FEE SCHEDULE - DENY W/EOB 302.

5. IF A PROVIDER SUBMITS A CLAIM LACKING INFORMATION ON A DETAIL LINE, YOU MAY CARRY DOWN INFORMATION FROM THE PREVIOUS LINE IF ARROWS/SQUIGGLIES/DITTOS ETC HAVE BEEN USED. EXCEPTION: YOU MAY BRING DOWN INFO FROM DETAIL LINE ABOVE FOR A BILLED ENCOUNTER CODE. KEY ONLY 1 UNIT AND $000 IF NOT ALREADY PRESENT.

6. REFERRING # (17A) PERFORMING # (33 PIN) BILLING # (33 GROUP)
   A. NUMBERS ON THE CLAIM - KEY AS BILLED.
      EXCEPTION: PT 43 (LAB) W/MOD 90 - SEE #10 NEXT PAGE
   B. NO NUMBERS, NAME ONLY ON THE CLAIM -
      1. REFERRING - KEY DUMMY # (8999500) "BOX 17"
      2. PERFORMING - KEY DUMMY # (8999500) "BOX 33 PIN" IF NAME IN 33 PIN AREA ONLY (THE PIN AREA IS CONSIDERED ANYWHERE IN THE LEFT SIDE OF BX 33). OTHERWISE, DO NOT KEY IN THE DUMMMY # IF ANYWHERE ELSE IN BOX 33 UNLESS THE EXCEPTION 174 POSTS, THEN YOU MAY KEY DUMMY # IN FROM ELSEWHERE IN BOX 33. NOTE: DO NOT KEY IF LOCUM TENENS, BILLING CLERK, OFFICE HELP, ETC. EXCEPTIONS TO # 8 SEE BELOW:

7. AGENCY INTERPRETER (PROVIDER TYPE 40 W/SPECIALTY 60) (9992M-9995M) DO NOT KEY IN DUMMY NUMBER FOR PERFORMING PROVIDER THROUGH 3/31/99 DOS. POLICY DOES NOT APPLY AFTER THESE DOS.

8.LABORATORY SERVICES (PROVIDER TYPE 43) MOD 90
   A. DO NOT KEY DUMMY # FOR PERFORMING PROV, FOLLOW EXCEPTION 174.
   B. DO NOT KEY THE SAME # AS THE PROVIDER # IN THE PERFORMING PROV FIELD.
   C. IF THE PERFORMING PROV # IS THE SAME AS THE BILLING PROV # - REMOVE IT.

9. MISSING MODIFIER -
   A. IF CLAIM OR COMMENT INDICATE OR GIVES A DESCRIPTON OF A VALID MODIFIER THAT WOULD EFFECT PAYMENT OR PROCESSING AND NO MOD WAS USED - DENY ENTIRE CLAIM W/EOB 562.
      I.E. TECHNICAL COMPONENT,ASSIST,ANESTHESIA,HEALTH DEPT,CO-SURG, PROFFESSIONAL COMPONENT,BI-LATERAL. IF YOU ARE UNSURE SEE SUPERVISOR.
   B. IF MODIFIER 1C/HA HAS NOT BEEN SUBMITTED - DO NOT ADD OR DENY.
   C. DO NOT REMOVE THE MODIFIER 1C/HA FROM THE CLAIM.

10. MULTIPLE MODIFIERS - ON SAME DETAIL LINE. (PRICING/PRIORITY)

    26,27,TC,50,53,54,55,56,62,66,78,80,81,82, 1C OR HA (BABY ON MOMS PIC ONLY),1H,1R,1M,9T,AA,AB,AC,AD,AS,QK,QX,QY,QZ,SL,ST,SU TG. *BJS
    EXCEPTION-HA MODIFIER BILLED BY PT 75 (CHEM DEP) IS FOR YOUTH & CHILD CODES FOR HIPAA XWALK. KEY HA IN 1ST MOD FIELD. *SR

   A. MULTIPLES OF SAME MOD - KEY THAT MOD ONCE, DO NOT KEY MOD 99.
   B. ANY COMBINATION OF THE ABOVE MODS - KEY MOD 99 & O'LOC TO 09
      EXCEPT: MOD 26/TC ON SAME LINE - DENY W/EOB 562.
      EXCEPT: MOD TG & 80 OR 62 ON SAME LINE - KEY IN 80/62 IN 1ST FIELD, TG IN 2ND FIELD & USE INFO EOB 001.(DO NOT PRICE FOR THE HIGH RISK, NOT PD BY MAA).
      NOTE: SURGERIES (10000-69999, 93501-93545,93561-93562,0001T-0002T,0005T-0009T,0012T-0013T,G0104-G0105,G0168,G0185-G0187) EXCEPT 36415 - SEE H BELOW.
      EXCEPT: MULTI OF MODS AA - QZ - DENY W/EOB 562.
   C. IF MULTIPLE IS CREATED BY MOD OTHER THAN THOSE LISTED ABOVE - KEY THE MOD LISTED ABOVE IN THE FIRST MOD FIELD, FOLLOWED BY

ANY ADDITIONAL MODS. EXCEPTION: IF MOD 90 IS ONE OF THE MODS, KEY IT IN THE FIRST MOD FIELD. IF A 0174 EXC. POST, VERIFY PERFORMING PROVIDER # HAS NOT BEEN MISSED, AND IF NO PERFORMING PROVIDER # ON CLAIM, DENY THE 0174 EXC. IF 0174 EXC. DOES NOT POST, KEY AS DIRECTED ABOVE. *BJS

D. KEY LT/RT IN FIRST MOD POSITION IF OTHER MOD IS NOT ONE LISTED ABOVE.

E. MOD RT & LT ON SAME LINE:
   1. ONLY MODS ON LINE - DENY W/EOB 538/235.
   2. BOTH LT & RT BILLED IN COMBO W/MOD LISTED ABOVE -O'LOC TO 09.

F. MULTIPLE IS CREATED BY MODS NOT LISTED ABOVE - KEY IN ORDER GIVEN. SURGERIES SEE BELOW.

G. IF PROVIDER BILLING W/99 AND MULTIPLE MODS ON SAME DETAIL LINE - IF ONLY ONE OF THE ABOVE MODS CREATES THE MULTIPLE - KEY PRICING MOD IN FIRST POSITION.

H. SURGERIES:
   ADDITIONAL MODS: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT,5A,5B,U1,U2
   1. 5A/5B THRU DOS 6/30/03 OR U1/U2 FOR 7/1/03 DOS & AFTER CREATE THE MULTIS:
      A. PT 22 - KEY IN FIRST POSITION.
      B. OTHER PT - KEY IN AND DENY W/EOB 700.
   2. OTHERWISE, FOLLOW DIRECTIONS IN A-G ABOVE TO DETERMINE IF CLAIM NEEDS MOD 99 FOR RES REVIEW, IF SO - O'LOC TO 36 FOR RES SURGERY REVIEW.

NOTE: WORK OTHER EDITS POSTING.

11. MULTIPLE PROVIDERS ON THE SAME CLAIM FORM:
---A PHYSICIAN ASSISTANT (PA) MAY BILL ON THE SAME CLAIM AS THE SURGEON W/MOD 80,81,82, HOWEVER, AN ASSISTANT SURGEON CAN NOT BILL ON THE SAME CLAIM.
A. IF NO DESCRIPTION W/MOD 80,81,82 - ALLOW.
B. CANNOT DETERMINE WHICH PHYSICIAN IS BILLING - DENY THE ENTIRE CLAIM W/EOB 961.
C. CAN DETERMINE WHICH PHYSICIAN IS BILLING - DENY THE OTHER SERVICE W/EOB 961.
---ALLOW MULTIPLE PROVIDERS ON THE SAME CLAIM FOR (PT 73,74,75)
---DO NOT ALLOW MULTIPLE PROVIDERS ON THE SAME CLAIM IF CALLS - DENY W/EOB 961.

12. RN ASSIST - IF DESCRIPTION OR REPORT INDICATES RN ASSIST, SEE IF SPECIAL AGREEMENT ON FILE AND PAY IN ACCORD. RN FIRST ASSIST MAY BILL 59514 OR 59620 W/MOD 80. ALL ELSE- DENY W/EOB 325 THRU DOS 12/31/99.

13. E&M CODES W/ 1 UNIT AND DIFFERENT BEGINNING AND ENDING DOS:
A. 99231-99239, 99201-99215, 90801, 90804-90827, 90841-90844 - DENY WITH EOB 305.
B. 99221-99223 - DENY W/ EOBS 417/431.

14. FQHC ENCOUNTER CODE FAILING HMO/PCCM EXCEPTION - IF THE EXCEPTION IS FAILING ON THE DETAIL LINE OF THE ENCOUNTER CODE AND AT LEAST ONE SERVICE ON THE CLAIM FOR SAME DOS IS PAYING -FORCE.

15. FQHC ENCOUNTER CODES:EE/RES - IF YOU HAVE A CLAIM W/MULITPLE FEE FOR SERVICE AND ENCOUNTER CODES FOR EACH FEE FOR SERVICE AND YOU ARE DENYING ONE OR MORE OF THE LINES OF FEE FOR SERVICE, ALSO DENY THE ENCOUNTER/S THAT GOES WITH SERVICES W/EOB 757. (560 EDIT WILL NOT POST ON THE CLAIM AGAINST THE DENIED FEE FOR SERVICE BECAUSE THERE IS PAYABLE FEE FOR SERVICE ON SAME DAY).

16. IF BOX 24K ON CLAIM FORM HAS CONSULTANT DISPOSITION SUCH AS D 114/373 - IT INDICATES TO DENY THAT LINE ONLY W/EOB'S 114/373. ALSO IF CONSULTANT INDICATES "INCLUDED" YOU WOULD DENY THAT LINE W/EOB 324/373. IF CONSULTANT INDICATES TO DENY W/EOB 373, NOT COVERED - DENY W/EOB 325/373. IF THE CONSULTANT SIGNATURE IS ON CLAIM - ENTER A "Y" IN THE LMC AND USE EOB 373 IN 2ND HEADER EOB.
17. WHEN A CLAIM IS SUBMITTED WITH AN ATTACHED INVOICE AND SERVICES ON CLAIM DO NOT MATCH INVOICE DESCRIPTION - DENY W/EOB 459.

18. WHEN PRICING FROM AN INVOICE - USE INFORMATIONAL EOB 552. IF YOU ARE PAYING A SERVICE PER AN INVOICE, MANUAL PRICE AT THE INVOICE AMOUNT. IF TAX &/OR FREIGHT ARE INDICATED, COMPUTE AS FOLLOWS:
    --NOTE:(DO NOT ALLOW ANY ADDITIONAL $ FOR TAX &/OR FREIGHT THAT IS HANDWRITTEN IN).
    A. TAX - CALCULATE AT 8% OF THE SUPPLY CHARGE.
    B. FREIGHT - TAKE THE TOTAL FREIGHT CHARGE DIVIDED BY THE # OF ITEMS SHIPPED EQUALS THE ALLOWABLE AMOUNT PER ITEM.

19. (RES ONLY) WHEN SENDING CLAIM TO MED CONSULTANT/DSHQS -CYCLE ON SCREEN W/EOB 103 IN ORDER TO INDICATE STATUS OF CLAIM.

20. IF PROVIDER #7810302 OR #7067150 (SEATTLE KING CO HEALTH DEPT) KEY THEIR MEDICAL RECORD NUMBER INCLUDING THE SPACES AS INDICATED.

21. DO NOT PAY FOR MULTIPLE FACILITY FEES (SEE COMMENTS OR DESCRIPTION) ON SAME DAY IE (9804M) "USUALLY BILLED W/MULTIPLE SURGERIES" PAY ONLY ONE AND DENY ALL SUBSEQUENT CHARGES W/EOB 324/339.

    NOTE: BIRTHING CENTERS WILL BILL USE OF FACILITY WITH PROCEDURE CODE 59409 W/MOD SU EFFECTIVE 7/1/03. ALLOW 1 PER PREGNANCY.

22. IF DSHS PHARMACY IS THE BILLING PROVIDER KEY THE DUMMY PROVIDER NUMBER (9999905) AND DENY THE EXCEPTION 968 HEADER LEVEL. ROUTE TO FSU MS 5562 - ANN LAWRENCE.

23. RES/ADJ - IF YOU ARE UNABLE TO DETERMINE CORRECT PAYMENT OF A CLAIM OR DETAIL LINE BECAUSE OF INCORRECT BILLING PROCEDURES OR CONFLICTING INFO BETWEEN PROVIDERS ON CLAIM OR IN HX - DENY W/EOB 190. YOU MAY USE ADDITIONAL EOBS IF NECESSARY FOR CLARIFICATION.

24. RES/ADJ -
    --POS - IF IT IS CLEAR THAT THE PROVIDER HAS BILLED THE WRONG POS FOR THE SERVICES BILLED - DENY W/EOB'S 581/589.
    --DOS - IF IT IS CLEAR THAT THE PROVIDER HAS BILLED THE WRONG DOS FOR THE SERVICES BILLED - DENY W/EOB'S 119/589.

25. RES/ADJ - WHEN TIMELINESS AND DUPS ARE BOTH SUSPENDING AND THE SERVICES BILLED COULD BE PAID AS MULTIPLE SERVICES. (IE) PT 73), ADDRESS BOTH THE TIMELINESS AND DUP ISSUES, OTHERWISE IF DENYING THE DUPE, IGNORE THE TIMELINESS (125).

26. FACILITY FEE, CAST ROOM, ETC, BILLED UNDER ANY OTHER PROCEDURE CODE THAN 9801M - 9808M, 9810M - 9811M, 9812M-9816M - BEFORE DATE OF SERVICE 10/15/03- DENY W/EOB 350. EXCEPTION: BIRTHING CENTERS WILL BILL USE OF FACILITY W/PROC CODE 59409 W/MOD SU AS OF 7/1/03. (NOTE: THIS DOES NOT APPLY TO PT 22)

27. RES: YAKIMA VALLEY ER/7845605 - PER PHONE CONVERSATION FROM PRU TO PROVIDER, WE ARE DENYING THEIR CLAIMS THAT FAIL 899 W/EOB 968/506. THEY INDICATED THEY NEED TO BILL THESE UNPAYABLE SERVICES TO OUR DEPT. IN ORDER TO KEEP THE RECORDS ACCURATE.

28. IF YOU DETERMINE THAT THE HISTORY CLAIM WAS PREVIOUSLY PROCESSED IN ERROR BY OUR DEPARTMENT - DENY CURRENT CLAIM W/EOB'S 871/589 AND ADJUST THE HISTORY CLAIM FOR CORRECTIONS AND APPROPRIATE ADJUDICATION.

29. ANESTHESIA:
MOD. AA,AD,QK,QX BILLED ON THE DETAIL LINE.
IF TIME IS LISTED ON THE CLAIM/COMMENTS - COMPUTE TIME AS FOLLOWS, (NUMBER OF MINUTES =UNITS) TO SEE IF CORRECT UNITS WERE BILLED. IF SO KEY UNITS AS BILLED. IF NOT, KEY CORRECT UNITS AND USE EOB 101 IN SECOND EOB SLOT.

30. ANESTHESIA: IF PROVIDER BILLS MORE THAN 99,999 UNITS ON THE CLAIM, LEAVE UNITS OUT, KEY AN "X" IN LMC, O'LOC TO RES (LOC 38) FOR REVIEW & PROCESSING.

31. INJECTABLE DRUGS (J/Q/S CODES) W/UNITS EXCEEDING 999 (THIS IS EFFECTIVE UP THRU 8/29/03 ONLY)
IF THE CODE PAYS AT 100% PER PDDD OR PDDD FILE INDICATES A MAX SUSPEND ALLOWANCE, KEY 1 UNITS & O'LOC TO 14 W/ONLINE COMMENTS OF TOTAL UNITS. ALL ELSE - LEAVE UNITS BLANK & O'LOC TO 83 W/ONLINE COMMENTS OF TOTAL UNITS.

32. BOX 19 ON THE HCFA HAS AN:
- "H" (CHILDREN W/SPECIAL HEALTH CARE NEEDS) OR A STAMP "DEPT OF HEALTH/OCSHON CO-ORDINATOR" ANY WHERE ON THE CLAIM OR IF OCSHCN CERTIFICATION/AUTHORIZATION FORM IS ATTACHED, KEY AN "H" IN THE ITA FIELD. RES/ADJ - IF INITIALS "CSHCN" IN COMMENTS ON EMC CLAIMS OR ON ADJ FORM - KEY "H" IN ITA FIELD. IF "H" IN ITA FIELD OF HX CLAIM, EXCLUDE FROM THERAPY LIMITATION.
- "K" (NOT RELATED TO HOSPICE) KEY A "K" IN THE ITA FIELD.
- "T" (SCHOOL CONTRACTED SERVICES BY PRIVATE PROVIDERS FOR SPECIAL ED) KEY A "T" IN THE ITA FIELD. RES/ADJ - IF "T" IN ITA FIELD OF HX CLAIM, EXCLUDE FROM THERAPY LIMITATION AUDIT COUNT.

33. MEDICARE BACKUP (RA/EOMB) ATTACHED SHOWING PAYMENT AND 261 NOT POSTING: (MEDICARE TIMELINESS RULES APPLY)
A. EXCEPTIONS 162,183,361,ETC. BLOCK MEDICARE; CHECK ELIGIBILITY

FILE, PAGE 2, COLUMN E.
1. IF NO 1 OR 7 IN COLUMN E - DENY MEDICARE PAID LINES WITH EOB 335 AND O'CODE 111. (AUDREY FINNIGAN FOR REVIEW)
2. IF 1 OR 7 IN COLUMN E- DENY MEDICARE PAID LINES WITH EOB 335.

B. NO EXCEPTION BLOCKING MEDICARE - DENY MEDICARE PAID LINES W/EOB 335 AND ADJUDICATE MEDICARE DENIED LINES PER INFORMATION IN THE 261 TEXT UNDER ACTION CODES & O'CODE 111. (AUDREY FINNIGAN FOR REVIEW)

34. RES/ADJ -(DISTINCT PROCEDURAL SERVICE) PERCENT OR DENY AS INCLUDED IF APPROPRIATE, UNLESS CLAIM OR BACKUP INDICATES (DIFFERENT OP SESSION, DIFFERENT SITE, SEPARATE LESION, OR SEPARATE INJURY), THEN YOU NEED TO TAKE OUR PROCEDURE AND POLICY INTO CONSIDERATION. IF OVERIDING THE GB MOD USE OVERCODE 810.
NOTE: IF (GB) MOD IS USED W/E & M CODES, IGNORE, IT WILL SOON FAIL EXCEPTION 169.

35. (EXCEPTION TO POLICY) CLAIMS THAT HAVE BEEN REVIEWED AND PRICED BY A MEDICAL CONSULTANT SHOULD BE PAID BY CLAIMS PROCESSING AS PRICED. ALL RELATED SURGICAL CLAIMS SHOULD ALSO BE SENT FOR REVIEW STATING ON ROUTING SLIP (THESE SURGERIES WERE DONE AT THE SAME OP SESSION AS SURGERIES HE PREVIOUSLY PRICED). ALWAYS USE EOB 383 ON THE LINE/LINES IF THE MEDICAL CONSULTANT ADJUSTS THE FEE. USE EOB 373 AT HEADER. ANY QUESTIONS SHOULD GO THROUGH YOUR SUPERVISOR/MMIS.

36. PATIENT ACCOUNT NUMBER - DO NOT KEY PRECEDING ZEROS, DOTS, DASHES, ETC.

37. RES/EXAM ENTRY - IF YOU HAVE A CLAIM W/MULTIPLE SURGERIES (10000-69999) & YOU ARE DENYING AT LEAST 1 SURGERY (FOR OTHER THAN THE EXCEPTIONS 326,361,378) AND PAYING AT LEAST ONE SURGERY, ADD THE EOB 189 IN THE SECOND EOB SLOT.

38. RSN AUTH #'S THAT BEGIN WITH (88) ARE NOT AUTHORIZATION FOR ANYTHING EXCEPT INPATIENT ADMITS. THEY DO NOT OVERIDE OUR POLICY. APPLY EDITS AND AUDITS AS INSTRUCTED.

39. TRIMESTER/HIGH RISK (5951M-5955M) - BILLING SPAN OF DATES WITH 1 UNIT - CHANGE THE "TO" DOS TO MATCH THE "FROM" DOS W/INFO EOB 417.

40. IF SERVICES BILLED W/DX OF V59.0-V59.9 & CLAIM/COMMENTS INDICATE DONOR OR NOT A DUPE OR PROCEDURE INDICATES DONOR OR RECIPIENT FOR TRANSPLANT IN CODE DESCRIPTION - REVIEW FOR POSSIBLE PAYMENT & FORCING OF AUDITS POSTING. (REASONING: WE PAY FOR DONOR SERVICES UNDER THE CLIENTS PIC AND THEIR MAY BE MULTIPLE DONORS)

41. EXAM ENTRY: ADMINISTRATION CODES (90471 &/OR 90472) ON ONE CLAIM & VACCINES (90371 - 90749) FOR SAME DATE ON SAME CLAIM OR ON ANOTHER CLAIM & THERE IS OR SHOULD BE MOD 1H/SL ON ALL OF THE VACCINES - CREATE & DENY EXCEPTION 131 W/EOB 365. (THIS IS TO COVER DENYING ADMINS BILLED INCORRECTLY ON SEPARATE CLAIMS PER EXCEPTION 577).

42. RES: IF YOU DETERMINE YOU HAVE A CLAIM THAT IS A REBILL OF A PAID CLAIM, HOWEVER, THE PERFORMING PROVIDERS ARE DIFFERENT, YOU MAY HAVE A BILLING ERROR, DENY SERVICES W/EOB 041/280.

43. RES EXAMINERS WHO WORK W/9T/ST MOD IN (IE) LOC 09,12,18,36: EFF 4/4/02 PROCESS DATE THROUGH 6/30/03 DOS MOD 9T IS NOT A PRICING MOD:
   A. IF ONLY MOD 9T ON CLAIM - RETAIN. DO NOT USE ANY SPECIAL EOBS.
   B. IF MULTI MODS ON CLAIM & ALL ARE INFO - RETAIN 9T ON CLAIM. DO NOT USE ANY SPECIAL EOBS.
   C. IF PRICING MODS ON CLAIM - REMOVE 9T & ADD TO COMMENTS, INDICATING THE LINE # IT WAS ON, USE INFO EOB 877 AT HEADER, AND ENTER THE PRICING MOD ON DETAIL LINE EFF 4/4/02 .

NOTE: THE OBJECTIVE IS TO SAVE EXAMINER TIME ON MANUAL PRICING PAYMENT MODS AROUND THE MOD 9T. ANY QUESTIONS - SEE SANDY A. IN THE MMIS SECTION.

44. ADJ EXAMINERS W/TRAUMA CLAIMS (9T MOD) EFF 7/22/02. SYSTEM TESTING IS NOW COMPLETED AND MAA WILL PROCESS TRAUMA CLAIMS FOR ADJUSTMENTS ONLY W/THE FOLLOWING CRITERIA:
   A. THESE INSTRUCTIONS ONLY APPLY TO LINES THAT NEED MANUAL PRICE.
   B. RETAIN MOD 9T, UNLESS TRAUMA DOES NOT APPLY & THEIR IS ANOTHER PRICING MOD, THEN USE EOB 877 IN INFO HEADER.
   C. WE WILL NOT PAY MORE THAN WE ORIGINALLY PAID ON THE LINE, UNLESS PROVIDER IS BILLING A PROCEDURE THAT REIMBURSES AT A HIGHER FEE.
   D. USE EOB'S IN INFO EOB ON LINE LEVEL
   E. 3 SCENARIOS AS FOLLOWS:
      1. PAYMENT ON LINE INCLUDING THE TRAUMA STAYS THE SAME - USE EOB 003. IE BELOW.
         A. 90040 PAID $10 + TRAUMA = $30, ADJ TO CHANGE CODE TO CODE 90050 PAYING AT $20 + TRAUMA = $60, BUT WE WILL NOT PAY MORE THAN THE ORIGINAL PAYMENT, SO ADJ PAYMENT TO $30.
         B. ADJ TO LINE W/NO CHANGES TO PAYMENT.
      2. NEW PDDD ALLOWED AMT IS MORE THAN THE ORIGINAL TOTAL PAYMENT - USE EOB 873. (IE) 90040 PAID $10 + TRAUMA = $30. ADJ TO CHANGE CODE TO 90060 WHICH PAYS $40. WE WILL PAY MORE WITH NEW ALLOWED, BUT NO TRAUMA.
      3. NEW ALLOWED AMT DECREASES - USE EOB 026. (IE) 90060 PAID $40 + TRAUMA = $120. ADJ TO CHANGE CODE TO 90040 WHICH PAYS $10 + TRAUMA = $30. WE WILL PAY LESS THAN ORIGINAL CLAIM.

