

MMIS Documentation Manual

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Pricing Program

Institutional process happens in the following three ways.

UB82 Home Health claim and Bill type 711 and the provider was eligible and there is no revenue code of 983 on the claim and (the 1st day of service on the claim is within the providers current effective dates and there is a value in the current opt RR or a revenue code on the claim is 521 or 522 and the 1st day of service is after 12/31/2001 and the provider is within 5000 thru 5999 range or the 1st day of service is greater than or equal to the previous opt effective date and the previous opt RR is greater than zero and the revenue codes are not 521 and 522).

OR

Institutional Claim (record code 'I', 'O', 'N')

OR

UB82 Claim (record code 'Q', 'R', 'U')

Professional process happens in the following situations;

Professional claim (record code 'M', 'L', 'S', 'R') and (the record code is not 'R'(UB82 Home Health) or Bill Type is not 711 or provider is not eligible or there is no current opt RR).

OR

Claim has Revenue code 983

OR

Crossover Claim (record code 'X').

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Professional Processing

Look up level 3 pricing and store on pricing table for later use.

The pricing indicator determines how the claim is priced.

If Price indicator is 7 (already priced) and it is a cross over claim and a take over region add the allowed charge on the detail line to the total claim charge on the header. Claim is done pricing.

If this is a dental claim with type of service code of 7 on the detail line and the 1st day of service for the detail line is greater than 12/01/1997 or this is a medical claim and the procedure code is D1203; and there is no error 008 or 009 on the claim and the age of the recipient is under 21 use pricing indicator of 2 (Level 2 pricing).

If this is a dental claim with type of service code of 7 on the detail line and the 1st day of service for the detail line is greater than 12/01/1997 or this is a medical claim and the procedure code is D1203; and there is no error 008 or 009 on the claim and the age of the recipient is 21 or over use pricing indicator of 3 (Level 3 pricing).

If this is a dental claim with type of service code of 7 on the detail line and the 1st day of service for the detail line is greater than 12/01/1997 or this is a medical claim and the procedure code is D1203; and there is error 008 or 009 on the claim use pricing indicator of 9 (Do Not Pay pricing).

If this is not a dental claim or the type of service code is not 7 on the detail line and the 1st day of service for the detail line is equal to or less than 12/01/1997 and this is not a medical claim or the procedure code is not D1203; If the procedure codes are A0425 and A0426 or A0427 use pricing indicator of 2 (Level 2 pricing).

If this is not a dental claim or the type of service code is not 7 on the detail line and the 1st day of service for the detail line is equal to or less than 12/01/1997 and this is not a medical claim or the procedure code is not D1203; If the procedure codes are not A0425 or not A0426 and A0427 use pricing indicator off the pricing three record from the read done prior.

If pricing indicator is 0(normal claim)

If there is an error on the provider file or the provide has type code of 65 and a specialty code of 16 or the provider has type code of 67 and a specialty code of 93 skip level 1 pricing.

Set up key to look up level 1 pricing.

If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 1 lookup otherwise use the type of service code that is coming in on the detail line.

Coding for Wheelchair Van

If Medical claim and last date of service > 12/31/2004
and provider 050000 thru 059999

If the dtl procedure code is A0131 deny claim with EOB: detail B18 header B5
If the detail procedure code is S0209

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- check to see if there is procedure code A0130 also on the claim with same DOS
 - if no A0130
 - if not adjustment give EOB B18
 - if adjustment give error 750
 - else check units of service
 - if ≤ 15 deny detail with EOB B5
 - if > 499 give error 460
 - detail is priced level 3 minus 15 units

If the detail procedure code is A0130

- check to see if there is procedure code S0209 on claim with same DOS
 - if no S0209 on claim, A0130 is priced level III
 - else A0130 is priced level II

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If UB82 Home Health or HCBC Elderly Disabled or the provider on the claim is with in 19000 thru 19099 range use the provider on the claim; But if it is not one of these three situations and the claim is a professional claim use the claims provider; but if this is not a professional claim and it is not one of the above three situations use the detail physician on the detail line to look up level 1 information.