ANY QUESTIONS SEE SANDY A/MMIS

45. EXAM ENTRY: DO NOT O'LOC TO 83 IF ANY OTHER EDIT OR AUDITS 101/102/599 ARE POSTING TO THE SAME LINE OR IF AUDITS 101/102/599 ARE POST TO ALL LINES OF THE CLAIM - O'LOC THE CLAIM TO THE OTHER EDIT OR AUDIT 101/102/599 LOCATION LISTED AT THE END OF THE 4-LINE. ANY QUESTIONS - SEE YOUR SUPV/LEADWORKER/TRAINER/MMIS.

TEXT KEY TEXT DESC
994

DENTAL CLAIMS (K)

** IF THE PROVIDER SUBMITS A CLAIM FORM WITH A FIELD CALLED "AREA OF ORAL CAVITY" (FIELD 25 ON THE ADA 2002 CLAIM FORM), AND HAS ENTERED AN ARCH OR QUADRANT DESIGNATION OF 01,02,10,20,30,OR 40, YOU CAN NOW KEY THESE DESIGNATIONS INTO THE QUADRANT FIELD. IF THE PROVIDER IS USING AN OLD FORM, THEY MAY PUT THESE DESIGNATIONS IN THE TOOTH SURFACE FIELD, SO KEY THESE INTO THE QUADRANT FIELD.

IF THE PROVIDER IS USING OLD QUADRANT AND ARCH DESIGNATIONS (UA,LA, UL,UR,LL,LR), KEY THESE INTO THE TOOTH NUMBER FIELD AND WHEN YOU HIT ENTER, THE SYSTEM WILL AUTOMATICALLY CONVERT THE OLD DESIGNATIONS TO THE NEW AND MOVE THEM TO THE QUADRANT FIELD.

1. IF A PROVIDER SUBMITS A CLAIM WHERE THE WRITTEN DESCRIPTION OF SERVICE DOES NOT MATCH THE PROCEDURE CODE, MANUALLY DENY EACH DETAIL LINE WITH EOB 340.

IF PROVIDER IS USING AN UNLISTED OR INAPPROPRIATE PROCEDURE CODE WHEN THERE IS A MORE DESCRIPTIVE CODE IN FEE SCHEDULE, DENY EACH DETAIL LINE WITH EOB 302.

2. SPECIAL HANDLING BATCHES (WITH THE EXCEPTION OF FAIR HEARINGS) SHOULD BE OVERLOCKED TO 85. WHEN KEYING SPECIAL HANDLING BATCHES, KEY "S" IN LMC FIELD. IF FOR ANY REASON YOU NEED THE CLAIM TO SUSPEND, PA-2. OTHERWISE FORCE THE 116 EXCEPTION. PA-2 ANY EXCEPTIONS POSTING THAT ARE NOT ADDRESSED IN THE THE SPECIAL INSTRUCTIONS.

3. FAIR HEARING CLAIMS SHOULD BE OVERLOCKED TO 81. (SEE GENERAL 999 TEXTFILE) DO NOT WORK EXCEPTIONS. PA-2 TO LOCATION 81 TO WORK.

4. OVERCODES:

005 --- TO BE USED WHEN COMMENTS ABOUT DENTURES (D5110, D5120, D5860, 5110D, 5120D), OR PARTIALS (D5211, D5212, D5213, D5214, 5211D, 5212D, 5213D, 5214D) IF RELINE PROCEDURE CODES D5750, D5751, D5760 D5761 AND COMMENTS SAY THIS IS A DIFFERENT PARTIAL OR DENTURE.

014 --- INDICATES TO THE RESOLUTION UNIT THAT REPORTS ARE ATTACHED - IE OP REPORTS OR ORTHODONTIC

INFORMATION SHEETS OR WHEN "PRE OP" OR "POST OP" ANYWHERE ON CLAIM.

080 --- INDICATION ON CLAIM OR BACKUP THAT THE SERVICES

ARE AN ASSIST AT SURGERY OR A CO-SURGERY.
PUT AN "X" IN THE LMC FIELD, ENTER AND PA-2
THE 116 EXCEPTION.

444 --- INDICATES THAT ON EITHER CLAIM LEVEL OR LINE LEVEL, THERE IS A NOTATION THAT THIS "IS NOT A DUPLICATE SERVICE OR BILLING."

998 --- INDICATES THIS CLAIM HAS BEEN APPROVED FOR AN "EXCEPTION TO POLICY " OR FAIR HEARING BY ASU/PRU.

5. IF MULTIPLE SERVICES (ROOT PLANINGS, EXTRACTIONS, RESTORATIONS, PULP VITALITY TESTS, PALLIATIVE TREATMENT, ETC) SAME LINE, DENY THAT LINE WITH EOB 538.

6. ANY SPECIAL DISPOSITION ON CLAIM FROM DENTAL CONSULTANT FOUND EITHER ON LINE DESCRIPTIONS OR IN RIGHT MARGINS ON CLAIM SHOULD BE NOTICED & USED IN THE MANUAL PRICING USING 373 INFO LINE LEVEL EOB. IF THERE IS A CONSULTANT DENIAL ON A LINE, USE THE EOBS HE HAS INDICATED ON THAT LINE (I.E. 112/373). IF A LINE SAYS "INCLUDED" - DENY WITH EOB 324/373. IF CONSULTANT JUST INDICATES "DENIED" DENY WITH EOB 373. IF CONSULTANT INDICATES "NOT COVERED" OR "DOESN'T MEET CRITERIA" DENY WITH EOB 325/373. IF DENTAL CONSULTANT'S WRITTEN OR STAMPED SIGNATURE, OR INITIALS, ENTER A "Y" IN THE LMC FIELD WITH EOB 373.

7. PERIDEX RINSE - DENY WITH EOB 325.

STERILE TRAYS - DENY WITH EOB 325.
HOME FLUORIDE - DENY WITH EOB 325.

8. COMBINE LINES WITH THE SAME DATE OF SERVICE FOR THE FOLLOWING SPECIFIC PROCEDURE CODES:

00230/D0230 (UP TO 13)
00240/D0240 (UP TO 4)
02951/D2951 (UP TO 4 PER TOOTH #)

WHEN YOU COMBINE THESE LINES, COMBINE THE UNITS AND FEES, IF BILLING OVER THE ABOVE LIMITS, DENY ADDITIONAL UNITS WITH EOB 339.

09. ANESTHESIA PROCEDURE CODES 09220/D9220, OR 09221/D9221: IF MULTIPLE LINES OF PROCEDURE CODE 09220/D9220 AND SAME DATE OF SERVICE ARE BILLED, COMBINE LINES & CHARGES & TIME TO KEY ONLY 1 LINE. IF 09220/D9220 & 09221/D9221 ARE BOTH USED, COMBINE TIME AND MONEY UNDER 09220/D9220. LEAVE THE CHARGE FOR 09221/D9221 AT ZERO AND DENY THE 184 EXCEPTION WITH EOB 248/542.

10. ARCH CONVERSIONS
UPPER ARCH CAN BE DESIGNATED AS FOLLOWS ON CLAIM:

UA OR 01 FUD
F/ CUD
MAXILLARY CU/

LOWER ARCH MAY BE DESIGNATED ON CLAIM AS FOLLOWS:

LA OR 02 FLD
/F CLD
MANDIBULAR /CU

11 QUADRANTS ARE DESIGNATED AS FOLLOWS ON CLAIMS:

UPPER RIGHT = UR OR 10 OR R/
UPPER LEFT = UL OR 20 OR L/
LOWER RIGHT = LR OR 40 OR /R
LOWER LEFT = LL OR 30 OR /L

12. TOOTH SURFACES

THESE ARE IDENTIFIED ON CLAIM BY EITHER A DESCRIPTIVE WORD OR ABBREVIATED LETTER:

MESIAL --- M
OCCLUSAL -- O
BUCCAL -- B
DISTAL -- D
INCISAL -- I
FACIAL --- F
LINGUAL -- L

IF PROVIDER INDICATES A TOOTH SURFACE OF LA OR LAB AND BILLED WITH OR WITHOUT ANOTHER VALID TOOTH SURFACE, KEY THE VALID TOOTH SURFACE, REMOVE UNITS, DENY EXCEPTION 183 WITH EOB 523, THEN PUT UNITS BACK IN.
IF A TOOTH NUMBER OR LETTER IS NOT REQUIRED, THEN A SURFACE IS NOT NEEDED.

13. TEETH

A. NUMBERS 1 THRU 32 (PERMANENT OR ADULT)
B. LETTERS A THRU T (PRIMARY OR BABY)
C. SUPERNUMERARY SN (EXTRA TOOTH IN SET)

14. MANUAL PRICING, PER DENTAL CONSULTANT'S INSTRUCTIONS:

A. IF TOTALLY DENYING A CLAIM AT HEADER LEVEL, DO NOT DO THE MANUAL PRICING.
B. IF MANUAL PRICING IS SHOWN BY DENTAL CONSULTANT, AND YOU ARE NOT DENYING CLAIM AT HEADER, KEY IN THE PRICING WRITTEN BY THE DENTAL CONSULTANT WITH EOB 373 IN 2ND EOB SLOT ON THAT LINE AND EACH LINE, IF MULTIPLE LINES WERE SPECIALLY PRICED.

15. PRIOR - AUTHORIZATION ON CLAIM -- BUT NO DATES OF SERVICE:
DENY CLAIM AT HEADER LEVEL WITH EOB 969. MAKE NOTATION ON BATCH COVER SHEET. ATTACH THE GREEN "RETURN" FORM LETTER AND SEND TO PROVIDER, VIA THE ROUTING SLOT IN EXAM ENTRY AREA.

16. ROOT PLANING (PROCEDURE CODE 4341)

A. THIS PROCEDURE CODE REQUIRES A QUADRANT (UR, UL, LR, LL).
B. IF THE DENTIST IS BILLING THE FULL MOUTH, EACH QUADRANT SHOULD BE LISTED SEPARATELY ON LINES.
C. IF FM (FULL MOUTH) IS USED INSTEAD OF A QUADRANT, DENY THAT LINE WITH EOB 543.

17. CARRY - DOWN OF INFORMATION ON CLAIM
YOU CAN NOT CARRY DOWN THE FOLLOWING INFORMATION ON DENTAL CLAIMS -- UNLESS THERE ARE DITTO MARKS OR ARROWS DOWN THE COLUMNS:
A. DATES OF SERVICE & CHARGES
B. TOOTH NUMBER OR LETTER
C. PROCEDURE CODE

18. IF YOU HAVE EXACT DUPLICATE CLAIMS, KEY AN "X" IN LMC FIELD AND DENY THE 116 EXCEPTION, HEADER LEVEL, WITH EOB 042. REMOVE THE "X" AND ENTER.

19. PROCEDURE CODES 0843D-0844D, 0867D, 0869D, 0871D, 0873D, D8010-D8030, D8070, D8080 (ORTHODONTIC ADJUSTMENTS) COVERS 3 MONTHS OF TREATMENT. ENTER THE MOST RECENT DATE IF THE PROVIDER INDICATES A SPAN OF DATES OF SERVICE. ALSO TOTAL THE FEES FOR THE TIME SPAN & ENTER ON THE LINE WITH THE MOST RECENT DATE.

20. PATIENT ACCOUNT NUMBER - ONLY PICK UP IF IT IS UNDER THE TOOTH CHART, OR IF ADA VERSION 2000, LOOK AT FIELD #61, ADA VERSION 2002 LOOK AT FIELD #23. KEY ALPHA AND NUMERIC. DO NOT KEY PRECEDING ZEROS, DOTS, DASHES ETC. IF NUMBER APPEARS TO BE AN AUTHORIZATION NUMBER (HAS 9 DIGITS AND STARTS WITH 48, 49 OR 87) KEY IN AUTH FIELD, NOT PATIENT ACCOUNT FIELD.

21. PLACE OF SERVICE/TREATMENT FIELD - IF THE PROVIDER HAS ENTERED A ONE OR TWO DIGIT PLACE OF SERVICE - KEY. IF NO PLACE OF SERVICE IS INDICATED - KEY 11. IF A BOX IS CHECKED - KEY AS FOLLOWS:
OFFICE - 11
HOSP - 22
ECF - 31
OTHER - 99

22. IF THE LETTER "B" IN FIELD 15C OR IN THE COMMENTS/REMARKS FIELD, KEY THE LETTER IN THE ITA FIELD.

23. IF MEDICARE HAS MADE PAYMENT ON A DENTAL CLAIM, ENTER OVERCODE 680 AND OVERLOC TO 83 (IF DENYING CLAIM DON'T OVERLOC).

24. FACILITY FEES - 4444D UNIVERSITY OF WASHINGTON - IF ALL OTHER SERVICES ON THE CLAIM ARE BEING DENIED, ALSO DENY THE 4444D CODE WITH EOB 757. EXCEPTION: IF EITHER SERVICES ARE BEING DENIED BECAUSE OF TPL - ALLOW THE 4444D CODE TO PAY.

25. CHILDREN WITH SPECIAL HEALTH CARE NEEDS CLAIMS - IF THE CLAIM HAS A STAMP "DEPARTMENT OF HEALTH/OCSHCN CO-ORDINATOR" OR "REGION _ CLEFT LIP & PALATE PROGRAM COORDINATOR" ANYWHERE ON THE CLAIM OR IF OCSHCN CERTIFICATION/AUTHORIZATION FORM IS ATTACHED, KEY AN "H" IN THE ITA FIELD.

26. INFORMATIONAL EOBS FOR DENTAL CLAIMS

115 TOOTH #/QUAD NOT REQUIRED OR APPROPRIATE FOR PROC CODE
240 TOOTH NUMBER/ARCH/QUADRANT NOT APPROPRIATE FOR PROC CODE
434 MULTIPLE ROOT PLANINGS/EXTRACTIONS/RESTORATIONS MUST BE BILLED ON SEPARATE LINES.
451 PROCEDURE CODE REQUIRES VALID TOOTH NUMBER/ARCH/QUADRANT
523 PROCEDURE CODE REQUIRES A VALID SURFACE (M,O,D,B,L,A,I,F) FOR RESTORATIONS THE # OF SURFACES MUST MATCH THE DESCRIPTION IN THE PROCEDURE CODE.
538 MULTIPLE SERVICES MUST BE BILLED ON SEPARATE LINES
543 ONLY ONE QUADRANT BILLED PER LINE
554 PROCEDURE CODE REQUIRES VALID TOOTH NUMBER OR LETTER
555 PROCEDURE CODE REQUIRES VALID ARCH
556 PROCEDURE CODE REQUIRES VALID QUADRANT
594 SEALANTS ARE COVERED ON OCCLUSAL SURFACE OF TEETH NUMBERED 2,3,14,15,18,19,30,31
962 CLAIM HAS BEEN REFERRED TO DENTAL/ORTHO-DONTIC CONSULTANT. THIS CLAIM IS STILL PENDING, PLEASE DO NOT REBILL.

27. IF A PROVIDER SUBMITS A CLAIM WITH TWO PERFORMING PROVIDER NUMBERS IN BOX 39, KEY THE FIRST NUMBER. IF THERE ARE TWO NAMES IN BOX 39, KEY THE 8999500 DUMMY NUMBER. FOR BOTH SITUATIONS, PUT AN "X" IN THE LMC TO CREATE A HEADER LEVEL EXCEPTION, DENY WITH EOB 961, REMOVE THE "X" AND ENTER.

28. IF THE PROCEDURE CODE IS BEING BILLED WITH 6 CHARACTERS, DON'T KEY IT AND LET EXCEPTION 172 AUTO DENY.

29. IF 2 AUTH #S AND ONE IS 870000999, ENTER IT IN THE AUTH FIELD AND REFERENCE THE OTHER AUTH # ON THE COMMENTS SCREEN (F7). IF 2 AUTH #S AND NEITHER ONE IS 870000999, DO NOT KEY ANY AUTH # ON SCREEN. IF AUTH EXC FAILS, DENY WITH EOB 407. SEND A COPY OF THE CLAIM/WORKSHEET TO PRU, MAILSTOP 5562 FOR PROVIDER TRAINING. INDICATE THE PROBLEM ON THE PRU REFERRAL FORM.

30. CLAIMS THAT HAVE PRE-AUTHORIZATION, CONSULTANT SIGNATURE OR INITIALS AND/OR AUTHORIZATION NUMBER ON CLAIM, AND THE ENTIRE CLAIM IS BEING DENIED AT EITHER HEADER OR EVERY LINE, DENY THESE CLAIMS AT HEADER WITH EOB 969. SEND THE CLAIM BACK TO PROVIDER WITH GREEN COVER SHEET STATING THE REASON FOR DENIAL. REMIND PROVIDER THAT WHEN THEY ARE BILLING TO INCLUDE THE AUTH

NUMBER. WRITE ON THE BATCH COVER SHEET THAT THE CLAIM HAS
BEEN SENT BACK TO PROVIDER - RTP.

TEXT KEY TEXT DESC
995 EPSDT CLAIM TYPE "L"

1. IF A PROVIDER SUBMITS A CLAIM WHERE THE WRITTEN DESCRIPTION OF SERVICE DOES NOT MATCH THE PROCEDURE CODE, MANUALLY DENY EACH DETAIL WITH EOB 340. IF USING UNLISTED OR INAPPROPRIATE CODE WHEN THERE IS A MORE DESCRIPTIVE CODE IN FEE SCHEDULE DENY 302.

2. SPECIAL HANDLING:
SPECIAL HANDLING BATCHES (WITH THE EXCEPTION OF FAIR HEARINGS) OVERLOC TO 53. DO NOT DENY ANY CLAIM. KEY "S" IN THE LMC FIELD. IF FOR ANY REASON YOU NEED TO SUSPEND THE CLAIM, PA-2, OTHERWISE FORCE THE 116 EXCEPTION.

3. OVERCODING:
444 - THE CLAIM OR A SINGLE LINE INDICATES THE STATEMENT "ADDITIONAL SERVICES OR NOT A DUP".
998 - APPROVED FOR EXCEPTION TO POLICY/FAIR HEARING BY PRU/CAU.

777 - - TRIPLET A
778 - - TRIPLET B
779 - - TRIPLET C
886 - - TWIN OR TRIPLET - UNIDENTIFIED
888 - - TWIN A
889 - - TWIN B
NOTE: ALSO KEY AN "X" IN LMC.

4. MISSING MODIFIERS - IF CLAIM OR COMMENT INDICATES OR GIVES A DESCRIPTION OF A VALID MODIFIER THAT WOULD AFFECT PAYMENT OR PROCESSING AND NO MOD WAS USED - DENY ENTIRE CLAIM W/EOB 562. IE. TECHNICAL COMPONENT, ASSIST, ANESTHESIA, HEALTH DEPT, CO-SURG, PROFESSIONAL COMPONENT, BI-LATERAL. IF YOU ARE UNSURE SEE SUPERVISOR.

5. MULTIPLE MODIFIERS ON THE SAME DETAIL LINE:
A. PROCEDURE CODES 99381 THRU 99395: IF ONE OF THE MODS IS 21 - KEY THAT MOD IN 1ST POSITION, OTHERWISE MODS NR/YR HAVE PRIORITY.
B. PROCEDURE CODES 99201 THRU 99215: MOD HA/1C/EP. MOD HA/1C ARE DATE SENSITIVE - KEY IN THE ORDER THEY ARE BILLED IF BOTH ARE BILLED. IF EP IS ALSO ON THE CLAIM W/HA/1C - KEY THE HA/1C IN 1ST POSITIION & EP IN 2ND.
C. PROCEDURE CODES 90585 THRU 90749: MOD SL/1H ARE DATE SENSITIVE - KEY IN ORDER THEY ARE BILLED IF BOTH ARE BILLED.
D. OTHER PROCEDURES: MOD 26 OR TC HAVE PRIORITY, KEY IN 1ST POSITION, KEY OTHER MODS IN ORDER GIVEN.
MOTE: EXCEPTION 117/169 MAY POST IF CORRECT DATE SENSITIVE MOD IS NOT BILLED IN 1ST POSITION, FOLLOW ABOVE & DENY 117/169 IF NECESSARY.
6. IF PROVIDER IS BILLING ON HCFA-1500-C2 (1-84) CLAIM FORM, USE INFORMATIONAL HEADER EOB 096.

7. ANY TEXT FILE THAT DOES NOT HAVE SPECIFIC INSTRUCTIONS FOR THE EPSDT CLAIM TYPE, PLEASE FOLLOW THE INSTRUCTIONS FOR "J" PHYS CLAIM TYPE.

8. PATIENT ACCOUNT NUMBER: KEY ALPHA AND NUMERIC. DO NOT KEY PRECEDING ZEROS, DOTS, DASHES, ETC.

9. EXAM ENTRY: ADMINISTRATION CODES (90471 &/OR 90472) ON ONE CLAIM & VACCINES (90371 - 90749) FOR SAME DATE ON SAME CLAIM OR ON ANOTHER CLAIM & THERE IS OR SHOULD BE MOD 1H ON ALL OF THE VACCINES - CREATE & DENY EXCEPTION 131 W/EOB 365. (THIS IS TO COVER DENYING ADMINS BILLED INCORRECTLY ON SEPARATE CLAIMS PER EXCEPTION 577).

TEXT KEY TEXT DESC

996 CROSSOVER CLAIMS (O)
EXAM ENTRY:
NOTE: CLAIM WITH "SG" MOD PRESENT - KEY A "Z" IN TOS
ANY QUESTIONS - SEE YOUR LEAD, SUP, TRAINER.

NOTE: EFF 2/1/03, CP CAN REMOVE OR CHANGE THE DX/MDCR PD DATE FIELDS ON THE PHYSICIAN MEDICARE PART B CLAIM FORM FOR HARDCOPY CLAIMS ONLY.

1. CLAIMS BILLED WITHOUT MEDICARE RA/EOMB - DENY W/EOB 490. (PA2 ALL OTHER EXCEPTIONS EXCEPT ELIGIBILITY & TIMELINESS)

2. IF CLAIM INDICATES "MANAGED MEDICARE" OR "CO-PAY" AND BACKUP IS MANAGED MEDICARE (REFER TO TEXT 999)- PUT AN X IN LMC AND OVERLOC TO 55.

3. KEY MEDICARE ALLOWED, MEDICARE PAID, MEDICARE PAID DATE, UNITS AND DEDUCTIBLE FROM ATTACHED RA/EOMB. TO BE APPLIED TO TOS 3, Z, 9 AND R. (IF BACKUP DOESN'T MATCH SEE INSTRUCTIONS ON PAGE 7).
EXCEPTION: TOS (3) UNITS
A. (00100-01999) EFF MDCR PD DATE 3/1/01 - KEY UNITS FROM CLAIM (USE MINUTES ON CLAIM TO COMPUTE IF AVAILABLE) & DO NOT BE CONCERNED ABOUT BACK UP & CLAIM UNITS NOT MATCHING.
B. ALL ELSE FOR TOS (3) - IF UNITS MATCH, KEY IN, IF UNITS DO NOT MATCH - SEE PAGE 12.

4. IF CLAIM/BACKUP INDICATES GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION (GEHA) PUT A "Y" IN TPL AND PA-2 TO TPL FOR REVIEW. THIS IS NOT MEDICARE AND MAY HAVE TO BE REPROCESSED WITH INSURANCE PAYMENT.

5. IF A PROVIDER SUBMITS A CLAIM WHERE THE WRITTEN DESCRIPTION OF SERVICE DOES NOT MATCH THE PROCEDURE CODE, MANUALLY DENY EACH DETAIL LINE WITH EOB 340. IF PROVIDER IS USING UNLISTED OR INAPPROPRIATE PROCEDURE CODE, DENY WITH EOB 302.

6. IF A PROVIDER SUBMITS A CLAIM AND THE FIRST DETAIL LINE HAS A DATE OF SERVICE AND SUBSEQUENT LINE ITEMS DO NOT HAVE DATES OF SERVICE, BUT YOU CAN TELL THE SERVICES ARE RELATED, CARRY DOWN THE FIRST DATE OF SERVICE ON SUBSEQUENT LINES.

7. SPECIAL HANDLING BATCHES, WITH THE EXCEPTION OF FAIR HEARINGS, SHOULD BE OVERLOCKED TO 85. WHEN KEYING, PUT "S" IN LMC FIELD. FORCE THE 116 EXCEPTION. FOLLOW INSTRUCTIONS ON BATCH COVER SHEET AND PA-2 ANY EXCEPTIONS NOT ADDRESSED ON BATCH COVER. IF CLAIM STATES NOT A DUP THEN DO NOT FORCE 116. IF CLAIM SAYS TO PUT AN 'X' IN LMC THEN DO NOT FORCE 116 EXC.

8. FAIR HEARING CLAIMS SHOULD BE OVERLOCKED TO 81. WHEN KEYING,

PUT AN "S" IN ITA FIELD. DO NOT WORK ANY EXCEPTIONS. PA-2 CLAIM TO LOCATION 81 FOR DISPOSITION.

9. OVERCODES: USE APPROPRIATE OVERCODE IF CLAIM CONTAINS ANY ITEM BELOW. IF MORE THAN ONE APPROPRIATE OVERCODE, USE THE HIGHEST NUMBER - 444 RATHER THAN 014.

NOTE: DO NOT O'CODE IF CAN KEY MODIFIER IN FIELD.
NOTE: ALWAYS REVIEW MULTIPLE MODIFIER SECTION FIRST BEFORE O'CODING IF MULTIPLE MODIFIERS ON SAME DETAIL LINE.

014 - A REPORT IS ATTACHED
434 - CLAIM ADJUDICATED PER MEDICARE MANAGED CARE BACKUP LOC 55
435 - MEDICARE HMO/MTM COPAY LOC 55
436 - MEDICARE/MANAGED CARE COPAY PAID WITHOUT BACKUP LOC 55
444 - ENTIRE CLAIM OR A LINE ITEM HAS A NOTATION THAT THIS IS NOT A DUPLICATE SERVICE OR BILLING"
603 - CLAIM WAS REVIEWED AND MANUALLY PRICED BY MMIS BECAUSE OF CROSSWALK DATE SENSITIVITY SITUATION.
801 - MOD 51 (RES)
806 - MOD 55 (RES)
807 - MOD 26 (RES)
808 - MOD TC (RES)
809 - MOD 53 (RES)
810 - MOD 59 (RES)
811 - MOD 54 (RES)
813 - MOD 78 (RES)
818 - MOD 50 (RES)
998 - CLAIM HAS APPROVAL FOR AN EXCEPTION TO POLICY/FAIR HEARING BY ASU/PRU

10. DIAGNOSIS: (SAME DOS ON ALL LINES ON CLAIM). THE FIRST DX CAN CAN BE BROUGHT DOWN FROM BOX 21 ON HCFA 1500 WHEN:

A. THERE IS NO REFERENCE NUMBER/DX LISTED ON LINE.

B. THE PROVIDER HAS REFERENCED A DIAGNOSIS THAT IS NOT IN BOX 21 (IE - THE DX REFERENCED IS "5" & THERE IS NO 5TH DX IN BOX 21).

11. MEDICARE RA/EOMB IS ATTACHED:

A. AND SHOWS MONEY PAID TO BENEFICIARY AND/OR INDICATES MEDICARE REMARKS CODE MA-28 - RIGHT CORNER OF CLIENT INFORMATION, DENY WITH EOB 988 (PROVIDER DID NOT ACCEPT ASSIGNMENT). IF MEDICARE BACKUP IS "MEDICARE SUMMARY NOTICE" SHOWING THAT MEDICARE PD BENEFICIARY,"INFORMATION SENT TO MEDICAID", BUT NO INDICATION FROM PROVIDER THAT THEY DID ACCEPT ASSIGNMENT AND NO TAPE CLAIM FROM MEDICARE IN HISTORY - DENY W/EOB 988.

IF MEDICARE RA/EOMB,MEDICARE SUMMARY NOTICE INDICATES "DID NOT ACCEPT ASSIGNMENT" AND BOX 27 ON HCFA IS CHECKED YES DID ACCEPT ASSIGNMENT - DENY W/EOB 988 BECAUSE OF CONFLICT WITH BACKUP DOC(S). IF UNSURE - OVERLOC 83.

IF MEDICARE SUMMARY NOTICE INDICATES "DID NOT ACCEPT ASSIGNMENT" OR "UNASSIGNED CLAIM(S)" AND BOX 27 ON HCFA1500 CHECKED NO DID NOT ACCEPT ASSIGNMENT - DENY W/EOB 988. IF UNSURE O'LOC TO 83.

B. AND HAS REASON CODE PR-122 ON A LINE: (NO LONGER APPLICABLE AS OF ICN 02050)
   1. KEY "2" IN THE MPI FIELD.
   2. FORCE THE 589 IF POSTING. (589 EXC SET TO AUTO PAY 021902)

C. AND IS ALTERED OR MISSING INFORMATION:
   1. NO COLUMN TITLES (I.E. BILLED, ALLOWED, PROVIDER PAID) OR NO REMARKS/REASON CODES - DENY 281.
      NOTE: IF MEDICARE PAID DATE IS ALSO MISSING THEN DENY 228 EXCEPTION WITH 281 SECOND EOB.
   2. IF BACKUP HAS BEEN ALTERED - DENY 234/281.

D. IF BACKUP DOES NOT MATCH CLAIM INFORMATION:

   1. CLIENT AND/OR DOS DO NOT MATCH - DENY W/EOB 105.

   2. PROCEDURE CODES DON'T MATCH:
      A. (TOS 3 OR Z)
       *DOS 10/1/03 AND AFTER - DENY WITH EOB 903.
        DOS BEFORE 10/01/03 - FOLLOW DIRECTIONS BELOW. *G
         1. CODE DOES NOT MATCH, DO NOT KEY CODE, BUT DO KEY INFO FROM BACKUP FOR THAT DETAIL LINE, KEY AN "X" IN LMC & O'LOC TO 85 OR,
         2. 99070/76499/76999 WHEN ON CLAIM AND WITH DESCRIPT OF "TRANSPORT/SETUP" & R0070/R0075/Q0092 ON CLAIM AND/OR BACKUP:
            A. 76499/76999 (TRANSPORT) CLAIM ONLY & R0070/R0075 ON BACKUP - KEY 76499/76999 - DENY W/EOB 302.
            B. 76499/76999(TRANSPORT) & R0070/R0075 ON CLAIM AND BACKUP - KEY 76499/76999 - DENY W/EOB 324.
            C. 99070 (SETUP) ON CLAIM ONLY & Q0092 ON BACKUP - KEY 99070 - DENY W/EOB 302.
            D. 99070 (SETUP) ON CLAIM & Q0092 ON CLAIM & BACKUP - KEY 99070 - DENY W/EOB 324.
            E. P3001 ON CLAIM AND Q0091 ON BACKUP - DENY W/EOB 0105.
   4. CODES 0370M - 0381M ON CLAIM & 90801 - 90899 ON BACKUP - DENY W/EOB 105 OR,
   5. 36415/36416 ON CLAIM & G0001 ON BACKUP - PROCESS PER CLAIM.
   6. 2979M-2981M ON CLAIM & Q4001-Q4018 ON BACKUP - IF DESCRIPTION ON Q CODE HAS WORDS "FIBERGLASS CAST SUPPLIES" - PROCESS PER CLAIM.
   7. 2983M-2987M ON CLAIM & Q4001-Q4018 ON BACKUP - IF DESCRIPTION ON Q CODE HAS WORDS "PLASTER CAST SUPPLIES" - PROCESS PER CLAIM.
   8. 0070M ON CLAIM & 96100 ON BACKUP - DENY W/EOBS 105/302.

9. 0070M ON CLAIM & 90801 ON BACKUP - PROCESS PER CLAIM.
10. 90862 ON CLAIM & M0064 ON BACKUP - PROCESS PER PER CLAIM.
11. 9085M-9087M ON CLAIM AND ITA = I, STATEMENT OF ITA ON CLAIM OR ITA BACKUP & 99075 ON MEDICARE BACKUP - PROCESS PER CLAIM.
12. 7612M ON CLAIM AND Q0092 ON MEDICARE BACKUP -
    A. IF R0070 OR R0075 ALSO BILLED ON SAME DOS - PROCESS PER CLAIM AND DENY W/EOB 324.
    B. IF R0070 OR R0075 NOT BILLED ON SAME DOS - PROCESS PER CLAIM.
13. ALL ELSE - FOLLOW 1.A ABOVE, PUT AN "X" IN LMC & O'LOC TO 85.

LOC 85 - MEET W/MMIS BIWEEKLY FOR TRAINING & TEXT UPDATES.

B. (TOS 9 OR R) - EVERYTHING MATCHES BUT PROCEDURE CODE
    1. GROUND OR AIR AMBULANCE - PT 51 OR 53, OK TO PROCESS.
    2. 'J' CODE ON CLAIM AND NDC (NATIONAL DRUG CODE - 11-DIGITS IN LENGTH) ON MEDICARE BACKUP, OK TO PROCESS.
    3. ALL ELSE - DENY W/EOB 903.
    4. NEITHER PROC CODE NOR MONEY MATCHES
        1. AMBULANCE (PT51) - OK TO PROCESS.
        2. ALL ELSE - DENY W/EOB 105.

3. BILLED AMT DOES NOT MATCH -
   A. PROV IS BILLING MDCARE ALLOWED/CO-INS FROM EOMB - KEY CORRECT BILLED AMT FROM EOMB.
   B. (TOS 9 OR R) - KEY BILLED AMOUNT FROM CLAIM AND PROCESS (PROVIDER MAY HAVE ADDED OR SUBTRACTED TAX).
      IF NEITHER PROC CODE NOR MONEY MATCH
      1. AMBULANCE (PT51) - OK TO PROCESS.
      2. ALL ELSE DENY W/EOB 105.
   C. (TOS 3 OR Z) - KEY BILLED AMOUNT FROM CLAIM AND PROCESS (IF SIGNIFICANT DIFFERENCE BETWEEN CLAIM & BU - O'LOC TO 32).

4. MODIFIER DOESN'T MATCH -
   (TOS 9 OR R)
   A. 'RR' ON BACKUP BUT NOT ON CLAIM - KEY TO MATCH BACKUP, UNLESS THERE IS A 5B ON CLAIM AND RR ON BACKUP THEN KEY FROM CLAIM.
   B. IF MOD FIELD BLANK ON CLAIM BUT MEDICARE EOMB HAS SOME OTHER CODE BESIDES 'RR' LEAVE MOD FIELD BLANK.
   (TOS 3 OR Z) -
   A. IF ANY PRICING MOD ON EOMB BACKUP AND NOT ON CLAIM - KEY MOD FROM BACKUP.
   B. IF MOD 51 ANYWHERE ON CLAIM OR BACKUP - KEY MOD 99 AND O'LOC TO 36. *G

5. NUMBER OF LINES DON'T MATCH -
   (TOS 9 OR R) -

A. "COMBINED" PAID LINES WITH DENIED LINES - DENY W/EOB 105.
B. IF PROVIDER HAS "COMBINED" LINES BUT
MONEY ADDS UP THEN GO AHEAD AND PROCESS.
C. IF PROVIDER HAS "SPLIT" LINES:
1. IF CODE HAS BEEN SPLIT FROM "E0255" TO "E0294 & E0310"
THEN PAY E0294 ENTIRE AMT & DENY E0310 BY LEAVING OUT
THE "CHARGE" AMOUNT AND DENYING THE 184 EXCEPTION.
2. IF CLAIM HAS SPLIT CODES W/ MONEY ALSO SPLIT AND IT
ADDS UP - PAY.
3. ALL OTHER CODES - OVERLOC TO 83.
(TOS 3 OR Z)
A. CLAIM/RA HAVE SAME PROCEDURES & MONEY ADDS UP - O'LOC TO
83.
B. MOD 50 - O'LOC TO 09, 368 EXC SHOULD BE FAILING AND
WORKED IN RES LOC 09.
C. ALL ELSE - DENY W/EOB 105.
ANY QUESTIONS - SEE SUPERVISOR/TRAINER.

6. UNITS DON'T MATCH -
(TOS 9 OR R) -
KEY FROM BACKUP, OK TO PROCESS.
(TOS 3) -
A. EFF W/MDCR PD DATE (3/1/01) PROC CODES (00100-01999) -
KEY UNITS FROM CLAIM USING TIME ON CLAIM TO COMPUTE IF
AVAILABLE & DO NOT BE CONCERNED ABOUT BACKUP & CLAIM
UNITS NOT MATCHING. (UNITS PASSED BY MDCR IN ERROR)
B. ALL ELSE - O'LOC TO 32 (MDCR REVIEW)

7. NOT ADDRESSED ABOVE SEE SUPERVISOR/LEADWORKER/TRAINER/MMIS.

E. CONTRACT ADJUST FIELD WITH MONEY LISTED OR ONE OF THE ITEMS
BELOW LISTED ON THE ATTACHED EOMB/MSN - TOS 3, DENY W/565.

- PROVIDER # (6 DIGIT) AT TOP OF RA/EOMB BEGINS WITH A "5"
- ONE LINE ON THE RA AND MULTIPLE LINES ON THE CLAIM
- RURAL HEALTH, COMMUNITY HEALTH OR HOSPITAL IS INDICATED
IN PROVIDER NAME FIELD ON RA/EOMB.
- BILL TYPE ON THE RA/EOMB BEGINS WITH A "1" (I.E. "141")
- BACKUP STATES PART A
- BACKUP STATES PART B & AT LEAST ONE OTHER ITEM ON THIS
LIST IS PRESENT
- ANY OTHER ISSUES NOT ADDRESSED AND YOUR SUPERVISOR
CANNOT DETERMINE, O'LOC TO 83.

TOS 9 - CONTRACT ADJUST
1. PHYSICAL THERAPY (PROV TYPE 34) - IF SIX DIGIT PROVIDER
NUMBER, OR SIX DIGIT NUMBER FOLLOWED BY A AT TOP OF RA/
EOMB - DENY W/EOB 565.
2. GROUND OR AIR AMBULANCE (PT 51 OR 53) -
EXAM ENTRY - O/L TO LOC 32 *DC
RESOLUTIONS - SEE 856 TEXT.

F. MCARE EOMB HAS CO-B4 (LATE FILING PENALTY)

AT LINE LEVEL -(MEDICARE PAID FIELD) KEY IN MEDICARE NORMAL 80% TOTAL (MEDICARE ALLOWED MINUS ONLY THE CO-INSURANCE).

AT HEADER LEVEL MEDICARE PAYMENT FIELD - KEY IN MEDICARE ACTUAL PAYMENT(MEDICARE ALLOWED MINUS CO-INSURANCE AND THE LATE FILING FEE) WHICH IS LISTED AS NET ON MEDICARE RA.

12. ENCOUNTER CODES 9000M, 9001M, 9005M, 9007M OR 5900M - DENY WITH EOB 248.

13. MEDICAL RECORD NUMBER - KEY ALPHA AND NUMERIC. DO NOT KEY PRECEDING ZEROS, DOTS, DASHES, ETC.

14. NO INSURANCE BACKUP BUT THERE IS MONEY IN BOX 32, AND MEDICARE RA/EOMB VERIFIES MONEY EQUALS MEDICARE PAID/COINSURANCE AND/OR DEDUCTIBLE, REMOVE MONEY FROM INSURANCE FIELD AND USE INFO EOB 482.

15. MULTIPLE MODIFIERS (TOS 3 & Z ONLY)
NOTE: PRICING MODS: 26,50,51,53,54,55,56,62,66,78,80,81,82,AA,AB,AC, AD,AS,QK,QX,QY,QZ,TC,SL,9T,ST,E1-E4,FA,F1-F9,TA,T1-T9,LT/RT, SG,59. *G

A. MULTIPLE OF SAME MOD - KEY THAT MOD ONCE, DO NOT KEY MOD 99.
B. ANY COMBO OF THE ABOVE PRICING MODS
   1. SURGERIES (10000-69999,92973-92998,93501-93545,G0104-G0105, G0121,G0127,G0159,G0168,G0185-G0187. EXCEPT 36415-36416)>>>
      A. MOD SG CREATES THE MULTIPLE - PT 22 ONLY:
         1. OTHER MOD IS FROM LIST ABOVE - KEY THE MOD FROM ABOVE IN MOD SLOT 1 AND MOD SG IN MOD SLOT 2.
         2. ALL ELSE - KEY MOD SG IN MOD SLOT 1 AND OTHERS IN REMAINING SLOTS. RES OVCD IF NECESSARY.
      B. IF COMBINATION OF ABOVE PRICING MODS KEY MOD 99 AND O'LOC TO 36.
      C. ALL ELSE - KEY MOD 99 AND O'LOC TO 36 FOR RES REVIEW. *G

   2. ALL ELSE - EE ENTER MOD 99 AND PA-2.
      RES: MULTIPLE PRICING MODS, ENTER MODS IN SLOTS 1-4 AND MANUAL PRICE PER MODS AND PDDD FILE APPROPRIATELY.
C. IF MULTIPLE IS CREATED BY A MOD LISTED ABOVE AND ANOTHER NOT FROM ABOVE - KEY THE MODIFIER FROM THE ABOVE LIST IN MOD SLOT 1 AND ALL OTHERS IN MOD SLOTS 2-4. RES OVCD IF NECESSARY.
D. MULTIPLE IS CREATED BY MODS NOT LISTED ABOVE - KEY FIRST MOD IN MOD SLOT 1 AND SO ON IN REMAINING MOD SLOTS. RES OVCD IF NECESSARY.
E. IF PROVIDER BILLING W/MOD 99 AND MULTIPLE MODS ON SAME LINE - FOLLOW THE ABOVE DIRECTIONS.
F. IF MULTIPLE MODS AND NOT ADDRESSED ABOVE - KEY MOD 99 AND PA-2.

NOTE: ANY QUESTIONS SEE SUPERVISOR/LEADWORKER/TRAINER.

MULTIPLE MODIFIERS (TOS 9 OR R) -
A. 5B OR U2 WITH RR - KEY ON LINE WITH X IN LMC AND OL TO 83.
B. RR AND ANY OTHER MOD(S) - KEY RR IN 1ST POSITION.

C. ALL ELSE, KEY MODS IN ORDER GIVEN.

16. MODIFER 9T/ST RES/ADJ: DO NOT PAY ANY ADDITIONAL MONIES FOR X-OVER CLAIMS. TRAUMA (9T/ST) IS AN MAA PROGRAM & IF MDCR IS THE PRIMARY DISTRIBUTOR OF FUNDS, MAA WILL NOT APPLY TRAUMA PAYMENT TO A MDCR CLIENTS SERVICES. WHETHER OR NOT MAA IS MAKING ANY ADDITIONAL PAYMENT TO THE CLAIM, IF MOD 9T/ST IS BILLED, ADD INFO MOD 937.

17. TAPE CLAIMS (RES)
    A. PT 26, 39, 51 - TOS SHOULD BE "9".
    B. "J" CODES & PT 51 (TOS SHOULD BE "9") - IF LINE IS NOT ALREADY AUTO DENYING, CREATE EXCEPTION & DENY W/EOB 859.
    C. PT 30 - IF TOS IS "3" W/MED VENDOR CODES THEN CHANGE TO TOS "9"

18. SERVICES DENIED BY MDCR (452/453 POSTING) W/AN MPI OF "0" AND DOS IS MORE THAN 1 YEAR (365 DAYS) FROM CURRENT OR REFERENCED ICN - DENY W/EOB'S 018/095.

TEXT KEY TEXT DESC
997 MED VENDOR - CLAIM TYPE (P)

1. IF A PROVIDER SUBMITS A CLAIM WHERE THE WRITTEN DESCRIPTION OF SERVICE DOES NOT MATCH THE PROCEDURE CODE, MANUALLY DENY EACH DETAIL LINE WITH EOB 340. IF A PROVIDER IS USING UNLISTED OR INAPPROPRIATE CODES WHEN THERE IS A MORE DESCRIPTIVE CODE IN FEE SCHEDULE, DENY WITH EOB 302. (AMBULANCE SERVICES - SEE PAGE 6,#10A)

2. IF A PROVIDER SUBMITS A CLAIM AND THE FIRST DETAIL LINE HAS A DATE OF SERVICE AND SUBSEQUENT LINE ITEMS DO NOT HAVE DATES OF SERVICE, BUT YOU CAN TELL THEY ARE RELATED, CARRY DOWN THE FIRST DATE OF SERVICE ON THE SUBSEQUENT LINE ITEMS. DO NOT CARRY DOWN P.O.S.

3. MEDICAL NUTRITION: IF COMMENTS ON CLAIMS:SUSAN YAKE AT BREMERTON NAVAL HOSPITAL IS A DIETICIAN REGISTERED WITH THE HEALTH PROFESSION QUALITY ASSURANCE DIVISION. DUE TO HER MILITARY STATUS SHE DOES NOT HAVE A STATE DIETICIAN NUMBER-FORCE.

4. SPECIAL HANDLING BATCHES WITH THE EXCEPTION OF FAIR HEARINGS, SHOULD BE OVERLOCKED TO 85. WHEN KEYING SPECIAL HANDLING BATCHES - PUT "S" IN THE LMC, UNLESS CLAIM REQUESTS TO USE "X" IN LMC. IF "X" IN LMC - PA2 116 EXCEPTION, IF "S" - FORCE 116 EXCEPTION.
WORK CLAIM ACCORDING TO DIRECTIONS ON BATCH COVER AND/OR CLAIM ANYTHING NOT ADDRESSED WORK AS NORMAL.

FAIR HEARING BATCH/CLAIM, PUT "S" IN LMC AND OVERLOC TO LOC 81. IF FOR ANY REASON THE CLAIM NEEDS TO BE REVIEWED IN LOC 81, PA2. OTHERWISE FORCE THE 116 EXCEPTION.

5. WHEN A CLAIM APPEARS TO BE A REQUEST FOR APPROVAL (CLAIM IS IN-COMPLETE): DENY CLAIM WITH EOB 155 AND ROUTE CLAIM TO QUS. INDICATE ON BATCH COVER SHEET, D-155. INDICATE ON THE CLAIM, D-155/QUS AND PLACE CLAIM IN 155 ROUTING SLOT IN EXAM ENTRY UNIT AREA.
NOTE.... THIS DOES NOT APPLY TO HOME HEALTH CLAIMS.

IF CLAIM HAS SPECIAL DISPOSITION FROM MEDICAL CONSULTANT/AUTH FILE:

MANUALLY PRICE THAT LINE ACCORDINGLY WITH INFO EOB 373.
IF CONSULTANT INDICATES "INCLUDED" - DENY W/EOB 334/373.
IF CONSULTANT INDICATES "DENIED" - DENY W/EOB 242/373.
IF CONSULTANT INDICATES "PENDING" - DENY W/EOB 198/373.
WHEN YOU MANUALLY PRICE A LINE YOU MUST KEY AN "A" IN SOURCE CODE FIELD TO RETAIN YOUR PRICING.