Look up level 1 information and store on a table for later use, if there is a bad price and the detail physician had not been used use that provider and relook up the level 1 pricing and store that information on a table for later use.

If it is a UB82 Home Health claim and the bill type is 711 and the providers current or previous opt RR is greater than zero use revenue code to look up the price on the level 1 stored price table; if the revenue code matches the code on the table check the level 1 effective date if it is not greater than the detail 1st procedure date calculate the allowed charge on the detail line with the level1 cust med charge times the unit of service on the detail line, but if the level 1 effective date is greater than the 1st procedure date calculate allowed charge on the detail line with the level 1 previous cust charge time the units of service on the detail line.

If the claim is not a UB82 Home Health or the bill type is not 711 or the providers current and previous opt RR is zero use the revenue code if this is a UB82 Home Health to look up information on the level 1 stored price table or if this is not a UB82 Home Health claim use the procedure code to look up the information on the level 1 stored pricing table; If there is a match on the store level 1 pricing table and the level1 Effective date is not greater than the 1st procedure service date on the detail line calculate level1 cust med charge on the detail line with level 1 cust med charge on the table time the units if service on the detail line; If the Level 1 Effective date is greater than the 1st procedure service date calculate level 1 cust med charge on the detail line with previous cust charge time the units of service on the detail line.

If (not proc code A0425 or not A0428 and not A0429) and (not A0425 or A0428 or A0429 or A0426 or A0427) and (not A0425 or if it is not on the first detail line) and (not A0428 and not A0429) and (not A0426 and not A0427) and (not A0430) and (not A0431) and (not T2006 and not S4505) get level 2 information

Set up key to look up level 2 pricing.

If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 2 lookup otherwise use the type of service code that is coming in on the detail line.

Use 1 for location code on the level 2 key.

Use 0 for Specialty Code on the level 2 key.

Look up level 2 pricing and store on table for later use.

If level 2 effective date on the level 2 price table is not greater than the 1st procedure service date on the detail line calculate the level 2 prvl charge on the detail line with level 2 prvl charge on the pricing table times the unit of service on the detail line; If the level 2 effective date on the level 2 pricing table is greater than the 1st procedure service date on the detail line calculate level 2 prvl charge on the detail line with the previous level 2 prvl charge on the pricing table times the units of service on the detail lines.

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If the type of service code on the detail line is 1 or H or J and the procedure code is 90585 thru 91999 or 92016 thru 99240 or 99275 thru 99499

OR

If the type of service code on the detail line is 2 or 9 and the procedure code is 10040 thru 69999 or 99201 thru 99499

OR

If the type of service code on the detail line is 3 and the procedure code on the detail line is 99241 thru 99274

OR

If the type of service code on the detail line is 4 or 6 or H or J and the procedure code on the detail line is 10000 thru 79999

Look up RVU Coeff and RVU Factor where the 1st procedure service date on the detail line is after the RVU date and also has a RVU type of service that matches the type of service code on the detail line.

If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous rel val time the RVU Coeff times the RVU Factor time the units of service on the detail line.

If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is zero or less and level 3 previous allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous allowed charge times units of service on the detail line.

If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 rel val time the RVU Coeff time the RVU Factor times the units of service on the detail line.

If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is zero and the level 2 allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 allowed charge on the price table time the units of service on the detail line.

If the type of service code on the detail line is A and the level 3 rel val on the pricing table is greater than zero calculate level 2 allowed charge in the detail line with level 3 rel val on the price table time 15 plus the units of service on the detail line.

If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times 1.

If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table is greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times the units of service on the detail line.