6. IF YOU SEE A PRESCRIPTIONBILLED ON A MED-VENDOR HCFA 1500 CLAIM FORM, DENY THAT LINE OR CLAIM WITH EOB 508.

7. OVERCODES:
   A. 003 -- INDICATES 3RD TRIP (AMBULANCE) ON SAME DAY - PRIOR TO DOS 7/1/00 ONLY.
   B. 004 -- INDICATES 4TH TRIP (AMBULANCE) ON SAME DAY. KEY AN

X IN THE LMC.
C. 014 -- OP REPORTS, HISTORY, CHART NOTES
D. 031 -- INDICATES LT MODIFIER ON CLAIM OR IN COMMENTS ON THIS LINE.
E. 032 -- INDICATES RT MODIFIER ON CLAIM OR IN COMMENTS ON THIS LINE.
F. 040 -- CLAIM DECISION/ADJUDICATION BY MMIS.
G. 041 -- CLAIM DECISION BY K.WOODS/AASA
H. 055 -- INDICATES TO RES MEDICARE/MEDICAID CODE REVIEW NEEDED.
I. 086 -- CLAIM PENDING FOR CONSULT OR STAGING. (NON-INST RES & ADJ UNIT)
J. 088 -- INDICATES CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) HEARING AID AUTHORIZATION AND SIGNATURES. (EFFECTIVE 10/1/03 DO NOT USE O'CODE 088 SEE PG 9)
K. 111 -- MDCR COB REVIEW OF PAID/DENIED CLAIMS.
L. 112 -- SAME CLIENT,SAME DAY,SAME SERVICE,DIFF PROVIDER (103).
M. 224 -- INDICATES THAT RESOLUTIONS HAS REMOVED THE AUTH # AND CYCLED THE CLAIM.
N. 434 -- <RES> CLAIM ADJUDICATED PER MEDICARE MANAGED CARE BACKUP.
O. 436 -- <RES> MEDICARE/MANAGED CARE COPAY PAID WITHOUT BACKUP.
P. 444 -- CLAIM STATES "NOT A DUP" PUT AN 'X' IN LMC & OVERCODE 444 AND OVERLOC TO 35.(REGARDLESS OF ANY OTHER COMMENT ALONG WITH "NOT A DUP", SUCH AS "UNPAID CLAIM") OR AUTH FOR MULT UNITS PUT AN'X'IN LMC AND OVERCODE 444 AND OVERLOC TO 35.
Q. 680 -- MEDICARE BACKUP ATTACHED.
R. 690 -- NO MEDICARE BACKUP BUT DISCLAIMER FROM PROVIDER ON CLAIM, BACKUP OR COMMENTS STATING "NO MEDICARE", "ALIEN", "REFUGEE", "NEMB" OR "NOT ELIGIBLE". --NOTE: THIS DOES NOT APPLY ON CLAIMS SAYING "MEDICARE DOES NOT COVER."
S. 998 -- INDICATES APPROVAL FOR EXCEPTION TO POLICY/FAIR HEARINGS BY ASU/PRU.
T. -- 777 - BABY UNDER PARENT'S PIC - TRIPLET A
U. -- 778 - BABY UNDER PARENT'S PIC - TRIPLET B
V. -- 779 - BABY UNDER PARENT'S PIC - TRIPLET C
W. -- 886 - BABY UNDER PARENT'S PIC - TWIN OR TRIPLET-UNIDENTIFIED
X. -- 888 - TWIN A, BABY #1, FIRST, ETC.
Y. -- 889 - TWIN B, BABY #2, SECOND, ETC.

---MULTIPLE BIRTHS - UNIDENTIFIED, OVERCODE 886 AND DENY W/EOB 779.

---IF CLAIM INDICATES MORE THAN ONE CLIENT - DENY W/EOB 271.

8. UNITS:
A. IF PROVIDER BILLS OVER 99999 UNITS ON CLAIM-LEAVE UNITS OUT, F7 AND ENTER A COMMENT STATING LINE# AND UNITS BILLED AND PA2 TO RESOLUTIONS.
RES: SPLIT LINE TO PAY TOTAL UNITS BILLED.
EXCEPTION: MEDICAL NUTRITION AND PARENTERAL SOLUTIONS - LEAVE OUT UNITS AND DENY THE 183 EXCEPTION.

B. IF UNITS ARE BILLED WITH DECIMALS (I.E. 6.4) - LEAVE UNITS

BLANK AND DENY 183 EXCEPT IF PROV TYPE 33 OR 44 SEE INSTRUCTIONS ON PAGE 11.

9. HOME HEALTH: PT 44 (REV CODES 421,431,441,551,558,571,580,590) IF IN A MED VENDOR BATCH - DENY W/333 AND RE-ICN CLAIM AS AN M.

10. GROUND AMBULANCE:

A. IF MILEAGE BILLED IN FRACTION OF MILES (I.E. 6.5) LEAVE UNIT FIELD BLANK AND DENY 183 EXCEPTION.

B. PLACE OF SERVICE IS ALWAYS "9" NO MATTER WHAT PLACE OF SERVICE IS INDICATED OR IF IT IS BLANK.
EFFECTIVE 9/4/03: KEY PLACE OF SERVICE AS INDICATED ON CLAIM. IF BLANK-DENY.

C. AMBULANCE PROVIDERS BILLING FOR TRANSPORT AND THE PATIENT WASN'T TRANSPORTED- DENY WITH 325 EOB.
EXCEPTION: IF CLAIM STATES "DECEASED" AND BILLING CODES OTHER THAN 0013A,0014A - DENY ENTIRE CLAIM W/EOB 248.

D. IF DX CODE (BOX E ON DETAIL LINE) IS BLANK OR MISSING AND THERE IS DX CODE(S) IN BOX 21, USE FIRST VALID CODE IF MORE THEN ONE LISTED.
IF NO DX LISTED ON CLAIM - KEY V900 IN DX FIELD ON AMBULANCE CLAIMS ONLY, OTHERWISE LEAVE BLANK.

E. PRIOR TO DOS 7/1/00 -
IF STATEMENT ON CLAIM "3RD TRIP" - OVERCODE 003
IF STATEMENT ON CLAIM "4TH TRIP" - OVERCODE 004.

DOS 7/1/00 & AFTER -
PROVIDER MUST USE 3RD TRIP CODE AND OVERCODE 003 SHOULD NO LONGER BE USED.
4TH TRIP PROVIDER SHOULD USE 3RD TRIP CODE WITH OVERCODE 004.

11. WHEN A CLAIM IS SUBMITTED WITH AN ATTACHED INVOICE AND SERVICES ON CLAIM DO NOT MATCH INVOICE DESCRIPTION, DENY WITH EOB 459.

WHEN PRICING FROM AN INVOICE - USE INFORMATIONAL EOB 552 AND BE SURE YOU USE "A" IN SOURCE CODE.

12. HEARING AID CLAIMS (PROVIDER TYPE 84) IF BOX 19 ON THE HCFA HAS AN H OR BOX 23 HAS A CSHCN (CHILDREN W/SPEC HEALTH CARE NEEDS) STAMP W/ SIGNATURE/INITIALS OF CSHCN COORDINATOR, KEY AN H IN THE ITA FIELD. EMC CLAIMS, CHECK COMMENT FIELD FOR INITIALS CSHCN AND IF PRESENT KEY H IN ITA.

13. IF BOX 19 ON HCFA HAS A "K" (NOT RELATED TO TERMINAL ILLNESS), KEY A "K" IN THE ITA FIELD.

14. MEDICARE BACKUP (RA/EOMB) ATTACHED SHOWING PAYMENT AND 261 NOT POSTING:

A. EXCEPTIONS 162,183,271,361,ETC. BLOCK MEDICARE. CHECK ELIGIBILITY FILE, PAGE 2, COLUMN E.
1. IF NO 1 OR 7 IN COLUMN E - DENY MEDICARE PAID LINES WITH EOB 335 & O'CODE 111. (AUDREY FINNIGAN FOR REVIEW).

2. IF 1 OR 7 IN COLUMN E - DENY MEDICARE PAID LINES W/EOB 335.

B. NO EXCEPTION BLOCKING MEDICARE - DENY MEDICARE PAID LINES W/EOB 335 AND O'CODE 111. (AUDREY FINNIGAN FOR REVIEW).

15. IF PROVIDER IS BILLING ON HCFA-1500(C-2) OR (SC)(1-84) CLAIM FORM, USE INFORMATIONAL HEADER EOB 096.

16. PAT-CNT - KEY ALPHA AND NUMERIC. DO NOT KEY PRECEDING ZEROS, DOTS, DASHES, ETC.

17. NURSE DELEGATION SERVICES (8900N-8903N) -

A. IF THE PROVIDER IS BILLING ERRONEOUS UNITS, IE 2.25,1.5,ETC DO NOT ROUND UP OR DOWN, LEAVE BLANK AND OVERLOC TO 83.

B. THESE SERVICES MAY BE BILLED BY BOTH PROVIDER TYPE 33 AND 44. IN ORDER FOR PT 33 OR PT 44 TO BILL FOR NURSE DELEGATION SVS THE PROVIDER FILE MUST INDICATE (NURSE DELEGATION) UNDER THE NAME.

PT 33 SHOULD BILL ON A HCFA 1500 (P) CLAIM TYPE

PT 44 SHOULD BILL ON A UB-92 (P) CLAIM TYPE.

IF NO INDICATION IN PROVIDER FILE FOR NURSE DELEGATION - DENY W/EOB 934.

18. MULTIPLE MODIFIERS - KEY IN ORDER GIVEN UNLESS NOTED BELOW.
A: WHEN 5B OR U2 WITH RR - KEY ON LINE WITH X IN LMC AND OL TO 83.

19. PROGRAM DESCRIPTIONS:

DURABLE MEDICAL EQUIPMENT (DME) PT 26 OR 39
INCLUDES: WHEELCHAIRS, BEDS, WALKERS, CANES, BATHROOM EQUIPMENT, COMMODES, BLOOD GLUCOSE MONITORS, ALL EQUIPMENT ACCESSORIES AND MODIFICATIONS, SUCH AS, BED RAILS, HANDGRIPS, TRAPEZE BARS, BATHTUB & TOILET GRAB BARS AND LABOR AND PARTS FOR REPAIRS OF EQUIPMENT.

NONDURABLE MEDICAL EQUIPMENT (NONDME) & MEDICAL SUPPLIES (MSE) PT 26 OR 39
INCLUDES: BANDAGES, TAPES, GAUZE, DRESSING, GLOVES, WOUND FILLERS, LUBRICANTS, SALINE SOLUTIONS, GERMICIDES AND ANTISEPTICS, OSTOMY SUPPLIES, INCONTINENT AND UROLOGICAL SUPPLIES, BRACES, BELTS AND SUPPORTIVE DEVICES (EXCLUDING 'L' CODES), DECUBITUS CARE PRODUCTS (NON-WHEELCHAIR CUSHIONS, SHEEPSKIN PADS AND HEEL AND ELBOW PROTECTORS), TENS SUPPLIES, EYE PATCHES, LICE COMBS & GEL.

PROSTHETIC & ORTHOTIC - PT 38 OR 39

ALL PROCEDURE CODES IN THIS PROGRAM BEGIN WITH 'L'.

20. PROVIDER TYPE 34 PHYSICAL THERAPY: IF CLAIM INDICATES NEW, DIFFERENT OR SEPARATE INJURY KEY X IN LMC AND OVERLOC 37.

21. MEDICARE TO MEDICAID CROSSOVER CODES ARE BEING ENTERED ON THE DESCRIPTION LINE OF THE PROCEDURE CODE-THEY WILL BE IN PARENTHESIS. THIS IS TO HELP IDENTIFY IF THE PROVIDER IS SUBMITTING THE CORRECT CROSSOVER CODE TO THE PROCEDURE CODE.

TEXT KEY TEXT DESC
998 TPL INFORMATIONAL TEXT

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2 INFORMATION FOUND IN 000 TEXT
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30 TPR HEALTH/MEMOS AND MISC. INFORMATION

49 TPL CASUALTY/MISCELANEOUS INFORMATION

AGED REPORT GUIDELINES -

1. CLAIMS THAT ARE 15 DAYS OLD IN SYSTEM LOCATION WILL APPEAR ON THE AGED REPORT.

2. SYSTEM - SATURDAY - SYSTEM CYCLES
MONDAY - REPORT FOR ALL SYSTEM LOCATIONS WILL PRINT.

3. AGED REPORT INFORMATION INCLUDES -
- ICN - DAYS IN LOCATION
- PIC - CLAIM AGE
- DOS - EXCEPTIONS, BOTH ADJUDICATED AND SUSPENDING
- PROVIDER

----- INFORMATION FOUND IN 000 TEXT -----

BATCH RANGES AND CLAIM TYPES

CSO (COMMUNITY SERVICE OFFICE) LIST

MEDICAL ELIGIBILITY CODES

PROGRAM CODES AND MATCH CODES

TPR BILL STATUS CODES

CODE	DESCRIPTION
SP(SPACE)	PENDING
A	APPLIED TO DEDUCTIBLE
B	BENEFITS EXHAUSTED
C	NOT COST EFFECTIVE TO PURSUE
D	DELETE
E	COVERAGE NOT IN EFFECT FOR DOS
F	MATERNITY FOR DEPENDENT CHILDREN N/C

G	ELECTRONIC PAY & CHASE MATERNITY/SURRENDER
H	INSURANCE PAID PROVIDER/RECOUP LETTER SENT
I	PREEXISTING CONDITION
J	BEYOND INSURANCE COMPANY FILING LIMIT
K	KEEP
L	CHECK ISSUED - POSTING FORTHCOMING
M	WAITING PERIOD NOT MET
N	NOT A COVERED SERVICE
P	INSURANCE PAID PROVIDER - RECOUP DONE
Q	DO NOT USE. REFER TO BILL STATUS 8
R	REFERRED TO OFR
S	REFUND REQUEST LETTER SENT
T	INDEMNITY POLICY AMOUNT USED AS INCOME/SURRENDER
U	DEDUCT LETTER SENT
V	SURRENDER - POS/NETWORK PHARMACY
W	WRITE OFF
X	ADJUSTMENT CAUSING RECOUPMENT
Y	SURRENDER - STATE ONLY CODE, NO CPT CODE
Z	SENT MORE INFORMATION TO CARRIER
1	CASH CONTROL ADJUSTMENT CLAIM WRITTEN
2	SEE PENDING FILE FOR DETAILS
3	ADDITIONAL INFORMATION LETTER SENT
4	WAITING FOR PRIMARY TO CONSIDER
5	UNIT DOSE BILLING FOR NURSING HOME CLIENTS
7	REFERRED TO COS
8	ACCOUNTS RECIEVABLE FILE
9	DUE DILIGENCE

TPR CODE LIST

THIS LIST IS A COMBINATION OF BOTH THE OLD AND THE REVISED, 1994 LIST OF EDIT CODES. THE NEW CODES HAVE AN ASTERISK (*) BY THE CODE. PLEASE DO NOT USE ANY OF THE CODES WITHOUT THE ASTERISK WHEN BUILDING SCREENS. REPLACE, AND IF NECESSARY, DELETE, ANY OF THE CODES THAT ARE NO LONGER VALID.

A1	*	NO VISION
A2		EYE EXAMS N/C
A3	*	EYEGLASSES, CONTACTS N/C
A4	*	VISION ONLY
A5		DENTAL/VISION POLICY ONLY
A6		VISION - ORTHOTIC TRAINING ONLY
A7	*	HEARING AIDS N/C
A8		VISION FOR EYE EXAMS ONLY
A9	*	NO DENTAL
A10		NO DEPENDENT DENTAL, SUBSCRIBER ONLY
A11	*	ORTHODONTIST N/C
A12	*	DENTURES N/C
A13		NO DEPENDENT VISION, SUBSCRIBER ONLY
A14	*	NO DRUG COVERAGE
A15		ROUTINE EYE EXAM N/C
A16		DENTAL ONLY, NO MEDICAL
A17		VISION UNDER ANOTHER CARRIER
A18		DRUG COVERAGE VERIFIED WITH INSURANCE CARRIER

A19		DENTAL SEALANTS N/C
A20		DENTAL COVERAGE VERIFIED WITH INSURANCE CARRIER
A21		ORAL SURGERY AND EXTRACTIONS N/C
A22		AUDIO BENEFITS N/C
A23		PROSTHESIS FITTING N/C
A24	*	ORTHODONTIA BENEFIT MAXED
A25	*	INDEMNITY POLICY MUST ASSIGN BENEFITS
A26	*	INSURANCE REQUIRES UP FRONT PAYMENT FROM SUBSCRIBER FOR PRESCRIPTIONS... AND WILL ONLY PAY THE SUBSCRIBER..
A27	*	MAIL ORDER RX/DISCOUNT CARD.
A28	*	INSURANCE ACCEPTS ONLINE BILLING FROM PHARMACY BUT WILL ONLY ISSUE PAYMENT TO SUBSCRIBER.
A29	*	REFERRED TO COBRU (INCLUDE PROVIDER# AND DATE)
B1		OFFICE CALLS N/C
B2		HOME AND OFFICE CALLS N/C
B3		OFFICE CALLS COVERED IF MINOR SURGERY OR INJURY RELATED
B4	*	PHYSICIAN CALLS TO NURSING HOMES N/C
B5		BAXTER-SHORT TERM PRESCRIPTION DEPT
B6	*	CAPITATED PLAN
B7	*	FEE FOR SERVICE PLAN
B8	*	REFERENCE ONLY SCREEN; PROVIDER SOURCE OF INFORMATION
C1	*	PREVENTIVE OR ROUTINE CARE N/C
C2	*	WELL CHILD CARE N/C
C3	*	FAMILY PLANNING N/C
C4		IMMUNIZATIONS N/C
C5		INJECTIONS N/C
C6		NEWBORN CARE N/C
C7	*	DENTAL,VISION,HEARING COVERAGE ONLY
C8	*	REFER TO CARRIER CODE NOTES
D1		HOSPITALIZATION ONLY(SRV IN PREPAY NO DRUGS)
D2		SURGICAL AND HOSPITAL ONLY
D3		PHYSICIAN CHARGE COVERED IF HOSPITALIZED
D4		PHYSICIAN CHARGE PAID TO INPATIENT SURGEON ONLY
D5		ICU ONLY
D6		SURGERY ONLY
D7		SURGEON CHARGES ONLY
D8		ILLNESS COVERED ONLY IF INTENSIVE CARE
D9		COVERS NURSING HOME FOLLOWING A HOSP STAY OF AT LEAST 3 DAYS
D10		SKILLED NH COVERAGE VERIFIED WITH INSURANCE CONV CENTER N/C.
D11	*	INSURANCE PAYS CLASS 24
D12	*	VERIFIED NO PRIOR MEDICARE STAY
D13	*	VERIFIED ACTUAL DATE OF ADMIT TO NURSING HOME
D14	*	NO NURSING HOME ROOM & BOARD COVERAGE
D15	*	INSURANCE PAYS DAYS 21-100 & THEN 101+ IF MEDICALLY NECESSARY. VERIFIED NOT CURRENTLY ELIGIBLE.
D15+	*	INSURANCE PAYS DAYS 21-100; DAYS 101+ IF MEDICALLY NECESSARY. NOT VERIFIED
D16	*	INSURANCE MAKES BENEFIT DETERMINATIONS BASED ON LEVEL OF CARE. VERIFIED NOT CURRENTLY ELIGIBLE.
D16+	*	INSURANCE MAKES BENEFIT DETERMINATIONS BASED ON LEVEL OF CARE. NOT VERIFIED

D17 * HOSPICE SERVICES NOT COVERED
D21 * VERIFIED NOT A MEDICARE SUPPLEMENT
D22 * BENEFIT PERIOD MAXED
D24 * CLASS 24 CHECKED. DSHS PAID O
D26 * LONG TERM CARE POLICY.
D99 * (DATE) 100 MEDICARE DAYS NOT MET.WILL PAY 101+ IF MET.

E1 * MEDICARE SUPPLEMENT
E2 MEDICARE PART B N/C
E3 MEDICARE PART A N/C
E4 LO-OPTION MEDICARE PART B DEDUCTIBLE N/C
E5 NOT A MEDICARE SUPPLEMENT
E6 * MEDICARE SUPPLEMENTAL WITH DRUG COVERAGE
E7 * PART B DEDUCTIBLE NOT COVERED
E8 * PARTS A AND B DEDUCTIBLE NOT COVERED
E9 * MANAGED MEDICARE

F1 * MENTAL HEALTH N/C
F2 * OUTPATIENT MENTAL HEALTH N/C
F3 * INPATIENT PSYCHE BENEFITS N/C
F4 MENTAL DISEASES OR DISORDERS N/C
F5 MENTAL HEALTH SHOTS N/C
F6 MENTAL HEALTH COVERAGE ONLY
F7 ALCOHOLISM TREATMENT N/C
F8 WK01 - DETOX N/C UNTIL 11TH DAY
F9 INVOLUNTARY MENTAL HEALTH N/C
F10 * MENTAL HEALTH BENEFITS MAXED FOR THE YEAR(EX:F10-4-10-92)
F11 INPATIENT PSYCHE BENEFITS IN A STATE HOSPITAL N/C
F12 DRUG ABUSE/MAINTENANCE N/C
F13 * ATTEMPTED SUICIDE N/C
F14 * MENTAL HEALTH BENEFITS MAXED FOR LIFETIME
F15 MENTAL HEALTH COVERED ONLY BY LICENSED MD
F16 * SUBSTANCE ABUSE NOT COVERED

G1 * MEDICAL SUPPLIES N/C
G2 * SUPPLIES, DRESSINGS, GLOVES, APPLIANCES NOT COVERED
G3 * DISPOSABLE DIAPERS/GLOVES/INCONTINENT SUPPLIES N/C
G4 * SUSTAGEN/FOOD SUPPLEMENT N/C
G5 * INTROFEEDING (TUBE) AND SUPPLIES N/C
G6 * ALL DIABETIC SUPPLIES AND OTHER SUCH NON-DRUG ITEMS N/C
G7 * CONTRACEPTIVES N/C
G8 * NON-PRESCRIPTION DRUGS N/C (EX: VITAMINS)
G9 * PARENTERAL & ENTERAL NUTRITIONAL THERAPY N/C
G10 * PSYCHOTROPIC DRUGS N/C
G11 * DIAPERS COVERED PER INSURANCE COMPANY
G12 * NORPLANT CONTRACEPTIVES N/C
G13 * CATHETER SUPPLIES N/C

H1 * DME PURCHASE OR RENTAL N/C
H2 * DME REPAIRS N/C
H3 PROSTHETICS N/C
H4 * ORTHOTICS N/C
H5 * DME IN NURSING HOME N/C
H6 * BATHROOM SAFETY EQUIPMENT N/C

J1		SPEECH AND REHAB THERAPY N/C
J2	*	SPEECH THERAPY N/C
J3	*	REHAB THERAPY N/C
J4	*	PHYSICAL THERAPY N/C
J5		SPEECH AND HEARING THERAPY N/C
J6		LEARNING DISABILITY N/C
J7	*	OCCUPATIONAL THERAPY NOT COVERED
K1	*	ACCIDENT POLICY ONLY
K2		EMERGENCY OR ACCIDENTS ONLY
K3		ACCIDENT ONLY-SCHOOL INSURANCE (24 HOURS PER DAY)
K4		ACCIDENT AND OUTPATIENT SURGERY ONLY
K5		OUTPATIENT EMERGENCY ROOM FOR ACCIDENT ONLY
K6		ACCIDENT ONLY-SCHOOL INSURANCE(TO,FROM, AND DURING ONLY)
K7	*	INSURANCE COVERAGE EXTENDED FOR DISABILITY ONLY.RE:CASUALTY
K8		EMERGENCY POLICY ONLY WHILE 50+ MILES (HM99)
K9	*	PRIMARY CARE PROVIDER PLAN
K10		HOSPITALIZATION AND ACCIDENT RELATED COVERAGE ONLY
K11		WORK RELATED INJURIES N/C
L1		DIAGNOSTIC LAB AND X-RAY N/C
L2		INPATIENT LAB AND X-RAY N/C
L3		DIAGNOSTIC LAB AND X-RAY COVERED IF RELATED TO HOSPITAL STAY
L4		ROUTINE X-RAY N/C
L5		OUTPATIENT LAB AND X-RAY N/C
M1	*	MATERNITY N/C
M2	*	DIABETES N/C
M3	*	OXYGEN N/C
M4		SURGERY N/C
M5	*	CHIROPRACTIC N/C
M6		DEPENDENT MATERNITY CARE COVERED, NEWBORN CARE N/C
M7	*	ABORTION N/C
M8	*	PRE-EXISTING CONDITION N/C (EX: M8/6/92)
M9		INSURANCE COVERAGE EXTENDED FOR MATERNITY ONLY
M10		DIABETES COVERED ONLY
M11		EPILEPSY TREATMENT AND MEDICATIONS N/C
M12	*	STERILIZATION N/C
M13		MATERNITY N/C; PREGNANCY COMPLICATIONS COVERED ONLY
M14	*	COVERAGE FOR NEWBORN ONLY
M15		PODIATRY N/C
M16		CHIROPRACTIC COVERAGE ONLY
M17		WAIVER FOR CONDITION ON FILE N/C
M18	*	SPECIAL DUTY NURSING N/C
M19		DEPENDENT IN STATE FUND INSTITUTION NOT ELIG FOR CHAMPUS COV.
M20		OSTEOPATHIC SERVICES N/C
M21		CONDITIONS RELATING TO MENSTRUAL DISORDERS & OVARIAN CYST N/C
M22		PULMONARY AIDE TREATMENT N/C
M23	*	RESPIRATORY THERAPY/SUPPLIES N/C
M24		PENTAMINDINE AEROSOL DELIVERY N/C FOR NONACTIVE PNEUMOCYSTIC PNEUMONIA ADMINISTERED ON A DAILY BASIS
M25	*	IV THERAPY N/C
M26		ADMINISTERING (SUPPLIES) N/C FOR EXPERIMENTAL PRESCRIPTIONS
M27	*	DEPENDENT MATERNITY & NEWBORN CARE NOT COVERED

M28 * DEPENDENT MATERNITY COVERED;NEWBORN COVERED UNTIL HOSPITAL DISCHARGE
M29 * DEPENDENT MATERNITY IS COVERED.
M30 * MATERNITY IS COVERED.

N1 DENTAL COVERAGE IF INJURY
N2 * AIDS DIAGNOSED
O1 OUTPATIENT HOSPITAL VISITS N/C
O2 HOME HEALTH CARE/VISITING NURSES N/C
O3 HEALTH DEPARTMENT SERVICES N/C
O4 OUTPATIENT HOSPITAL EXPENSES N/C
O5 * PRIVATE DUTY NURSING N/C
O6 * VISITING NURSE NOT COVERED
O7 * HOME HEALTH NOT COVERED
P1 RENAL FAILURE ONLY COVERED
P2 KIDNEY INSURANCE ONLY
P3 KIDNEY DIAGNOSES N/C
P4 KIDNEY DIALYSIS N/C
P5 REVENUE CODE 835/DIALYSIS HELPER N/C
P6 * NOTIFIED PCOP OF BUILT SCREEN
P7 NOTIFIED PCOP OF TERMED SCREEN
P8 PCOP INFO BUILT SCREEN
P9 * PCOP INFO TERMED SCREEN
P10 * SENT LETTER 30
P11 * NOTIFIED BHPP RECON UNIT

Q1 COVERS CHARGES RELATED TO HEART AND LUNG CONDITION ONLY
Q2 COVERS CHARGES RELATED TO BRAIN CONDITION ONLY
Q3 COVERS CHARGES RELATED TO BACK CONDTION ONLY
Q4 COVERS CHARGES RELATED TO NEWBORN, 1ST 30 DAYS ONLY

R1 * CANCER POLICY ONLY
R2 DREADED DISEASE/CATASTROPHIC ILLNESS POLICY ONLY
R3 CANCER POLICY COVERS INPATIENT & OUTPATIENT CHEMO/RAD ONLY
R4 CANCER POLICY COVERS ALL, EXCEPT CHECK-UP PHYSICIAN VISITS
R6 * CANCER POLICY ONLY; DX'D WITH CANCER

S1 * CUSTODIAL CARE N/C

T1 * NOT A COVERED DEPENDENT
T2 * NOT SUBSCRIBERS CHILD:MOTHER DIVORCED
T3 * NEWBORN NOT COVERED
T4 COVERS CHARGES RELATED TO NEWBORN, 1ST 30 DAYS ONLY (NO DEPENDENT COVERAGE UNDER THIS POLICY)
T5 * SUBSCRIBER DOES NOT HAVE DEPENDENT COVERAGE
T6 NOT SUPPORT RELATED
T7 * GRANDCHILDREN N/C
T8 * SUBSCRIBER BIRTHDAY(MMDDYY).

U * NON-COVERED DATES (EX:U4/92 OR U6-8/92)
U2 REFERRED TO OFR FOR COLLECTION
U3 DRUGS COV UNDER PAID PRESCRIPTION PLAN - PP27
U4 DRUGS COV UNDER PHARMACEUTICAL CARD SYSTEM - PH04

V	*	INSURANCE BENEFITS EXHAUSTED FOR YEAR (EX: V94)
V1	*	INSURANCE BENEFITS EXHAUSTED FOR CONDITION(EX:V1 REHAB)
V2		INSURANCE COVERAGE EXTENDED FRO CONDITION ONLY PER INS COMP.
V3		INSURANCE POLICY COVERS $_____ PER DAY FOR INPATIENT
V4		INSURANCE COVERAGE TERMINATED BY SUBSCRIBER, VERIFIED W/INS
V5	*	ACTUAL EFFECTIVE DATE OF INSURANCE COVERAGE IS _____
V6		INS POL COVERS 40% ONLY IF PAID IN FULL W/30 DAYS OF BILL DAT
V7	*	RETIREMENT POLICY-COVERS SERVICES NOT ALLOWED BY MEDICARE
V8		COBRA BENEFITS CANNOT BE PAID BY THE DEPARTMENT,VERIFIED MCE
V9	*	DO NOT TERM THE INS WITHOUT 1ST SEEING PREMIUM PAYMENT SPEC.
V10	*	COBRA TERMINATED-ACTIVE FILE
V11	*	EHIP SEE PREMIUM PAYMENT STAFF
V12	*	PENDING - AWAITING REFUND
V13	*	FILE CLOSED - REFUND RECEIVED
V14	*	NW KIDNEY CTR SEE PREMIUM PAYMENT STAFF
V15	*	ADDED 1 MONTH ELIGIBILITY TO PAY PREMIUM (DATE)
V16	*	REFERRED TO THE PREMIUM PAYMENT SPECIALIST (DATE)
W1	*	TAXIS, CABULANCE, AMBULANCE N/C (EXCEPT EMERG. HOME TO HOSP)
X1		INSURANCE COVERAGE WHILE IN STATE FOR SUBSCRIBER ONLY
X2		DUAL POLICY(A)ACCIDENT ONLY-COVERS EVERYTHING, AND (B) INPATIENT HOSP $___PER DAY ACCIDENT OR ILLNESS
X3	*	NEW CARRIER REPLACING ?? (EX: X3 CG01)
X4		CARRIER BANKRUPT - FUNDS AVAILABLE
X5		CARRIER BANKRUPT - NO FUNDS AVAILABLE
Z1	*	VERIFIED WITH INSURANCE COMPANY BY PHONE
Z2	*	VERIFIED WITH EMPLOYER
Z3		VERIFIED WITH RECIPIENT
Z4		VERIFIED WITH INSURED
Z5	*	VERIFIED WITH CSO
Z6	*	PER INSURANCE EOB - WRITTEN
Z7		VERIFIED TYPE OF COVERAGE
Z8	*	WRITTEN VERIFICATION FROM ATTORNEY
Z9	*	SSN NOT REQUIRED BY INSURANCE POLICY/GROUP NUMBER NEEDED ONLY
Z10		INFO FORM DATA MATCH
Z11		WRITTEN VEFIFICATION DIVORCE DECREE
Z12		WRITTEN VERIFICATION DISCHARGE PAPERS
Z13		WRITTEN VERIFICATION CSO
Z17	*	TERM DATE INDICATES NOT COVERED FOR DATE OF SERVICE
Z18	*	PROVIDER VERIFIED W/INSURANCE
Z19		VERIFIED W/SEIB
Z22		DEERS LETTER SENT
Z23	*	DIVORCE DECREE DATE PER SEMS
Z24	*	INSURANCE CANNOT ID
Z25		INFORMATION RECEIVED FROM SSA FORMS
Z26		MULTIPLE COVERAGE LETTER SENT
Z27		MULTIPLE COVERAGE LETTER ANSWERED - INS COMPANY REPROCESSING
Z28	*	VERIFIED BY PHONE WITH DEERS OFFICE
Z29		HIQ RETURNED. NO OTHER INSURANCE
Z30		INFORMATION CORRECTED BY CONTRACTOR
Z31		VERIFIED WITH DEERS (ONLINE)
Z32	*	VERIFIED WITH INSURANCE (AUTOMATED/PHONE)

Z33 * VERIFIED WITH INTERNET ON-LINE SYSTEMS
Z34 VERIFIED WITH HCA (HEALTH CARE AUTHORITY)
ZS * VERIFIED WITH SEMS

TPR EOB'S

005 - THERE IS NO PATIENT BALANCE PER THE INSURANCE EOB. (DELETED)

031 - THIS HAS BEEN PAID IN PART BY PRIVATE INSURANCE.

032 - THIS INSURANCE PAYMENT EXCEEDS THE DSHS ALLOWABLE FEE.

051 - PHARMACIST REPORTED DUE DILIGENCE AT OBTAINING BENEFITS, OR PATIENT'S INSURANCE IS 100% PREPAY PLAN OR 60 DAY LONG-TERM-CARE GRACE PERIOD IS REPORTED.

146 - PLEASE REBILL ATTACHING THE INS EOB INDICATING PAYMENT FOR MATERNITY SERVICES RENDERED THIS PATIENT. (DELETED)

220 - CLAIM PAID ACCORDING TO INSURANCE EOB OR IN ACCORDANCE WITH INSURANCE INFORMATION ON FILE.

224 - THE BACKUP DOCUMENTS/COMMENTS WERE NOT RECEIVED. PLEASE REBILL WITH THE APPROPRIATE INFORMATION.

226 - THIS CLAIM CANNOT BE BILLED ELECTRONICALLY. PLEASE RESUBMIT ON A UB-82 INDICATING MEDICARE CROSSOVER.

281 - THE BACK-UP DOCUMENTS/COMMENTS ARE INAPPROPRIATE OR LACKING INFORMATION. PLEASE REBILL WITH THE APPROPRIATE INFORMATION.

287 - THE EOB WAS FROM AN INCORRECT INSURANCE CARRIER. PLEASE REBILL WITH CORRECT EOB.

288 - MORE THAN ONE INSURANCE CARRIER IS AVAILABLE. PLEASE SUBMIT EOB BACKUP FOR EACH CARRIER.

290 - TOTAL CHARGE IS IN EXCESS OF CO-PAYMENT AMOUNT.

291 - THIS HAS BEEN VERIFIED WITH THE INSURANCE COMPANY AND THE EOB DENIAL SUBMITTED WAS IN ERROR (BY THE INSURANCE CARRIER). PLEASE REBILL THE INSURANCE CARRIER FOR A CORRECTED EOB.

397 - YOUR ADJUSTMENT REQUEST HAS BEEN REVIEWED, THE ORIGINAL DISPOSITION WAS CORRECT.

462 - PAID IN ACCORDANCE WITH INSURANCE EOB, CHARGES APPLIED TO DEDUCT.

463 - PAID IN ACCORDANCE WITH INSURANCE EOB, COVERAGE TERMINATED/DATE OF SERVICE DURING LASPE IN COVERAGE.

464 - PAID IN ACCORDANCE WITH INSURANCE EOB, NON COVERED SERVICE.

465 - PAID IN ACCORDANCE WITH INSURANCE EOB,INSURANCE BENEFITS EXHAUSTED

466 - PAID IN ACCORDANCE WITH INSURANCE EOB, WAITING PERIOD NOT MET.

467 - PAID IN ACCORDANCE WITH INSURANCE EOB, PRE-EXISTING CONDITION.

485 - INSURANCE INFO IS LISTED ON YOUR DSHS CLAIM FORM. DO NOT ENTER MEDICARE, MEDICAID OR HEALTHY OPTIONS AS INSURANCE. PLEASE REBILL WITH PRIVATE INSURANCE EOB. IF QUESTIONS CALL 1-800-562-6136.

487 - REVIEW OF THE CLAIM AND THE ATTACHED EOB HAS RESULTED IN DENIAL. THE PATIENT, DOS OR OTHER FIELDS ON THE CLAIM, DO NOT MATCH THOSE ON THE EOB. QUESTIONS CALL 1-800-562-6136.

493 - THIS CLAIM OR LINE ITEM HAS BEEN DENIED. WHEN REBILLING, PLEASE RESUBMIT WITH INSURANCE DOCUMENTATION.

506 - AFTER TELEPHONE CONFIRMATION, INFORMATION ON THIS CLAIM OR LINE ITEM HAS BEEN CORRECTED TO FACILITATE PROCESSING.

516 - VERIFICATION WITH THE INS CO HAS RESULTED IN A DETERMINATION THAT THIS CLAIM CONTAINED A BILLING OR PROCESSING ERROR. CONTACT THE INS CO FOR BILLING QUESTIONS OR NEW BILLING PROCEDURES.

533 - THIS CLAIM IS BEING REVIEWED BY THE TPL UNIT.

536 - THIS IS A REFUND FOR A PAYMENT THAT WAS PREVIOUSLY RECOUPED BECAUSE OF THIRD PARTY INSURANCE.

537 - THIS IS A REFUND BECAUSE PAYMENT WAS RECEIVED FROM INSURANCE COMP

539 - YOUR CLAIM IS BEING RECOUPED DUE TO NON-COMPLIANCE WITH DSHS THIRD PARTY LIABILITY REQUIREMENTS.

541 - THIS CLAIM HAS BEEN PAID BECAUSE THERE WAS NO INDICATION ON THE MEDICAL COUPON OF THE HEALTH MAINTENACE ORGANIZATION COVERAGE FOR THE DATES OF SERVICE.

551 - REVIEW OF THE CLAIM AND EOB HAS RESULTED IN DENIAL. THE CLAIMS BILLED AMOUNT, INSURANCE PAID AMOUNT OR OTHER DOLLAR AMOUNTS DO NOT MATCH THOSE ON THE EOB. QUESTIONS CALL 1-800-562-6136.

557 - THE INSURANCE PAYMENT THAT IS INDICATED ON YOUR CLAIM DOES NOT MATCH THE PAYMENT FIELD ON YOUR EOB. PLEASE REBILL WITH CORRECT AMOUNT. QUESTIONS CALL 1-800-562-6136.

558 - PAID IN ACCORDANCE WITH EOB, COVERAGE NOT IN EFFECT FOR DATE OF SERVICE. (DELETED)

570 - PAID IN ACCORDANCE WITH WAC 388-87-010 (10). CLAIM MAY BE REPROCESSED IF FUTURE INFORMATION IS RECEIVED.

585 - PLEASE BILL THESE SERVICES TO CRIME VICTIMS COMPENSATION PROGRAM, P O BOX 44520, OLYMPIA, WA 98504-4520.

586 - PLEASE BILL THESE SERVICES TO DEPT OF LABOR AND INDUSTRIES, P O BOX 44269, OLYMPIA, WA 98504-4269.

596 - THIS CLAIM HAS BEEN DENIED FOR OTHER REASONS IN ADDITION TO INSURANCE. THE INSURANCE PAYMENT EXCEEDS THE DSHS ALLOWABLE FEE THEREFORE, NO FURTHER PAYMENT IS DUE FROM THIS DEPT.

598 - YOUR PREMIUM PAYMENT HAS BEEN ADJUSTED AS THERE IS DUAL COVERAGE UNDER THE MANAGED HEALTH CARE PLAN

775 - INSURANCE PLAN NOT A RECOGNIZED CAPITATED PLAN. PLEASE REVIEW SECTION V OF GENERAL INFORMATION BOOKLET.

776 - PAID IN ACCORDANCE WITH VERIFIED CAPITATED PLAN.

784 - THE INSURANCE PAYMENT WAS NOT TRANSFERRED FROM BACKUP TO THE APPROPRIATE FIELD ON YOUR DSHS CLAIM FORM. PLEASE CORRECT AND RESUBMIT. IF QUESTIONS, PLEASE CALL 1-800-562-6136.

802 - THE CLAIM HAS MONEY ENTERED IN THE PAID FIELD. PLEASE REBILL INDICATING THE SOURCE OF PAYMENT. IF FROM AN INSURANCE COMPANY, ATTACH AN EOB. DO NOT ENTER DSHS PAST PAYMENTS AS CREDIT(S) ON CLAIMS. TRP 1-800-562-6136.

821 - LABOR AND INDUSTRIES PAYMENTS CONSIDERED PAYMENT IN FULL.

872 - THIS CLAIM HAS BEEN RECOUPED DUE TO DEERS ELIGIBILITY BEING RE-ESTABLISHED. PLEASE CONTACT OR REBILL THE THIRD PARTY INSURANCE CARRIER FOR PAYMENT OF THIS CLAIM.

944 - OUR RECORDS INDICATE THE PATIENT HAS RECEIVED A SETTLEMENT OR PAYMENT FROM THE INSURANCE COMPANY. PLEASE CONTACT THE PATIENT FOR PAYMENT. IF QUESTIONS, PLEASE CALL 1-800-562-6136.

973 - INTEREST PAYMENT.

974 - THE INSURANCE EOB DOES NOT CORRESPOND TO THIS CLAIM. PLEASE RESUBMIT WITH CORRECT EOB ATTACHED.

977 - THE INSURANCE EOB DOES NOT CONTAIN THE DENIAL CODE WITH THE PRINTED DENIAL REASON. UNABLE TO PROCESS.

978 - RECOUPED AT PROVIDERS REQUEST.

980 - NO INSURANCE EOB ATTACHED. RESUBMIT AND ATTACH A COPY OF THE RA AND INSURANCE EOB.

981 - NOT A VALID INSURANCE DENIAL.

982 - INSURANCE COMPANY'S REQUESTS MUST BE MET.

987 - THE INSURANCE PAYMENT HAS BEEN TRANSFERRED FROM BACKUP TO CLAIM, BY DSHS. THIS PROCESS WILL BE DISCONTINUED EFFECTIVE WITH DATES OF SERVICE 3/1/94 AND YOUR CLAIM WILL BE DENIED. IF QUESTIONS PLEASE

CALL 1-800-562-6136, EXT. 664-9593. (DELETED)

TPR TYPE OF INSURANCE CODES

A - CASUALTY - HOMEOWNERS
B - CASUALTY - AUTOMOBILE
C - CASUALTY - MALPRACTICE
D - CASUALTY - PRODUCTS LIABILITY
E - CASUALTY - OTHER
F - VETERANS
G - PREMIUM PAYMENT SCREEN
H - L & I
I - HEALTH INSURANCE NORTH
J - CRIME VICTIMS
K - VICTIM ASSISTANCE
L - NURSING HOME
M - POINT OF SALE
N - HEALTH INSURANCE-SOUTH
O - PROJECTS
P - MEDICARE
Q - MEDICARE/SUR
R - REVENUE CASUALTY
S - OSE
T - PROBATE
U - SUPPORT
V - SPECIAL NEEDS TRUST
W - REV IRS/FB

TPR HEALTH/MEMOS AND MISC INFORMATION

REQUESTS FOR MEDICARE EOMB'S

DUE TO COST-EFFECTIVENESS AND PROVIDER RELATIONS, REQUESTS FOR MEDICARE EOMB'S FROM PROVIDERS IS LIMITED TO SERVICES PROVIDED WITHIN THE LAST YEAR AND ONLY IF THE TOTAL DOLLAR AMOUNT IS $75.00 PER PROVIDER.ANYTHING LESS THAN $75.00 OR SERVICE DATES MORE THAN ONE YEAR OLD WILL BE WRITTEN OFF.

MEDICARE SUPPLEMENTAL POLICIES - COVERAGE CODING

DO NOT LOAD CLAIM TYPE CODES J & P ON MEDICARE SUPPLEMENTAL POLICIES (E1 & E2). WE SHOULD CONTINUE LOADING THEM ON P GRANTS (DISABLED),UNLESS IT HAS BEEN VERIFIED THAT THE COVERAGE IS A MEDICARE SUPPLEMENT.

ALSO LOAD J & P CLAIM TYPES ON HM POLICIES AS SOME NON COVERED MEDICARE SERVICES MAY BE COVERED BY MANAGED CARE PLANS.

GOOD CAUSE
(SUPPORT OBLIGATIONS AND TPR SCREEN)

"GOOD CAUSE" RULES ONLY APPLY WHEN THERE IS AN ABSENT PARENT INVOLVED.IF "OSE/TPL GOOD CAUSE ESTABLISHED" IS MARKED "YES" ON THE 14-194, YOU CAN ASSUME IT HAS BEEN APPLIED FOR. YOU NEED TO FOLLOW UP WITH THE LOCAL OFFICE OR CHECK SEMS TO SEE IF IT WAS GRANTED. (FORMAL NOTIFICATION OF

GOOD CAUSE)

TO GET INFORMATION OFF OF SEMS REGARDING GOOD CAUSE, LOOK FOR "AR COOP STATUS" IN THE BASIS CASE SCREEN ON THE RIGHT, UNDER "MED.SUP.INFOR".

A. A 2 IS A LEVEL A GOOD CAUSE
   A. DO NOT BUILD A TPL SCREEN - SEMS WILL NOT OPEN A FILE.
      BUILD AN INFORMATION-ONLY SCREEN.(THE AP IS A DANGER)

B. A 7 IS A LEVEL B GOOD CAUSE.
   A. OK TO BUILD A TPL SCREEN-SEMS WILL PURSUE(AP IS NO DANGER)

NURSING HOME INSTRUCTIONS

WHEN BUILDING NEW RESOURCE SCREENS-ANY CLIENT ON AN A,B,P,X,U PROGRAM (INCLUDING HM'S),SHOULD HAVE A SEPARATE POST PAY T SCREEN WITH TOI L. -- (EXCEPTION GE01)

SPECIAL NOTES: ALL AARP AA03 RESOURCE NEEDS A SEPARATE POST PAY T TOI L.
FEDERAL RESOURCE-BUILD A SEPARATE BC02 POST PAY T TOI L.
SKILLED NURSING FACILITY BENEFITS WERE NON-EXISTENT PRIOR TO 1/1/94.THEREFORE,T SCREENS WOULD NOT HAVE EFFECTIVE DATES PRIOR TO 1/1/94.

HM'S-ON ALL A,B,P,X,U PROGRAMS, BUILD A SEPARATE POST PAY T TOI L. -- (EXCEPTIONS HM01, HM65) THESE HM T SCREENS CAN BE BUILT BACK TO THE FILING LIMIT OR THE 1 YEAR. HM CII'S WILL BE GENERATED.

DO NOT PUT E1 ON ANY T NURSING HOME SCREENS.
HO50 - WHEN BUILDING SCREEN FOR UNIFORM PLAN BUILD "T" UNDER UM08.

PREMIUM PAYMENT ISSUES

1.THE PREMIUM PAYMENT SPECIALISTS (PPS) WILL DETERMINE THE FEASIBILITY OF PURCHASING POLICIES.

2.THE HICT UNIT WILL PROCESS THE PREMIUM ADJUSTMENTS AND CLAIMS FOR WITH THESE POLICIES. INFORMATION FROM INSURANCE EOB'S ABOUT NON-COVERED SERVICES (IE VISION SERVICES NOT COVERED) WILL BE CODED WITH THE APPROPRIATE TPL CODES BY HICT. HICT WILL FORWARD DENIED CLAIMS AND DENIED ADJUSTMENTS TO THE CASE MANAGERS FOR THEIR REVIEW.THE CASE MANAGERS WILL REVIEW THE PERTINENT NON-COVERED SERVICES(IE CANCER DX NOT COVERED) OR MAXED BENEFIT NOTATIONS (LIFE TIME BENEFITS HAVE BEEN REACHED).IF IT APPEARS THAT THE EOB INFO COULD INFLUENCE THE DECISION TO CONTINUE PAYMENT OF THE PREMIUMS, IT SHOULD BE REFERRED, IN WRITING, TO THE APPROPRIATE PPS.THEY WILL RESEARCH AND DECIDE WHETHER TO CONTINUE COVERAGE.