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- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times the units of service on the detail line.
- If the provider on the claim is in 59000 thru 59999 range and the procedure code on the detail line is on procedure list 127
- If UB82 outpatient claim or UB82 Home Health use cpt4 code on the detail line to look up lab file.
 - If not UB82 Outpatient claim and not UB82 Home Health use procedure code on the detail line to look up lab file.
 - If the 1st procedure service date on the detail line is not less than the current effective date on the lab file move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
 - If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is greater than zero move the previous rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
 - If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is zero or less move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
- If Type of service code is G A or K move the level3 allowed charge on the detail line to the allowed charge on the detail line mark level 3 pricing. Done pricing.
- If level 1 cust med charge on the detail line is greater than zero and HCBC Elderly Disable Or the provider is 50000 thru 59999 or 19000 thru 19099 or 5000 thru 5999 and it's a professional claim.
- If level 1 cust med charge on the detail line is greater than zero indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.
 - If level 1 cust med charge on the detail line is zero or less and level 2 prvl charge on the detail line is greater than zero, indicate level 2 pricing, move the level 2 prvl charge on the detail line to the allowed charge on the detail line. Done pricing.
 - If level 1 cust med charge on the detail line is zero or less and the level 2 prvl charge on the detail line is zero or less, indicate level 3 pricing, move level 3 allowed charge on the detail line to the allowed charge on the detail line. Done pricing.

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If level 1 cust med charge on the detail line is zero or less or not HCBC Elderly Disable and the provider is not 50000 thru 59999 and not 19000 thru 19099 and not 5000 thru 5999.
If level 2 prvl charge on the detail line greater than zero, indicate level 2 pricing, move level 2 prvl charge on the detail line to the allowed charge on the detail line. Done pricing.
If level 2 prvl charge on the detail line zero or less, indicate level 3 pricing, move level 3 allowed charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 2 prvl charge on the detail line is greater than zero and level 1 cust med charge on the detail line greater than the level 2 prvl charge on the detail line, indicate level 2 pricing, move level 2 prvl charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 2 prvl charge on the detail line is greater than zero and the level 1 cust med charge on the detail line less than or equal to the level 2 prvl charge on the detail line, indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 2 allowed charge on the detail line is zero, indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 3 allowed charge on the detail line greater than level 2 cust med charge on the detail line, indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.

If none of these situations are met than move level 3 allowed charge on the detail line to the allowed charge on the detail line and indicate level 3 pricing. Done pricing.

Perform Pac Applied ([see PAC APPLIED](#)).

If pricing indicator is 1(level 1 pricing)

If there is an error on the provider file or the provide has type code of 65 and a specialty code of 16 or the provider has type code of 67 and a specialty code of 93 skip level 1 pricing.

Set up key to look up level 1 pricing.

If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 1 lookup otherwise use the type of service code that is coming in on the detail line.

If UB82 Home Health or HCBC Elderly Disabled or the provider on the claim is with in 19000 thru 19099 range use the provider on the claim; But if it is not one of these three situations and the claim is a professional claim use the claims provider; but if this is not a professional claim and it is not one of the above three situations use the detail physician on the detail line to look up level 1 information.

Look up level 1 information and store on a table for later use, if there is a bad price and the detail physician had not been used use that provider and relook up the level 1 pricing and store that information on a table for later use.

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If it is a UB82 Home Health claim and the bill type is 711 and the providers current or previous opt RR is greater than zero use revenue code to look up the price on the level 1 stored price table; if the revenue code matches the code on the table check the level 1 effective date if it is not greater than the detail 1st procedure date calculate the allowed charge on the detail line with the level 1 cust med charge times the unit of service on the detail line, but if the level 1 effective date is greater than the 1st procedure date calculate allowed charge on the detail line with the level 1 previous cust charge time the units of service on the detail line.

If the claim is not a UB82 Home Health or the bill type is not 711 or the providers current and previous opt RR is zero use the revenue code if this is a UB82 Home Health to look up information on the level 1 stored price table or if this is not a UB82 Home Health claim use the procedure code to look up the information on the level 1 stored pricing table; If there is a match on the store level 1 pricing table and the level 1 Effective date is not greater than the 1st procedure service date on the detail line calculate level 1 cust med charge on the detail line with level 1 cust med charge on the table time the units if service on the detail line; If the Level 1 Effective date is greater than the 1st procedure service date calculate level 1 cust med charge on the detail line with previous cust charge time the units of service on the detail line.

If level 1 cust med charge on the detail line is greater than zero and the provider is within one of the following set of ranges 32000 thru 34999, or 38800 thru 39999 or 50000 thru 59999, or 19000 thru 19099, or 5000 thru 5999, move level 1 cust med charge on the detail line to the allowed charge on the detail line go to Pac Applied ([see PAC APPLIED](#)).

If the pricing indicator is 2 (Level 2 pricing)

Set up key to look up level 2 pricing.

If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 2 lookup otherwise use the type of service code that is coming in on the detail line.

Use 1 for location code on the level 2 key.

Use 0 for Specialty Code on the level 2 key.

Look up level 2 pricing and store on table for later use.

If level 2 effective date on the level 2 price table is not greater than the 1st procedure service date on the detail line calculate the level 2 prvl charge on the detail line with level 2 prvl charge on the pricing table times the unit of service on the detail line; If the level 2 effective date on the level 2 pricing table is greater than the 1st procedure service date on the detail line calculate level 2 prvl charge on the detail line with the previous level 2 prvl charge on the pricing table times the units of service on the detail lines.

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If level 2 prvl charge in the detail line is greater than zero and the procedure code is on the procedure list 127 and the provider is 59000 thru 59999.
If UB82 outpatient claim or UB82 Home Health use cpt4 code on the detail line to look up lab file.
If not UB82 Outpatient claim and not UB82 Home Health use procedure code on the detail line to look up lab file.
If the 1st procedure service date on the detail line is not less than the current effective date on the lab file move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is greater than zero move the previous rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is zero or less move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If a lab record not found move level 2 prvl charge to the allowed charge on the detail line perform pac applied ([see PAC APPLIED](#)).
If a lab record is found perform pac applied ([see PAC APPLIED](#)).
If level 2 prvl charge greater than zero and the provider is not in 59000 thru 59999 range or the procedure code is not on procedure list 127 move level 2 prl charge to allowed charge perform PAC Applied ([see PAC APPLIED](#)).

If pricing indicator is 3(level 3 pricing)

If the type of service code on the detail line is 1 or H or J and the procedure code is 90585 thru 91999 or 92016 thru 99240 or 99275 thru 99499

OR

If the type of service code on the detail line is 2 or 9 and the procedure code is 10040 thru 69999 or 99201 thru 99499

OR

If the type of service code on the detail line is 3 and the procedure code on the detail line is 99241 thru 99274

OR

If the type of service code on the detail line is 4 or 6 or H or J and the procedure code on the detail line is 10000 thru 79999

Look up RVU Coeff and RVU Factor where the 1st procedure service date on the detail line is after the RVU date and also has a RVU type of service that matches the type of service code on the detail line.

If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous rel val time the RVU Coeff times the RVU Factor time the units of service on the detail line.

If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is zero or less and level 3 previous allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous allowed charge times units of service on the detail line.

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- If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 rel val time the RVU Coeff time the RVU Factor times the units of service on the detail line.
- If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is zero and the level 2 allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 allowed charge on the price table time the units of service on the detail line.
- If the type of service code on the detail line is A and the level 3 rel val on the pricing table is greater than zero calculate level 2 allowed charge in the detail line with level 3 rel val on the price table time 15 plus the units of service on the detail line.
- If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table is greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times the units of service on the detail line.
- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times the units of service on the detail line.
- If level 3 allowed charge in the detail line is greater than zero and the procedure code is on the procedure list 127 and the provider is 59000 thru 59999.
- If UB82 outpatient claim or UB82 Home Health use cpt4 code on the detail line to look up lab file.
- If not UB82 Outpatient claim and not UB82 Home Health use procedure code on the detail line to look up lab file.
- If the 1st procedure service date on the detail line is not less than the current effective date on the lab file move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.