3.IF THE PPS DETERMINE THAT THEY SHOULD TERMINATE PREMIUM PAYMENTS,AND THERE IS AN OPEN FILE,THEY WILL TERM THE SCREENS USING THE V1O CODE AND SEND A WRITTEN FYI NOTE TO THE CASE MANAGER

4.INQUIRIES CONCERNING THE ADJUDICATION OF V9 CLAIMS WILL BE HANDLED

BY THE CASE MANAGERS IN THE HEALTH UNITS.THEY MAY NEED TO CODE THE TPL MASTER FILE WITH TPL CODES AND WRITE AN FYI NOTE TO THE PPS CONCERNING NON-COVERED SERVICES.

5. INQUIRIES CONCERNING PREMIUM PAYMENTS, COST EFFECTIVENESS, ETC, WILL BE HANDLED BY THE APPROPRIATE PPS.
6. QUALITY CHECKS OF TPL MASTER FILE SCREENS WILL BE DONE TO ASSURE THE CORRECTNESS OF THE SCREENS, AND THE COST EFFECTIVENESS OF THE PREMIUM PAYMENT.

INFORMTION TO REMEMBER WHEN BUILDING TPR SCREEN

WHEN RETRO POSTING INSURANCE SCREENS - POST BACK 1 YEAR UNLESS CARRIER CODE LISTING NOTES STATE OTHERWISE. (ACTUALLY 11 MONTHS FOR NEXT CII GENERATION)

EMERGENCY FILLS ON PRESCRIPTIONS

PHARMACIES CAN BILL FOR PATIENTS WHO ARE IN A NURSING HOME, WHEN THEY HAVE A MANAGED CARE POLICY, THE PROVIDER NEEDS TO BILL FOR A "3-DAY EMERGENCY SUPPLY".

IF THE CLIENT IS FILLING A PRESCRIPTION AFTER OUR TOLL-FREE HOURS OR IS TELLING THE PROVIDER THERE HM COVERAGE HAS ENDED, THE PROVIDER CAN FILL THE PRESCRIPTION ON AN EMERGENCY BASIS, INDICATING EMERGENCY SUPPLY. THIS WILL ALLOW THE PROVIDER TIME TO VERIFY WITH TPR.

DELETING OR CLEANING UP SCREENS

YOU MAY DELETE TPL SCREEN IF:
1. INSURANCE IS TERMINATED AND
2. LAST TRANSACTION IS OVER 2 YEARS AND
3. THERE IS NO ARCHIVE DATE.

YOU CAN DELETE A TPR SCREEN BY ENTERING A .(PERIOD) IN THE STATUS FIELD AND HITTING ENTER TWICE. BE VERY CAREFUL WHEN DELETING SCREENS AS THE RESOLUTION IS UPDATED SIMULTANEOUSLY.

CAPITATED CO-PAYS

WHEN THE PROVIDER INDICATES THEY ARE BILLING SERVICES FOR A RECIPIENT WHO IS COVERED BY A CAPITATED INSURANCE PLAN, TPR MAY PROCESS THE CO-PAYMENT WITH EOB 776- FORCE. (A CO-PAYMENT BILLING WILL BE REFLECTED BY THE USE OF A "G" INDICATOR IN THE DESIGNATED FIELD TO INDICATE CO-PAY.)

IF THE PLAN IS NOT A RECOGNIZED CAPITATED PLAN TPR WILL DENY-USE EOB 775

IF THE PROVIDER IS TRYING TO BILL FOR MORE THAN AN EXCEPTED (CO-PAYS CAN VERY PER INSURANCE PLAN, USUALLY AMOUNTS WILL BE EVEN I.E. $5.00) CO-PAY AMOUNT, DENY WITH EOB 290.

IF THE PROVIDER INDICATES A "NON-COVERED SERVICE" OR "LESS THAN CO-PAY" PAY WITH EOB 220.

ANY SPECIAL CIRCUMSTANCES THAT ARISE SHOULD BE PROCESSED WITH THE APPROVAL OF MANAGEMENT.

HOSPICE

HOSPICE IS A FORM OF CARE FOR TERMINALLY ILL CLIENTS THAT FOCUSES ON COMFORT RATHER THAN CURE. HOSPICE IS AN ALL ENCOMPASSING CARE, PROVIDING AND ARRANGING FOR ALL SERVICES RELATED TO THE TERMINAL DIAGNOSIS. THIS INCLUDES ALL PHYSICAL, PSYCHOLOGICAL AND SPRITUAL NEEDS OF THE CLIENT AND EMOTIONAL NEEDS OF THE CLIENTS FAMILY.

ONCE A CLIENT ELECTS HOSPICE, THE HOSPICE AGENCY NOTIFIES THE MAA HOSPICE COORDINATOR. UPON NOTIFICATION, THE HOSPICE AGENCY AND ATTENDING PHYSICIAN PROVIDER NUMBERS ARE PLACED IN THE MMIS 09 SCREEN PAGE 5, ALONG WITH THE BEGINNING AND ENDING DATES OF HOSPICE COVERAGE. THIS INFORMATION INFORMS CLAIMS PROCESSING TO RESTRICT REIMBURSEMENT. WHEN THE MMIS IS UPDATED, THE NEXT MEDICAID CARD PRINTED SHOULD HAVE THE HOSPICE INDICATOR ON IT.

THE HOSPICE AGENCY AND ATTENDING PHYSICIAN ARE THE ONLY PROVIDER ABLE TO BE REIMBURSED FOR SERVICES RELATED TO THE TERMINAL DIAGNOSIS ONCE THE MMIS INFORMATION HAS BEEN ENTERED. ALL OTHER PROVIDERS WILL BE DENIED.

FOR THE TIMEFRAME THAT THE CLIENT IS ON THE HOSPICE BENEFIT, THE HOSPICE AGENCY IS PAID A DAILY RATE AND WILL PROVIDE ALL SERVICES RELATED TO THE TERMINAL DIAGNOSIS. SOME EXAMPLES OF COMMON SERVICES ARE HOME HEALTH NURSING VISITS, HOME HEALTH AIDE VISITS, THERAPY VISITS, PRESCRIPTIONS, DME, SOCIAL SERVICES, COUNSELING, ETC.

CURRENTLY MEDICARE AND MEDICAID ARE UNIQUE IN PROVIDING "HOSPICE" BENEFITS. OTHER INSURANCE COMPANIES USUALLY PAY FEE FOR SERVICE SEPERATELY. SINCE OTHER INSURANCE COMPANIES VARY SO GREATLY FROM MEDICAID, IT WOULD BE COMMON FOR TPL TO SEE DENIALS TO HOSPICE AGENCIES FOR SEPERATE SERVICES. ALSO WHAT WE DO SEE BILLED TO AN INSURANCE CO MAY NOT AND MOST LIKELY WILL NOT MATCH WHAT IS BILLED TO MAA. MOST HOSPICE AGENCIES WILL EXHAUST ALL OTHER RESOURCES BEFORE BILLING MEDICAID.

MISC INFORMATION

1.KAISER HAS DRUG COVERAGE, DEPENDING ON EMPLOYER GROUP COVERAGE. THEY DO ACCEPT DSHS COUPONS. THE PHARMACY IS IN THE KAISER FACILITY.

2.EXAMINERS SHOULD BE PUTTING CLAIM TYPES V,O AND W ON "P" AND "A" PROGRAM RECIPIENTS.

3.WHEN TERMING SCREENS, BE SURE AND TERM MEDICAL, DENTAL, RX AND VISION SCREENS. ALSO CHECK ALL FAMILY MEMBERS FOR TERMINATION.

4. CALLS FOR ASU (AUTHORIZATION SERVICES UNIT)
ASK THE PROVIDER TO CHECK THEIR BILLING INSTRUCTIONS TO DETERMINE WHICH NUMBER TO CALL. PAGE VIII-7. IT'S BEST IF THE PROVIDER CHOOSES WHICH NUMBER FOR THE SERVICE THEY ARE PROVIDING.

5. MULTIPLE TPR SCREENS - SCREEN THAT HAS THE MOST CLAIM TYPES WILL BE

FIRST. YOU NEED TO CHECK ALL SCREENS.

6. TAKE SPECIAL CARE IN PROCESSING HOME NURSING CARE(MED VENDORS). SCREENS SHOULD BE CODED WITH SPECIAL BENEFIT INSTRUCTIONS.

7. "RESTRICTED" ON COUPONS GO TO MACSC.

8. EOB 031 SHOULD BE IN THE 2ND (INFORMATIONAL) EOB. CAN USE ANY EOB FIELD IF 2ND IS NOT AVAILABLE.

9. "CANCER ONLY POLICIES" - DO NOT BUILD SCREENS UNLESS WE FIND OUT THE PATIENT HAS CANCER. DO INFO ONLY SCREEN AND NOTE "THIS PATIENT HAS BEEN DIAGNOSED WITH CANCER".

10. AARP INDEMNITY PLAN."BY LAW YOUR ACCEPTANCE OF MEDICAL ASSISTANCE DIRECTS THAT WE AUTOMATICALLY ASSIGN BENEFITS TO THE PROVIDER OF SERVICE". THIS EOB MEANS THE INSURANCE IS AWARE THAT THE PATIENT IS ON PUBLIC ASSISTANCE AND HAS ASSIGNED THE BENEFITS TO THE PROVIDER. WE WILL BUILD A TPR SCREEN, BUT WILL NOT PURSUE IF THE INSURANCE INDICATES THE SUBSCRIBER HAS BEEN PAID.

11. WHENEVER BUILDING SCREENS,BE SURE TO ENTER THE GROUP NUMBER AND THE EMPLOYER IF YOU HAVE IT.

12. WE DO NOT BUILD SCREENS FOR THE VETERAN'S ADMINISTRATION BUT, IF A PROVIDER SENDS US A REFUND OR ASKS US TO RECOUP WE WILL PROCESS. ALTHOUGH YOU CAN BUILD AN INFORMATIONAL SCREEN VE02.

13. PPO MEANS PREFERRED PROVIDER OPTION-THE PATIENT HAS THE "OPTION" TO USE A PREFERRED PROVIDER IN WHICH CASE THE PATIENT IS RESPONSIBLE FOR A SMALLER AMOUNT OR GO TO ANY PROVIDER AND PAY MORE. THIS IS ALSO SOMETIMES REFERRED TO AS POINT OF SALE PLANS.

WHEN BUILDING TPR SCREENS, THIS LIST MAY BE HELPFUL TO REVIEW. PLEASE BE WARE THIS IS A GENERAL LIST AND CANNOT COVER EVERY SITUATION.

TYPE OF INSURANCE PLAN-CODING

TYPE OF PLAN	PRE PAY CLAIM TYPES	POST PAY	SEPARATE SCREEN
RETIREMENT, A,B,P,U,& X (PROGRAM CODES)	MRSJPVOWK	D	T(TOI L)
GENERAL	MRSJPLVOW	D	
GENERAL W/DENTAL	MRSJPLVOWK	D	
HM PLANS (NO T ON HM01 OR HM65)	MRSJPLVOWD		T(TOI L)
MEDICARE SUPPLEMENTAL ADD D IF AVAILABLE ON PLAN.	MRSVOW		T(TOI L) (DO NOT ENTER E1)

HM99 SCREEN	NO CODES OPEN EFFECTIVE DATES LIST THE ACTUAL PLAN CARRIER CODE IN THE POLICY NUMBER FIELD. HM99 DOES NOT FLAG FOE PCOP

ELIGIBILITY.

INDEMNITY (HOSPITAL)	SRV
CANCER ONLY	NO COVERAGE CODES*(SEE PAGE 3)
VETERAN ADMIN POLICY	NO COVERAGE CODES*(SEE PAGE 3)
ACCIDENT ONLY POLICY	DIRECT RESOURCE TO CASUALTY-SEE 998 TEXT FILE
VISION ONLY	I ON INCLUDE PROVIDER TYPE PREPAY 28/29
VISION/DENTAL ONLY	I ON INCLUDE PROVIDER TYPE PREPAY 27/28/29

ON PLANS WHERE "I ON INCLUDE"IS USED DO NOT ENTER CLAIM TYPES IN THE PREPAY OR POSTPAY CODE FIELDS

USE THE POLICY NUMBER, GROUP NUMBER, NAME OF INSURED, SSN # POLICY HOLDER FIELDS ONLY FOR THEIR INTENDED USE. THE FOLLOWING FIELDS WILL PRINT ON THE REMITTANCE ADVICE:INS CARRIER NAME AND ADDRESS, POLICY NUMBER, SSN#, AND NAME OF INSURED. FOR NON-COVERED SERVICES PLEASE USE YOUR TPR CODE LIST AND USE TPR-CDS FIELD ON THE MASTER FILE, IF MORE ROOM IS NEEDED USE MEMBERSHIP FIELD.

PLEASE READ ALL CARRIER CODES FOR SPECIAL INSTRUCTIONS AND FILING LIMITS. PLEASE SEE THE CARRIER CODE SPECIALIST FOR ANY CARRIERS THAT SEEM PROBLRMATIC OR HAVE SPECIAL OR UNUSUAL INSTRUCTIONS.

FYI INFORMATION

USE MENU 07 TO LOOK UP CARRIER BY CODE OR NAME. DO NOT USE A CARRIER THAT HAS AN * BEFORE THE CARRIER NAME AS THIS INDICATES CARRIER TO BE A CROSS REFERENCE ONLY, AND NEW SCREENS ARE NOT TO BE BUILT WITH THESE CODES.

AN * AFTER THE CARRIER NAME INDICATES SPECIAL INSTRUCTIONS AND/OR FILING LIMITS. READ COMMENTS FOR ANY SPECIAL SITUATIONS LIKE DIFFERENT DENTAL, PHARMACY, VISION, OR OTHER CARRIERS. SOME CARRIERS WILL HAVE COMMENTS ABOUT NON-COVERED SERVICES OR CIRCUMSTANCES SPECIAL TO THEIR COVERAGE.

THERE ARE CURRENTLY TEN MASTER FILE SCREENS. WHEN BUILDING SCREENS IF ALL TEN SCREENS ARE BEING USED AND NONE CAN BE DELETED, T FOR NURSING HOMES CAN BE ADDED TO APPROPRIATE MEDICAL SCREENS. SEE SPECIAL INSTRUCTIONS IN THE 998 TEXT ON HOW AND WHEN TO DELETE SCREENS.

IF LACKING INFORMATION TO BUILD A SCREEN, YOU MAY WANT TO CALL THE INSURANCE CO, OR CHECK YOUR "SEO-CC", "THE EMPLOYER DEX", "CARRIER CODES ON YOUR DESKTOP OR ROLLERDEX. THEN IF NO SUCCESS YOU CAN SEND A PIQ. DO NOT BUILD A SCREEN UNTIL YOU HAVE A SSN, UNLESS INSURANCE COMPANY DOES NOT REQUIRE SSN TO ID.

BEGIN DATE OF COVERAGE- IF NO BEGIN DATE OF COVERAGE LISTED, CHECK THE CARRIER CODE FILING LIMIT. IF NO FILING LIMIT LISTED, USE BEGIN DATE OF 11 MONTHS PRIOR TO CURRENT DATE. (EXCLUDE HM CARRIERS)

ENDING DATE OF COVERAGE- IF NO END DATE GIVEN USE 999999.

USE TPR-CD C8 WHEN NON-COVERED SERVICES ARE LISTED ON THE CARRIER CODE FILE.

MEDICARE SUPPLEMENT POLICIES ONLY COVER THE DEDUCTIBLES, & CO-INSURANCE LEFT AFTER MEDICARE PAYS.

PLEASE READ ALL CARRIER CODES FOR SPECIAL INSTRUCTIONS AND FILING LIMITS.

CANCER SCREENS ARE CODED WITH R1, TO INDICATE A CANCER ONLY POLICY, NO CLAIM TYPES WILL BE ENTERED. IF THE CLIENT IS DIAGNOSED WITH CANCER, CHANGE THE CODE TO R6 AND ADD CLAIM TYPES.

CONFIDENTIALITY

SHARING OF INFORMATION BETWEEN INSURERS FOR PURPOSES OF MEDICAL COORDINATION OF BENEFITS INFORMATION IS SPECIFICALLY EXCLUDED FROM THE FEDERAL PRIVACY ACT.

NURSING HOME

WHEN BUILDING HEALTH INSURANCE SCREENS ON A, P, U, X, AND B PROGRAMS, ALSO BUILD A SEPARATE NURSING HOME SCREEN. (EXCEPTIONS BEING HM01 GE01 AND HM65).

THE NURSING HOME SCREENS ARE BUILT THE SAME AS THE HEALTH SCREEN EXCEPT FOR THE FOLLOWING:
1. HM'S CAN BE BACKDATED ON NURSING HOME SCREENS TO THE FILING LIMIT OF THE INSURANCE CARRIER.
2. DO NOT ENTER E1 ON THE NURSING HOME SCREEN. (THE NURSING HOME CASES UTILIZE SEPARATE TPL CODES.)
3. T CLAIM TYPE WILL ALWAYS BE POSTPAY.
4. TOI (TYPE OF INSURANCE) WILL BE AN L.

WHEN TERMINATING A HEALTH SCREEN, ALSO TERMINATE THE NURSING HOME SCREEN.

THE ARCHIVE DATE ON A NURSING HOME SCREEN IS SPECIFIC TO THE NURSING HOME COVERAGE. THERE MAY BE A CURRENT STATUS ON THE HEALTH SCREEN, OR A DIFFERENT ARCHIVE DATE, THE TWO MAY BE ENTERED SEPARATELY.
IF THE RESOURCE DOCUMENT CONTAINS INSURANCE INFORMATION FOR ONLY SKILLED NURSING COVERAGE, THE COMPLETE DOCUMENT CAN BE GIVEN THE NURSING HOME CASELOAD DESK.

THE NURSING HOME CASE MANAGER BUILDS THE HEALTH SCREEN WHEN RESOURCE IS DISCOVERED FROM A TAD (TURN AROUND DOCUMENT),AWARD LETTER,PROVIDERS OR OTHER SOURCES.

FEDERAL EMPLOYEES FYI

ALL FEDERAL PLANS IDENTIFY WITH AN INDIVIDUAL NUMBER THAT BEGINS WITH AN R. IF CONVERTED TO A SSN FIELD THE R WILL BE REPLACED WITH AN 8 (THIS WOULD BE ON AN EOB).

THERE IS NO VISION (OTHER THAN MEDICAL DIAGNOSIS) FOR ANY FOR ANY FEDERAL PLANS- CODE A1.

THERE ARE NO MEDICARE SUPPLEMENTAL PLANS FOR FEDERAL EMPLOYEES.

ALL HOSPITAL CHARGES ARE TO BE BILLED TO BC02, INPATIENT AND
OUTPATIENT CHARGES.

ACCIDENT POLICIES ONLY

CASUALTY SHOULD RECEIVE A RESOURCE FROM THAT INDICATES ACCIDENT ONLY.
IF THE COMPANY IS ONLY FOR ACCIDENT POLICIES THE RESOURCE FORM CAN GO TO
DIRECTLY TO CASULTY. THEY WILL BE WORKING WITH CARRIER CODE PERSON
TO ESTABLISH A CASULTY CARRIER CODE FOR THESE INSURANCE COMPANIES.
IF THE INSURANCE COMPANY HAS MANY DIFFERENT PLANS, THE HEALTH
EXAMINER WILL VERIFY WHAT TYPE OF PLAN, AND IF IT IS VERIFIED TO
BE AN ACCIDENT ONLY POLICY, THE HEALTH EXAMINER WILL MAKE NOTE ON
THE RESOURCE FORM ANDF DIRECT THE RESOURCE FORM TO CASULTY.

CASULTY WILL ENTER THE INFORMATIONAL ONLY SCREEN WITH A CASULTY
CARRIER CODE AS REFERENCE ONLY, SAME TO AND FROM DATE OF COVERAGE, WITH
NO CLAIM TYPES. THEY WILL AWAIT ANY ACCIDENT CLAIMS THAT ARE POSTED BY
DIAGNOSIS.

CASUALTY

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TYPE OF INSURANCE

CODE	SHORT DESCRIPTION	LONG DESCRIPTION
A	HOMEOWNERS (PREMISE LIABILITY)	CASUALTY - HOMEOWNERS
B	AUTOMOBILE	CASUALTY - AUTOMOBILE
C	MALPRACTICE	CASUALTY - MALPRACTICE
D	PRODUCT LIABILITY	CASUALTY - PRODUCT LIAB.
E	CASUALTY OTHER	CASUALTY - OTHER
F	VETERANS	VETERANS
G	PATERNITY	PATERNITY
H	L & I	CASUALTY - L&I
J	CRIME VICTIMS	CRIME VICTIMS - STATE
K	VICTIM ASSISTANCE	VICTIM ASSISTANCE-PA REST
L	LONG TERM CARE	LONG TERM CARE
N	HEALTH INSURANCE	HEALTH INSURANCE
P	MEDICARE	MEDICARE
Q	MEDICARE / SUR	MEDICARE
S	OSE	OSE
T	PROBATE	PROBATE
U	SUPPORT	SUPPORT
R	CASUALTY PROJECT	PROJECT

I REVENUE-HEALTH STATUS

0	CASUALTY FILE
2	HEALTH INSURANCE FILE
3	L & I, RESTITUTION OR DFR FILE
4	PAY CARD MADE/NO FILE/$ APPLIED
5	CASH CONTROL - MONTHLY PAYMENTS
BLANK	NO FILE
N	NURSING HOME FILE
A	REFERRED TO OFR - CASUALTY
B	REFERRED TO OFR - HEALTH

COVERAGE SOURCE CODES

A	LOCAL OFFICE
B	DATA MATCH (PRIVATE SECTOR) AP RELATED
C	PROVIDER
D	CLIENT
E	EMPLOYER
F	ABSENT PARENT
G	INSURANCE COMPANY
H	ATTORNEYS, AAG, PROSECUTING ATTORNEY
I	CRIME VICTIMS - VICTIMS ASSISTANCE
J	DATA MATH 2 (GOVERNMENT SECTOR) AP RELATED
K	COB DISCOVERED
L	OSE
M	SSA
N	COURT REFERRAL
O	DATA MATCH AR RELATED
P	DATA MATCH STATE EMPLOYEE AR RELATED
Q	LOCAL OFFICE AP RELATED
R	PROVIDER AP RELATED
S	CLIENT AP RELATED
T	EMPLOYER AP RELATED
U	CONTRACTOR CONVERTS TO V
V	CONTRACTOR
W	BHP/MEDS
X	MACSC/ENROLLMENT UNIT
Y	OSE INTERMEDIATE FILE SCREENS
Z	OSE - CONTROL GROUP

TYPE OF INSURANCE CODES		TYPE OF COVERAGE	
HEALTH (I) NORTH (N) SOUTH.		REGULAR INSURANCE	1
SUPPORT ENFORCEMT	S	CASUALTY	2
A/P RELATED OBTAINED BY TPL	U	WHEN PCOP FLAGS OFF RESOURCE	3
LONG TERM NURSING HOME	L	BLDG SCREEN FROM NOTICE PLAN	4
POINT OF SALE	M		
PROJECTS -	O		
SPECIAL NEEDS	V		

TYPE OF COVERAGE
1 - PREPAY
2 - POSTPAY
- CLAIM TYPES -

D	DRUGS

J PHYSICIANS
K DENTAL
L EPSDT
M OUT PATIENT
O NON INSTITUTION CROSS-OVER
P MEDICAL VENDOR
R DRG
S IN PATIENT
T NURSING HOME
V IN PATIENT CROSS-OVER
W OUT PATIENT CROSS-OVER

NAME	PHONE NUMBER
AAA - LOS ANGELES	(213) 741-3111
AAA - OLYMPIA	(360) 357-5561
AAA - SPOKANE	(509) 455-3400
AAA - TACOMA	(253) 756-3044
AETNA - SOUTHERN WASHINGTON	(360) 694-5130
FARMERS - LOS ANGELES	(213) 932-3200
MEDICARE - COB	(800) 999-1118

M.S.P. CLAIMS INVESTIGATION PROJECT
PO BOX 5041
NEW YORK, NY 10274-0125
ATTORNEYS NEED TO SEND A LETTER TO THE ABOVE ADDRESS AND INCLUDE ALL INFO THAT THEY HAVE REGARDING THE CLAIM. OUR CONTACT AT THE SEATTLE OFFICE IS KATHY (425) 670-4453 IF WE HAVE QUESTIONS OR PROBLEMS.THEIR ADDRESS IS:MEDICARE,M.S.P. SUROGATION,PO BOX 2847,SEATTLE 98111-2847

MID CENTRURY - SEE FARMERS	
SAFECO - TACOMA	(253) 759-1712
SPOKANE TRANSIT AUTHORITY	(509) 325-6000
(GAB BUSINESS ERVICES HANDLES CLAIMS)	
WASHINGTON MUTUAL SAVINGS BANK	(206) 646-1800
HAS J.P. DORR FORBES INS CO.	(206) 461-2568
FRED MEYER & PAYLESS INSURED THRU: SELF INSURED MANAGEMENT SERVICES	(206) 753-5161

WASHINGTON STATE PATROL ACCIDENT RECORDS UNIT
P.O. BOX 42628 OLYMPIA, WA 98504-2628

ELAINE NOLAN, SUPERVISOR 923-2920

SOCIAL SECURITY ADMINISTRATION
ATTN: DOUG MCSWEYN
SUITE 2900, MS 303A
701 5TH AVENUE
SEATTLE, WA 98104-7075

FARMERS BCD NUMBERS

B6 - KIRKLAND - CARRIER CODE 03FE
F6 - EVERETT - CARRIER CODE 03FC
13 - SEATTLE NORTH - CARRIER CODE 03FF
67 - SEATTLE SOUTH - CARRIER CODE 03FG
14 - SPOKANE - CARRIER CODE 03FL

32 - TACOMA - CARRIER CODE 03FI
26 - YAKIMA - CARRIER CODE 03FN
X2 - AUBURN - CARRIER CODE 03FX
A3 - VANCOUVER - CARRIER CODE 03FJ
C9 - KENNEWICK - CARRIER CODE 03FK
F5 - EVERETT - CARRIER CODE 03FC
BB - MERCER ISLAND - CARRIER CODE 09FV

CASUALTY MISC INFORMATION

1. IN ORDER TO DENY 320/325 EXCEPTION, CREATE A 116 EXCEPTION BY KEYING AN X IN THE LMC FIELD AND ENTERING. WHEN THE 116 EXCEPTION POST, DENY IT WITH THE APPROPRIATE EOB AND FORCE/DENY THE 320/325 EXCEPTIONS.

2. FRAUD UNIT DIRECT # 438-8111 MAIL STOP 45818

TPL/CASUALTY CODES

CC L&I CLAIM CLOSED (W/DATE)
CD L&I CLAIM DENIED
CO L&I CLAIM OPEN
CR L&I CLAIM REJECTED
1A CHRONIC CONDITION, VERIFIED BY MCE (1A CJB)

CSO 072 AUBURN CSO MS N72-1
CSO 127 REGION 6 CALL CENTER MS 45448 1-877-980-9180
CSO 128 REGION 2 CALL CENTER MS 39-21 1-877-980-9140

CSO 129 MATTAWA CSO - PO BOX 1278, MATTAWA WA 99349
CSO 130 WASHCAP MS 45446

CSO 127 REGION 6 CALL CENTER MS 45448 1-877-980-9180
CSO 128 REGION 2 CALL CENTER MS 39-21 1-877-980-9140
CSO 129 MATTAWA CSO -PO BOX 1278, MATTAWA,WA 99349
CSO 130 WASHCAP MS 45446
CSO 131 REGION 5 CALL CENTER MS N 27-9 (253) 476-7300

TEXT KEY TEXT DESC
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NOTE: INCLUDES EXAM ENTRY, RESOLUTIONS AND ADJUSTMENTS.

-- THINGS TO REMEMBER --

01 WHEN A CLAIM WITH A PROVIDER NUMBER NEEDS TO BE DELETED OUT OF THE BATCH AND REPROCESSED (I.E., DENTAL, DRUG OR HOSPITAL CLAIM IN A PHYSICIANS BATCH) - DENY CLAIM WITH EOB 333. IF YOU NEED TO CREATE A HEADER LEVEL EXCEPTION TO DENY THE CLAIM, PUT AN X IN LMC APPROVAL FIELD AND EXCEPTION 116 WILL POST; THEN DENY 116 WITH EOB 333 (ALSO DENY ANY OTHER SUPER SUSPENDS). IF CLAIM SHOULD BE PROCESSED THROUGH ANOTHER OFFICE, IE: DISABILITY, L&I, WIN DENY WITH EOB 968 & ROUTE CLAIM TO PROPER AGENCY. SEE 000 FOR ADDRESSES.

02 CLAIMS WITH MISSING/INVALID PROVIDER NUMBER
- ADJUDICATE PER 121/122/300/416 4-LINE -

A. ONLY KEY PERFORMING PROVIDER # IN PROVIDER FIELD IF IT IS THE ONLY NUMBER IN BLK 33. *G

B. MEDICARE X-OVERS (CLAIM TYPE O) MULTIPLE LINE CLAIM:
ENTER ONE LINE WITH OLDEST & NEWEST DOS,
NO PROCEDURE CODE, 1 UNIT, CLAIM TOTAL ON LINE & HEADER, AND
MEDICARE STATEMENT DATE. ADDRESS TIMELINESS (IE 758/546).
DENY ALL SUPER SUSPENDS.

C. ALL OTHER CLAIM TYPES:
IN ORDER TO CUT DOWN ON KEYING AND EXPEDITE PROCESSING, IT IS NOT NECESSARY TO KEY ALL LINES ON MULTIPLE LINE CLAIM. IF FASTER, ENTER ONE LINE, KEYING THE NEWEST & OLDEST DOS, NO PROCEDURE CODE, 1 UNIT AND CLAIM TOTAL. ADDRESS TIMELINESS ON THE SCREEN AS NEEDED (I.E. 758/018) --DENY ALL SUPER SUSPENDS--

03 IF TWO CLAIMS SHARE THE SAME ICN NUMBER, THE CLAIM THAT HAS NOT BEEN KEYED SHOULD BE REMOVED FROM THE BATCH & PUT IN THE RE-ICN SLOT.

04 BACKUP MATERIALS THAT ARE ICN'D AS CLAIMS (I.E. APPROVAL DOCUMENTS, ETC.) - DENY WITH EOB 968 USING PROVIDER NUMBER 9999905. ENTER DOS.

BE SURE TO DENY EXCEPTION 416 WHEN USING THIS PROVIDER NUMBER AND EOB. DENY ALL OTHER SUPER SUSPENDS.

05 WHEN NEEDED BACKUP DOES NOT HAVE THE SAME ICN AS CLAIM, DENY CLAIM WITH EOB 333. ATTACH NECESSARY BACKUP AND RESUBMIT ENTIRE CLAIM TO BE PROCESSED PRIORITY. EXCEPTION: IF THE CLAIM IS IN A CCIS BATCH WITH THE ICN ENDORSEMENT ON THE BACK, VERIFY IMAGE RETRIEVAL IS IN ART, THEN ADJUDICATE PER THE CORRESPONDING BACKUP AND USE F-7 CLAIM COMMENTS TO DOCUMENT THE CROSS-REFERENCED CLAIM ICN.

06 SUPERSUSPEND (1 IN EXCEPTION CODE INDICATOR) -- WHEN DENYING ENTIRE CLAIM, USE THE SUPERSUSPEND EXCEPTION. IT MAY BE NECESSARY TO USE ADDITIONAL EOBS. (REMINDER - ALL SUPERSUSPENDS MUST BE ADDRESSED)

07 PRU SPECIAL HANDLING - GREEN BATCH COVER:
O'LOC ALL CLAIMS IN THE BATCH TO LOCATION 81. KEY AS BILLED, AND DO NOT DENY ANY EXCEPTIONS UNLESS INSTRUCTED TO DO SO ON CLAIM. IF "S" OR "X" INDICATED, OR A STATEMENT ON THE CLAIM, PUT "S" IN THE LMC FIELD AND PA-2 116 EXCEPTION TO LOCATION 81.

08 OTHER SPECIAL HANDLING:
A. O'LOC ALL CLAIMS IN BATCH TO LOCATION 85 WITH AN "S" IN THE LMC FIELD.
B. PROCESS PER SPECIFIC INFORMATION ADDRESSED ON THE CLAIM. IF NOT SPECIFICALLY ADDRESSED ON THE CLAIM, POLICY WILL APPLY.
C. ADJUDICATE THE 116 EXC:
1. CLAIMS SUBMITTED BY MMIS OR THE MEDICAL CONSULTANTS - LEAVE EXCEPTION 116 SUSPENDING AND PA-2 FOR RES REVIEW.

2. CLAIMS THAT STATE "DO NOT DENY FOR ANY REASON" - LEAVE 116 EXC SUSPENDING TO STOP AND HAVE THE ORIGINATOR REVIEW.
3. ONLY UPON COMPLETION OF ALL CLAIMS PROCESSING ISSUES, FORCE EXCEPTION 116.

RES - WORK ALL AUDITS TAKING INTO ACCOUNT ANY SPECIAL INSTRUCTIONS FIRST & ONLY FORCE EXCEPTION 116 UPON COMPLETION OF ALL CLAIMS PROCESSING ISSUES. CLEAR LOC 85 IF CLAIM NEEDS TO GO TO NEW LOC (I.E. TPL).

09 CLAIMS IN A REGULAR BATCH WITH PRU EXAMINER NAME, NUMBER, OR INITIALS THAT WILL BE DENIED FOR ANY REASON - WORK AS NORMAL & MAKE COPY. ON COPY NOTE ACTION TAKEN & ROUTE TO PRU, MAIL STOP 45562.

10 FAIR HEARING CLAIMS - OVERLOC TO LOCATION 81, UNLESS PRU/ASU ACTION IS NOTED ON THE CLAIM, OR IF INSTRUCTIONS ARE UNCLEAR. IF APPROVED BY PRU/ASU/MHCRA, OVERCODE CLAIM 998.

11 EXCEPTION TO POLICY, (ETP), LIMITATION EXTENSIONS, APPROVAL REQUESTS:
A. THIS DOES NOT INCLUDE REQUESTS TO OVERRIDE TIMELINESS - THESE REQUESTS SHOULD BE DENIED W/EOB 307 & ROUTED TO PRU.
B. THIS DOES NOT INCLUDE REQUESTS FOR PRICING OF CLAIMS.
C. OTHER THAN CLAIMS PROCESSING - IF PROVIDER/CLIENTS ARE CALLING FOR ETP, LIMIT EXTENSIONS OR APPROVAL - REFER INQUIRIES TO THE APPROPRIATE PERSON FOR THE SERVICE LISTED IN "D" BELOW.
D. ALL - IF WRITTEN REQUESTS THRU THE MAIL OR IN BATCHES:

CLAIMS PROCESSING: THERE MUST BE A STATEMENT ON THE CLAIM SUCH AS (EXCEPTION TO RULE OR LIMITED EXTENSION) & FORWARD TO APPEALS. OTHERWISE, DENY THE CLAIM & LET THE PROVIDER SUBMIT UNDER OUR DIRECTION IN BI OR DIRECTION THRU PRU. BE SURE THAT THE CLAIM CANNOT BE RESOLVED AT CP LEVEL BEFORE YOU SEND IT, OTHERWISE ROUTE TO THE APPROPRIATE PERSON FOR THE SERVICE LISTED IN "E" BELOW. NOTE: IF IN BATCHES - CLAIMS PROCESSING MUST DENY THE CLAIM W/EOB 155.

E. DENTAL: JACKIE TOMPKINS/QUS/45506
MEDICAL VENDORS: MARY DURGA/QUS/45506
MEDICAL - (PHYSICIANS & HOSPITALS): DEE DEE HOWDEN/QFFS/45506
PHARMACY: VALERIE VERTZ/QFFS/45506

NOTE: BE SPECIFIC CONCERNING YOUR REQUESTS ON YOUR ROUTING SLIPS. NOTE: IF CLAIM IS SENT BACK TO RE-ICN, USE O'CODE 998 WHEN PROCESSING. IF INSTRUCTIONS ON CLAIM FROM DHSQS/QFFS/PRU ARE UNCLEAR - SEE SUP/MMIS.

F. CLAIM TYPES J/L ONLY - IF REQUEST FOR PRE-AUTH, BUT PROCEDURE CODE DOES NOT REQUIRE APPROVAL - DENY W/EOB 166.

12 IF YOU HAVE A QUESTION ABOUT DENYING SERVICES ON ANY CLAIM THAT HAS CONSULTANT APPROVAL-CHECK WITH SUP FOR FURTHER PROCESSING DECISION.

13 IF A PROVIDER'S REQUEST FOR A SUPPLY OF CLAIM FORMS IS FOUND IN A BATCH OF CLAIMS OR A NOTE ON CLAIM, MAKE A COPY OF THE REQUEST BEING SURE THE PROVIDER NAME, ADDRESS, AND NUMBER ARE LEGIBLE AND FORWARD TO 1ST FLOOR CAGE, ESTER MARTIN Y BASCOS MS 45560. A COPY OF ANY REQUEST FOR AN ADDRESS CHANGE, NAME CHANGE, ID NUMBER, ETC SHOULD BE FORWARDED TO THE PROVIDER CERTIFICATION UNIT, MS 45562.

14 CROSS REFERENCE - WHEN A PIC IS KEYED CORRECTLY AND BRINGS UP A X-REFERENCE IN THE SAME FAMILY, SHOW SUPERVISOR FOR INSTRUCTIONS.

15 IF CLAIM CANNOT BE ADJUDICATED - SEE SUPERVISOR FOR POSSIBLE PHONE CALL TO PROVIDER.
E/E - IF CHANGE MADE ON CLAIM DUE TO CALL, DENY WITH EOB 333. BEFORE SUBMITTING CLAIM FOR RE-ICN INDICATE EOB 506 ON LINES WITH CHANGES.
RES/ADJ - IF CHANGE IS MADE DUE TO PHONE CALL, PROCESS WITH EOB 506. IF NO CHANGE, BUT CONFIRMATION RECEIVED, PROCESS WITH EOB 544.

16 IF THE CLAIM FORM HAS DOLLAR & CENTS COLUMNS AND PROVIDER HAS ONLY INDICATED DOLLARS - KEY IN "00" IN CENTS COLUMN.

17 REBILLINGS:

A. REBILLED LINE HAS OBVIOUS CHANGES FROM ORIGINAL PAID LINE - OR CLAIM ORIGINALLY PD AT $0.00 - DENY W/EOB 189.

B. IF ANY PORTION OF THE DETAIL LINE HAS BEEN X'ED OUT OR DELETED - DO NOT KEY. RETOTALING THE CLAIM MAY BE NECESSARY.

C. IF THE PROVIDER HAS TRIED TO CORRECT THE CLAIM AND YOU ARE UNABLE TO DETERMINE THE CORRECTIONS - DENY W/EOB 293.

D. IF THE DOS IS MORE THAN 3 YRS OLD - DENY W/EOB 967. ADJ MAY BE RETURNED WITH A STATEMENT, IF THEY HAVE NOT BEEN ICN'D. INDICATING" THIS CLAIM CANNOT BE PROCESSED FOR PAYMENT. MAA CANNOT VERIFY THE ORIGINAL DISPOSITION ON CLAIMS WITH DATES OF

SERVICE MORE THAN 3 YRS OLD". (EXCEPTION: THIS DOES NOT APPLY TO MDCR CROSS OVER CLAIMS. MAA IS ONLY OBLIGATED TO THE 6 MO RULE FROM MDCR PROCESS DATE).

18 IF CLAIM AND OR BACKUP IS ILLEGIBLE, HIGHLIGHTED OR FONT IS TOO SMALL - DENY W/EOB 283. HARD COPY OR KEYED FROM IMAGE CLAIMS WITH MULTIPLE LINES MAY BE ENTERED AS ONE LINE, KEYING THE NEWEST AND OLDEST DATE OF SERVICE, NO PROCEDURE CODE AND ENTIRE CLAIM TOTAL. ADDRESS TIMELINESS ON THE CLAIM AS NEEDED (I.E. 283/018).

19 AUTH NUMBERS - READ ALL SECTIONS BEFORE ADJUDICATING:

A. IF 2 AUTH NUMBERS @ HEADER, DO NOT KEY ANY AUTH # ON SCREEN. (DENTAL SEE 994 EXC) IF AUTH EXC FAILS, DENY WITH EOB 407. SEND A COPY OF THE CLAIM/WORKSHEET TO PRU, MAILSTOP 45562 FOR PROVIDER TRAINING. INDICATE THE PROBLEM ON THE PRU REFERRAL FORM.

B. CLAIM TYPE J AND P: BJS

1. MULTIPLE AUTH #'S ON DETAIL LINE - KEY AS BILLED.

2. MULTIPLE AUTH #'S ON CLAIM OR IN COMMENTS - KEY ON DETAIL LINE DESIGNATED BY PROVIDER. DO NOT KEY AUTH # ON ANY OTHER LINES. IF CLAIM HAS CYCLED, AND THERE ARE AUTH-RELATED EXCEPTIONS POSTING, REMOVE THE AUTH # FROM ANY LINES NOT DESIGNATED BY THE PROVIDER AND ENTER CLAIM BEFORE ADJUDICATING.

C. IF CLAIM HAS PREVIOUSLY CYCLED, VERIFY AUTH NUMBER HAS BEEN CARRIED TO DETAIL LINES ON SCREEN, IF NOT-ADD AUTH TO EACH DETAIL

D. IF A CORRECTION IS MADE TO A HEADER-LEVEL AUTH #. ON PAGE 1 OF THE MMIS SCREEN, THE AUTH # WILL NEED TO BE CORRECTED ON PAGE 2 - MMIS DOES NOT UPDATE THE SECOND SCREEN.

20 RESOLUTIONS: IF YOU ARE INQUIRING ON THE HISTORY FILE (04) USING THE PROVIDER # AND PIC CODE & CLAIM HAS EXCEPTION CODE 899 DENIED OR AN INVALID/BAD/MISSING PIC,THE CLAIM WILL NOT COME UP IF YOU PUT IN THE ICN # OR SEARCH JUST BY PROVIDER #. THIS IS BECAUSE THESE CLAIMS ARE NOT INDEXED BY PIC TO THE CLAIMS HISTORY FILE.

21 MEV (MEDICAL ELIGIBILITY VERIFICATION)
THE DATE AT TOP IS THE DATE OF INQUIRY. THE "AS OF" DATE IS THE ACTUAL DATE OF ELIGIBILITY. IF THE DOS ON THE CLAIM IS WITHIN THE SAME MONTH AS THE MEV ELIGIBILITY DATE, OVERLOC TO 65 IF POSTING AN ELIGIBILITY EXCEPTION. *C

22 PICS WITH A "-" IN THE TIEBREAKER FIELD ARE FOR BASIC HEALTH PLAN (BHP-HAS) CLIENTS AND THEY DO NOT HAVE MEDICAID. WE ARE SYSTEM GENERATING AND PROCESSING PREMIUM PAYMENTS (0350M) FOR BHP. DO NOT CHANGE A PIC WITH AN ALPHA-TIEBREAKER TO ONE OF THESE BHP-HAS PICS AND DO NOT CHANGE A (-) BHP-HAS PIC TO AN ALPHA TIEBREAKER.

23 VOIDS IN A BATCH. IF THE CLAIM IS LEFT IN THE BATCH, DO NOT KEY THE CLAIM. NOTE TIMELINESS AS NEEDED, PULL CLAIM AND PUT IN APPROPRIATE

RE-ICN SLOT.

24 EXAM ENTRY AND RES (MANAGED MEDICARE & LOCATION 55)
NOTE: CLAIM TYPE "O/M/S/R" LOC 55 - SEE 988 TEXT.
NOTE: WORK EXCEPTIONS 130, 250, 271, AND 549. IF DENYING 130, 250, 271, 549 OR IF EXC'S 260 OR 277 ARE POSTING - DO NOT O'LOC TO 55.

NOTE: APPLY THE FOLLOWING WHETHER OR NOT 261 OR 247 EXC'S ARE POSTING:

A. IF CLAIM/COMMENTS OR BACKUP INDICATES MANAGED MEDICARE

1. PUT AN 'X' IN LMC & OL TO 55.
2. DO NOT KEY A 'Y' IN TPL FIELD
3. DO NOT WORK ANY EXCEPTIONS EXCEPT ELIGIBILITY.

C. IF CLAIM INDICATES CO-PAY OR CO-INSURANCE & 263 EXC IS POSTING ON CLAIM AND THERE IS NO "MANAGED MEDICARE" STATEMENT ON CLAIM AND THE BACKUP IS NOT FROM ONE OF THE MANAGED MEDICARE PLANS LISTED BELOW THEN PUT A 'Y' IN TPL. (DO NOT OVERLOC TO LOC 55)

D. IF ANY QUESTIONS - SEE TRAINER/SUPERVISOR.

MANAGED MDCR PLANS EFF W/DOS 1/1/04

MANAGED MEDICARE PLANS CONT.

THE FOLLOWING INFORMATION ON CLAIM COMMENTS OR BACKUP DESIGNATES MANAGED MEDICARE:

1. MANAGED MEDICARE
2. MEDICARE HMO
3. GROUP HEALTH MEDICARE
4. OPTIONS HEALTH CARE MEDICARE
5. HEALTH NET OPTIONS MEDICARE
6. STERLINGS OPTIONS 1 (NOT STERLING OPTIONS AND STERLING PREMIER)
7. REGENCE HMO
8. FIRST CHOICE SIXTY-FIVE (65)
9. KAISER MEDICARE (MANAGED MEDICARE BY KAISER, MAY BE IN BLOCK 84 OR ANYWHERE ON CLAIM)
10. SENIOR ADVANTAGE(I OR II)
11. PACIFICARE MEDICARE(2003-2004) MEDICARE B/U SHOULD LIST EMPLOYER GROUP: HCFA
12. SECURE HORIZONS *G

MANAGED MEDICARE TO INCLUDE, BUT NOT LIMITED TO ABOVE - IF QUESTIONS SEE TRAINER/SUPERVISOR. *G

25 EXAM ENTRY FOR TPL

A. PUT A "Y" IN THE "TPL" FIELD IF CLAIM/BACKUP INDICATES GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION (GEHA) AND PA-2 TO TPL. THIS IS NOT MEDICARE.

B. DO NOT PUT A "Y" TPL FIELD IF THERE IS ANY MENTION OF AN INSURANCE COMPANY'S NAME OR INSURANCE COMPANY INITIALS (MSC, KCM,

PCMB, BHP, ETC.) IN COMBINATION WITH MEDICAID, MEDICARE, HEALTHY OPTIONS (HO).
EXAMPLES: CLAIM STATES KCM - KEY A "Y" IN TPL
CLAIM STATES KCM HO - DO NOT KEY A "Y" IN TPL
CLAIM STATES AETNA - KEY A "Y" IN TPL
CLAIM STATES AETNA MEDICARE - DO NOT KEY A "Y" IN TPL

SEE NEXT PAGE FOR LISTED STATEMENTS THAT A Y SHOULD NOT BE ENTERED

-----BELOW ARE EXAMPLES OF COMMENTS ON CLAIMS WHEN A Y SHOULD NOT BE ENTERED IN THE TPL FIELD:

CARECLAIM	MISC INS	DDDS
CSO	PROVIDER SERVICES	DSHS
DISABILITY INSURANCE	DIS DETERM SVCS	FRED HUTCHINSON
EPSDT	FIRST STEPS	PRE-PAY
BASIC HEALTH PLUS	PATIENT SUSPENDED	HEALTH DEPARTMENT
HEALTHY OPTIONS	HO/HOC/HOS	HOSPICE
INDIAN HEALTH	TRIBAL HEALTH	MATERNITY SUPPORT
MEDICAID	MEDICARE	MIGRANT COUNCIL
MIGRANT WORKERS	PA	PCCM
PCOP	SSPS	SLIAG
WELFARE	CNP	CNP/QMB
MIP	MEDICARE PART B	BC/BS OF ND
PRIVATE PAY	PRIVATE ACCOUNT	CRIME VICTIMS(UNLESS
SW WA MEDICAL DIRECT	BC/BS OF NM	CLAIM IS AN ADJ)
AND	KIDNEY DISEASE PROGRAM	

INVOLUNTARY COMMITMENT SERVICES/CRISIS & COMMITMENT SERVICES

IF INSURANCE IS NOTED ON COUPONS/MEV/OR COMPUTER PRINTOUTS OR MEDICARE EOMB- DO "NOT" PUT A "Y" IN TPL, UNLESS YOU HAVE INSURANCE BACKUP OR INSURANCE NAME OR COMMENTS INDICATED ON CLAIM.

C. PUT "Y" IN TPL IF:
LABOR & INDUSTRIES,MVA, OR MOTORCYCLE ACCIDENTS, CRIME VICTIMS (ONLY IF AN ADJUSTMENT), E. COLI RELATED SERVICES OR OTHER ACCIDENTS WHERE THERE MAY BE THIRD PARTY INVOLVEMENT, & EXC 320/325 IS NOT POSTING, PLACE A "Y" IN TPL FIELD & OVERLOC 30.

D. A "Y" SHOULD BE PUT IN "TPL" FIELD WHEN THERE IS A STATEMENT MADE ON THE CLAIM OR IN THE SPECIAL REMARKS SECTION ABOUT INSURANCE.

INSURANCE COMMENTS OF "NON-COVERED SERVICE", "SERVICE NOT COVERED BY INSURANCE", "NOT COVERED BY INSURANCE" "PVT INSURANCE DOES NOT COVER", SHOULD HAVE A "Y" EVEN IF INSURANCE NAME NOT MENTIONED.

A "Y" IS ALSO TO BE ENTERED IF INSURANCE BACKUP IS ATTACHED OR AN "I" IS IN THE REMARKS FIELD ON THE EMC CLAIM.

D. ALL HMO 4-LINES THAT REFLECT "WORK ALL NON-TPL EXCEPTIONS" MEANS WORK ALL EXCEPT 165,166 AND 263 EXCEPTIONS.

E. CLAIM INDICATES COPAYMENT & 261 NOT POSTING - KEY A "Y" IN TPL.

26 TPR VS HMO: (J,P,L,O)
A. HMO & 165 & 263 POSTING:(WORK HMO FIRST) IF BACKUP SEE E BELOW.
1. IF FORCING HMO - PA-2 THE 165 & 263.
B. HMO & 165 POSTING - REMOVE "Y" FROM TPL & WORK HMO.
C. 165 & 263 POSTING - PA-2.
D. 165 POSTING - PA-2. NOTE: DO NOT PUT A "Y" IN TPL IF DSHS, INDIAN HEALTH, OR HO.
E. HMO & 165 & 263 W/BACKUP:
1. IF BACKUP STATES HEALTHY OPTIONS OR GROUP HEALTH USING GROUP # 67000 (FOUND UNDER PATIENT NAME) OR MSC W/HO ABOVE THE DOS - USE BACKUP WHEN ADJUDICATING THE HMO EXCEPTION.
2. IF BACKUP DOES NOT APPEAR TO BE HEALTHY OPTIONS, DO NOT USE IT WHEN ADJUDICATING THE HMO EXCEPTION. PROCESS CLAIM AS IF THERE WERE NO BACKUP FOR HEALTHY OPTIONS.

27. "B" IN ITA FIELD
A. DO NOT KEY A "B" WHEN,
1. PIC IS FOR CHILD AGE 10 OR YOUNGER.
2. BABY IS 1 YR OR OLDER (THEY MUST HAVE THEIR OWN PIC)
3. THE PIC IS FOR PARENT'S AND THE BABY IS OVER 1 YR OLD, DENY THE CLAIM W/WOB 271.
B. KEY A "B" WHEN,
1. "B" ON THE CLAIM, USUALLY IN FIELD 19 OR IN COMMENTS.
2. STATEMENT ON CLAIM/COMMENTS SUCH AS "BABY ON MOM'S/PARENT'S" PIC", BABYS DOB LESS THAN 6 MO, NEWBORN OR SOMETHING SIMILAR.
3. MULTIPLE BIRTHS INDICATED, ALSO USE CORRECT O'CODE FROM CLAIM TYPE TEXT.
NOTE: RES: CONSIDER CLAIMS FOR BABY ON PARENTS PIC VS CLAIMS FOR PARENTS OR TWINS/TRIPLETTS (CURRENT/HX CLAIMS) AS BEING SEPARATE CLIENTS WHEN APPLYING LIMIT & DUPE AUDITS.
NOTE: CLAIM INDICATES MORE THAN ONE CLIENT - DENY W/EOB 271, EXCEPT;
1. PT 23 SPEC 52/90 & CLAIM'S FOR PARENT USING BABY PIC - PROCESS.
2. CLAIM IS FOR HMO NB PREMIUM PAYMENT (CODE 0351M) - PROCESS PER TEXT.
3. CLAIM INDICATES DONOR RECIPIENT - PROCESS.

28 MED VENDOR (P) AND OUTPATIENT (M) EXAM ENTRY - WHEN A UB92 CLAIM HAS BEEN SUBMITTED AS THE WRONG CLAIM TYPE, DO THE FOLLOWING:
A. IF THE PROVIDER NUMBER IS INAPPROPRIATE FOR THE SERVICES BEING BILLED (I.E. MED VENDOR PROVIDER NUMBER STARTS WITH A '9' AND THE SERVICES BILLED ARE FOR HOSPITAL CHARGES), DENY EXCEPTION CODE 313 WITH EOB 318.
B. IF THE PROVIDER IS BILLING ON THE INCORRECT CLAIM FORM (I.E. PHYSICIAN PROVIDER NUMBER, BILLING PHYSICIAN SERVICES), DENY EXCEPTION CODE 313 WITH EOB 934.
C. IF THE CLAIM HAS BEEN PUT INTO THE INCORRECT BATCH, DENY WITH EOB 333 AND RESUBMIT.
1. HOME HEALTH - MED VENDOR CLAIM TYPE 'P' - ARE TO BE BILLED WITH A '9' PROVIDER NUMBER.
2. HOSPITAL CLAIMS ARE TO BE BILLED WITH A '3' PROVIDER NUMBER.
3. SEE TEXT FILE 367 FOR LIST OF VALID REVENUE CODES.

29 WHEN A PROVIDER IS INQUIRING BY A STATEMENT ON THE CLAIM ABOUT NON-PAYMENT, DENY W/EOB 307 AND ROUTE THE CLAIM TO PRU. MS 5562.

30 WHEN DENYING ENTIRE CLAIM FOR TWO EXCEPTIONS, MANUALLY PUT IN BOTH EOB'S IN PRIORITY ORDER: ELIGIBILITY, TIMELINESS. (PER MANAGEMENT UPON IMPLEMENTATION OF WATERFALL ADJUDICATING) ALL OTHER EDITS ARE NOT ADDRESSED IF THEY ARE AT THE SAME CLAIM LEVEL, UNLESS THEY ARE THE ONLY EXCEPTION POSTING.

31 EXAM ENTRY - DENY DUPLICATE OR CARBON COPIES OF PREVIOUS CLAIM IN BATCH AT HEADER LEVEL. X IN LMC, DENY 116 EXC W/EOB 102, THEN REMOVE THE X FROM LMC.

32 CLAIMS REFERENCING (STOP-LOSS) ON THE BACKUP SHOULD BE DENIED W/EOB 810 AND FORWARDED TO THE APPROPRIATE MANAGED HEALTHCARE PROGRAM MANAGER. SEE YOUR SUP FOR NAME & MAILSTOP.

33 WHEN THE PROVIDER HAS USED OUR DUMMY # (8999500) AS THE REFERRING OR PERFORMING PROVIDER # AND NO NAME IS NOTED IN THE APPROPRIATE FIELD: (THIS PERTAINS TO HARDCOPY ONLY)

1. DO NOT KEY THE # IN,
2. DENY THE APPROPRIATE EXCEPTION (164 OR 174),
3. THEN KEY THE 8999500 AND ENTER YOUR CLAIM.

SEND SAMPLES TO PRU, MS 5562 FOR ACTION/PHONE CALL, ETC.

34 TWO PROVIDER NUMBERS IN BOX 33 (GROUP) ON HCFA 1500 CLAIM FORM - KEY IN THE 1ST NUMBER, KEY "X" IN LMC AND DENY 116 EXC. WITH EOB 961.

35 WHEN CLAIM IS STAGED/REMOVED FROM A BATCH TO SEND TO PRU, MRS, MAS, ETC. INDICATE THE LOCATION ON THE BATCH COVER SHEET AN IN F7 COMMENTS SCREEN.

36 FOR CLAIM TYPE J,K,L,O & P - DETAIL LINES ON A CLAIM MUST BE KEYED IF THERE IS A MONEY AMOUNT OR PROCEDURE CODE, THEN FOLLOW EXCEPTION INSTRUCTIONS. DIRECT ANY QUESTIONS TO YOUR SUPERVISOR.

37 WHEN THE PROVIDER BILLS TAX ON THE CLAIM-- DON'T KEY THE TAX LINE, FIX THE TOTAL/NET CLAIM CHARGES, USE 950 2ND EOB AT HEADER.

38 EXAM ENTRY SHOULD NOT REVIEW AUTHORIZATION FILES. IF AN EXCEPTION DIRECTS YOU TO DO SO, OVERLOC TO 23 FOR REVIEW.

39 FYI FOR LAB (DISEASE ORGAN PANELS/AUTOMATED/NON AUTOMATED) EFF 07/01/98 DOS.
-80002-80019, G0058-G0060 ENDED AND 80049 - 80055, 80058, 80059, 80061, 80072, 80090 - 80092 ARE REPLACEMENTS.
-8002M-8012M, 8016M,8018M,8019M,8058M,8059M,8060M (INTERNAL CODES)
-22 AUTOMATED LAB CODES
-22 NON AUTOMATED LAB CODES
-DISEASE ORGAN PANELS ARE MADE UP OF AUTOMATED AND NON AUTOMATED
-IF DISEASE ORGAN PANEL IS BILLED - SYSTEM PAYS AT PDDD PRICE.
-IF ENTIRE DISEASE ORGAN PANEL IS BILLED W/INDIVIDUAL CODES - SYSTEM PAYS DISEASE ORGAN PRICE DIVIDED EQUALLY FOR # OF CODES AND USES

A SOURCE OF "1".
-IF NOT ALL CODES ASSOCIATED W/DISEASE ORGAN PANEL ARE BILLED AND THEY ARE AUTOMATED - SYSTEM PAYS AT INTERNAL CODE PDDD FOR # OF TESTS BILLED AND USES A SOURCE OF "2".
-IF NOT ALL CODES ASSOCIATED W/DISEASE ORGAN PANEL ARE BILLED AND THEY AE AUTOMATED/NON AUTOMATED - SYSTEM PAYS AUTOMATED AT INTERNAL CODE PDDD AND NON AUTOMATED AT PDDD.
-IF AUTOMATED TEST BILLED AND NOT PART OF A PANEL - SYSTEM PAYS AT INTERNAL CODE PDDD PER # OF TESTS.
-IF ONLY 1 AUTOMATED TEST IS BILLED - SYSTEM PAYS AT PDDD INTERNAL CODE FOR 1 TEST OR PDDD WHICHEVER IS LESS.

40 CLAIMS PROCESSING CONSISTENCY MEETINGS WITH MMIS & FSU:

A. DIAGNOSIS: (SAME DOS ON ALL LINES ON CLAIM). THE FIRST DIAGNOSIS CAN BE BROUGHT DOWN FROM BOX 21 ON A HCFA 1500 WHEN:
1. THERE IS NO REFERENCE NUMBER/DIAGNOSIS LISTED ON THE LINE.

2. THE PROVIDER HAS REFERENCED A DIAGNOSIS THAT IS NOT IN BOX 21. (IE. THE DX REFERENCED IS "5" & THERE IS NO 5TH DX IN BOX 21.)

B. PROVIDER NUMBER:
1. CANNOT BE KEYED FROM A DSHS RA.
2. IF PIN & GROUP NUMBER ARE IDENTICAL, KEY IN BOTH FIELDS.

C. DENYING CLAIMS W/EOB 335 (BILL ON A CROSSOVER): ADDRESS ONLY EXCEPTIONS FOR;
1. ELIGIBILITY AND,
2. TIMELINESS.(REF TO 125 OR 192 TEXT FOR CROSSOVER DIRECTIONS)

D. MULTIPLE MODIFIERS BILLED WITH TOS 9 OR R - IF PRESENT, DY, 5B OR U2 SHOULD BE KEYED IN 1ST POSITION, OTHERWISE KEY MODS IN ORDER GIVEN.

41 TIMELINESS: ADJUSTMENTS WITH A DOS MORE THAN 3 YRS OLD.
A. IF REFERENCE ICN IS LESS THAN 3 YRS OLD - SUBMIT FOR PROCESSING AND DENY W/EOB 967.
B. IF REFERENCE ICN IS MORE THAN 3 YRS OLD (CANNOT BE ICN'D) - RETURN CLAIM WITH THE FOLLOWING STATEMENT: "THIS CLAIM CANNOT BE PROCESSED FOR PAYMENT. MAA CANNOT VERIFY THE ORIGINAL DISPOSITION ON CLAIMS WITH DATES OF SERVICE MORE THAN 3 YRS OLD".

42 987 TEXTFILE:
THIS TEXT WILL TIE OVERCODES TO NAMES OF PEOPLE WHO IN THE PAST HAVE RECIEVED CLAIMS & BACKUP BY OVERLOCING OR ROUTING. EFFECTIVE 07/01/00 EXAMINERS MAY USE THE DESIGNATED OVERCODE ON A CLAIM, WHEN THE TEXT STATES "FORCE/DENY & ROUTE A COPY" OR PER SOME OTHER DIRECTION IN TEXTS. OVERCODES WILL NEED TO BE ASSIGNED & ENTERED IN THE 987 TEXT BEFORE IT CAN BE USED. SUPS - PLEASE SEE MMIS TO HAVE AN OVERCODE REVIEWED & ASSIGNED. MMIS WILL NEED TO VERIFY THAT THE OVERCODE IS NOT CURRENTLY ASSIGNED FOR ANOTHER PURPOSE.

43. ONLINE COMMENTS SCREEN (F-7)
F-7 TO THE COMMENT SCREEN & KEY THE FOLLOWING: DATE/EXAMINER#/

COMMENT.(IE: 010101/040/LINE 2 MOD 26,76,9T) TO COMPLETE COMMENT ACTION - ENTER, F-7 TO RETURN TO CLAIM. "C" WILL APPEAR AT FAR RIGHT OF EXCEPTION ON SCREEN.

A. OVERCODES: IF A CLAIM REQUIRES MULTIPLE O'CODES & FIELDS ARE USED, USE ONLINE COMMENTS TO LIST THOSE NOT ADDRESSED ON THE CLAIM.

B. OVERLOCS: IF IT IS NECESSARY TO OVERLOC A CLAIM TO ANOTHER LOCATION FOR REVIEW & ITS FOR A REASON OTHER THAN A TEXT DIRECTION - ADDRESS REASON IN COMMENTS. NOTE: YOU MAY NEED TO "X" IN LMC TO HOLD THE CLAIM.

C. DENY 969/333: WHEN DENYING A CLAIM W/EOB'S 969 OR 333 - ADDRESS THE SPECIFIC REASON FOR RETURN/DENIAL, WHO CLAIM IS BEING SENT TO, RE ICNING, ETC IN COMMENTS.

44. RES ONLY:
A. IF CLAIM IN HX WAS PAID AT $0.00 OR IS TO BE PAID AT $0.00; OR
B. IF CLAIM IN HX IS (HX ONLY ADJ) BATCH RANGE (953-957); OR
C. IF CLAIM IN HX IS (HX ONLY ADJ) FOR QRS/PIP & CAMERA/REEL # IS (77);

SEE YOUR SUP/TRAINER/LEADWORKER FOR DIRECTION BEFORE PROCESSING. *C

45. J,P,L ONLY - IF A LINE ON A CLAIM NEEDS TO BE MANUALLY DENIED:
A. KEY MOD DL ON LINE, ENTER
B. REMOVE MOD DL, KEY EOB, DENY EXCEPTION 131, ENTER

NOTE: RE KEY ANY ORIGINAL MOD THAT MAY HAVE APPEARED ON THE CLAIM
NOTE: DO NOT USE MODIFIER DL OR 131 EXC IF ANY TEXTFILE OR 4-LINE INSTRUCTS TO MANUALLY DENY (E.G. 557 EXC AND 055 EXC), THEN MANUALLY DENY PRICING AT ZERO WITH APPROPRIATE DENIAL EOB INSTRUCTED.
NOTE: MODIFIER DL/131 EXC OR MANUALLY DENY INSTRUCTIONS ABOVE ARE FOR J/P/L CLAIM TYPES

46. ADJUSTMENTS O'LOC LOCATIONS:
A. PRU GENERATED ADJUSTMENTS - ANY QUESTIONS O'LOC TO 81 FOR REVIEW. PRU BATCH RANGE 913-914. ROUTE ADJUSTMENT AND FLATSHEETS TO PRU.

B. TPL CASUALTY ADJUSTMENTS WITH INDICATION OF LABOR & INDUSTRIES, MVA, MOTORCYCLE, ATTORNEY INVOLVEMENT, RESTITUTION CASE, OR OTHER ACCIDENTS WHERE THERE MAY BE THIRD PARTY INVOLVEMENT, PLACE A "Y" IN "TPL" FIELD & O'LOC TO 30. ROUTE ADJUSTMENT AND FLATSHEETS TO CASUALTY.

C. TPL/INSURANCE/COB ANY ADJUSTMENTS WITH TPL RELATED EXCEPTIONS OR QUESTIONS INVOLVING TPL GENERATED ADJUSTMENTS WITH BATCH RANGES 936-947 - O'LOC TO 63. ROUTE ADJUSTMENT AND FLATSHEETS TO CARMEN OR MARK BENYA.

47. MMIS/PRU EOBS:
143 - USE WHEN TOS IS CHANGED TO 3.
144 - USE WHEN TOS IS CHANGED TO 9.

358 - USE WHEN PROCEDURE CODE/REV CODE CHANGED PER MEDICAL GUIDE-
LINES.
129 - USE WHEN PROCEDURE CODE CHANGED TO A HCPCS/STATE UNIQUE CODE

48. NECESSARY COMMENTS (RETAIN ON SCANNER CLAIMS)
NOT A DUPLICATE
TWIN
BABY'S DOB LESS THAN 6 MONTHS & NOT IN MEDICAID
ADDITIONAL SERVICES
SECOND SERVICE SAME DAY
PATIENT MOVED &/OR TRANSFERRED CARE
TERMINATION OF PREGNANCY
NO MEDICARE
NO PART B
MANAGED MEDICARE
MVA (MOTOR VEHICLE ACCIDENT)
NON HOSPITAL BASED EQUIPTMENT
MOVED OUT OF STATE
BABY ADOPTED
FOSTER CARE
BABY DIED
"K" &/OR NOT RELATED TO TERMINAL ILLNESS
NEW, DIFFERENT OR SEPARATE INJURY / AREA
AUTHORIZATION
AUTHORIZATION FOR MULTIPLE UNITS
NEW DUE DATE __/__/__
TWIN A OR TWIN B
TRIPLET A, B, C OR TRIPLET
2ND, 3RD, NEW OR DIFFERENT PREGNANCY
ALIEN OR REFUGEE
DECEASED
100% NUTRITION - NOT INCLUDED IN NURSING HOME
NOT TUBE FED - MEDICARE DOES NOT COVER
ICN
PREVIOUS TPL DENIAL REASON
BACKUP VENTILATOR
NOT AVAILABLE FROM HEALTH DEPARTMENT
VACCINE OVERSTOCK
USING OLD OR PRIVATE STOCK
SUBMITTED PER PHONE CALL OR PER FIELD SERVICES
"B" OR BABY ON MOM'S PIC
COMPLICATIONS OF: FAMILY PLANNING METHOD
STERILAZATION
BIRTH CONTROL PILLS
OR IUD
PATIENT IS MALE/FEMALE
MULTIPLE FETUS OR MULTIPLE GESTATION
ANY NAME OF A MANAGED CARE PLAN
LABOR & INDUSTRIES
MOTORCYCLE
ATTORNEY INVOLVEMENT
RESTITUTION CASE
E. COLI RELATED SERVICES
ANY ACCIDENT W/POSSIBLE 3RD PARTY INVOLVMENT

INCARCERATED CLIENT
CLIENT IN JAIL
EXEMPT FROM MANAGED HEALTHCARE
MEDICARE DOES NOT COVER
NOT STERILIZED OR NO STERILIZATION DONE
NO VASECTOMY OR NO TUBAL DONE
NOT DONE PRIMARILY FOR THE PURPOSE OF STERILIZATION
REQUEST FOR EXCEPTION TO POLICY
PROVIDER DID NOT KNOW PATIENT WAS ON WELFARE SO NO DSHS CONSENT WAS OBTAINED
PATIENT STERILE AT TIME OF PROCEDURE
PREVIOUS TUBAL
PREVIOUS BTL
STERILE
POST - MENOPAUSE
LONG STANDING INFERTILITY IN COMBINATION W/ NEVER BEEN PREGNANT
PATIENT IS 60 OR OLDER
PROCEDURE DONE ON EMERGENCY BASIS
LIFE THREATENING CIRCUMSTANCE
A DRUG NAME, DOSAGE, STRENGTH &/OR NDC
NOT ELIGIBLE 3 DAYS BEFORE DELIVERY
NO MEDICAL CARE 30 DAYS BEFORE DELIVERY
NO SUBSTANCE ABUSE AT TIME OF DELIVERY
CLIENT IS VIOLENT OR DIFFICULT TO CONTROL
MULTIPLE CLIENTS REQUIRING MONITORING OR MEDICAL ATTENTION BEING TRANSPORTED
CLIENT WEIGHS 300 LBS. OR MORE
TRANSPORT OF ITA PATIENT OR INVOLUNTARY TRANSPORT
PERMANENT CONDITION
DOSE ADJUSTMENT REQUIRED
MULTIPLE PRESCRIPTIONS/TYPES REQUIRED
EMERGENCY FILL

49. CLAIMS WITH MORE THAN 99999 UNITS: KEY 0 UNIT, X IN LMC, O'LOC TO 21. LOC 21 - SEE INSTRUCTIONS IN 183 TEXT.
EXCEPT: HOSPITAL CLAIMS (M,R,S,W,V) SEE INFO 991 TEXT.

50. CLAIMS WITH DECIMALS IN THE UNITS: LEAVE BLANK & DENY. EXCEPTION DRUG CLAIMS, KEY AS BILLED.

51. MEDIA 3 (ECS, INTERNET CLAIMS):
EE: MOD 99, BUT NO MODS IN COMMENTS & STATEMENT "SEE ECS FOR MULTI MODS" - O'LOC TO 08.
LOC 08: VERIFY IN ECS, ADD CORRECT MODS TO CLAIM.

52. IF THE CLAIM HAS AN EXCEPTION IN AUTO-DENY STATUS AND THE EXCEPTION STATES TO OVERLOC TO A SPECIFIC LOCATION, SUSPEND THE CLAIM BY PUTTING AN X IN THE LMC FIELD AND PA 2 THE 116 EXCEPTION.

TEXT KEY TEXT DESC

1503

MAXIMUM OF 3 HOURS OF SUBSTANCE ABUSE INDIVIDUAL THERAPY IS ALLOWED PER DAY. (12 1/4 HOUR CODES)

1. IF BILLING SPAN OF DATES ON ONE LINE:
   A. IF UNITS CAN BE DIVIDED EVENLY SO THAT THERE ARE 12 UNITS PER DATE OF SERVICE - FORCE.
   B. IF UNIS DO NOT DIVIDE BY 12 EVENLY - DENY WITH EOB 417.

2. IF BILLING SINGLE DATE OF SERVICE PER LINE:
   A. CUT BACK TO 12 UNIT MAX IF NEEDED WITH EOB 101.
   B. IF UNITS APPEAR OVERLY EXCESSIVE FOR THE BILLED AMOUNT, DENY WITH EOB 452.
   C. ALL ELSE DENY.