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If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is greater than zero move the previous rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.

If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is zero or less move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.

If a lab record not found move level 3 allowed charge to the allowed charge on the detail line perform pac applied ([see PAC APPLIED](#)).

If a lab record is found perform pac applied ([see PAC APPLIED](#)).

If level 3 allowed charge greater than zero and the provider is not in 59000 thru 59999 range or the procedure code is not on procedure list 127 move level 3 allowed charge to allowed charge perform PAC Applied ([see PAC APPLIED](#)).

If pricing indicator is 9(do not pay).

Move zero to allowed charge on the detail line also perform Pac Applied ([see PAC APPLIED](#)).

If pricing indicator is 5(priced as billed)

Indicate price as billed on the claim.

Calculate level3 allowed charge on the detail line with level3 allowed charge on the pricing table times the units of service.

Move submitted charge on the detail line to the allowed charge on the detail line.

If crossover claim and take over region and total claim charge equals the net claim charge and procedure code on the detail line is 09991 add the allowed charge to the total claim charge.

Perform Pac Applied ([see PAC APPLIED](#)).

If pricing indicator is a valid indicator

Perform Pac Applied ([See PAC APPLIED](#)).

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Institutional Processing

- If claim is not UB82 claim review surgery codes if there is a surgery procedure code look up level 3 pricing and store on a table for later use.
- If claim is UB82 claim review the UB82 surgery codes if a surgery procedure code look up level 3 pricing and store on a table for later use also review the UB92 surgery codes and if there is a surgery procedure code look up the level 3 pricing and store for later use.
- If claim is not a nursing home claim
- If inpatient claim or UB82 inpatient claim
 - If 1st day of service on the claim is not less than the current effective date on the provider file use the providers current ipt rr for the Reimbursement percentage.
 - If 1st day of service on the claim is less than or equal to the current ipt effective date on the provider file use the providers previous ipt rr for the Reimbursement percentage.
 - If claim type O or Q or R and the 1st day of service is not less than proc current opt effective date move the providers current opt rr on the provider file to the reimbursement percent
 - If claim type is O or Q or R and the 1st day of service is less than the current opt effective date move the providers previous opt rr to the reimbursement percent.
- If provider is 35000 thru 37999 or 30000 thru 30699 and the 1st day of service is greater than 12/31/1998 and the claim is a LTC region get MDS rates off SB617010
- If provider is 35000 thru 37999 or 30000 thru 30699 and the 1st day of service is less than or equal to 12/31/1998 or this claim is not a LTC region get the rates off the provider file SB515010.
- If UB82 inpatient claim
- If the provider pay begin date in the provider file not greater than the last day of service on the claim and the provider pay end date is zero or the provider pay end date is not less than the last day of service and the provider pay code is 7 on the provider file
 - If there is a good return on the DRG look up and the DRG code is not 469 and not 470 and the providers location code is 1.
 - If provider effective date on the provider file not greater than the UB82 date of discharge and the provider effective date on the provider file is not zero store the providers base rate, capital amount, education amount, and insurance amount from the provider file.
 - If the claim is not a denied claim and the provider effective date is not greater than the UB82 date of discharge and the provider effective date is not zero or there is a forced 439 error look up DRG on the pricing file and store for later use.
 - If a good return on the pricing file look up and the drg effective date is not greater than the UB82 date of discharge and the drg effective date is not zero store DRG weight, Day Perc, Day Thres, Length of stay, Cost Thres, Cost Factor, and Cost Perc.

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If DRG pricing is found and the information is stored for later use process the DRG calculations.
Calculate basic DRG price on the claim with the providers base rate times the DRG wght.
If a forced 439 is not found on the claim or the allowed DRG price is zero or less calculate the allowed DRG price with the basic drg price on the claim plus the providers capital amount plus the provider education amount plus the providers insurance amount.
If the UB82 discharge to hospital and the DRG is not 456 calculate the transfer DRG price with the basic DRG price on the claim divided by the DRG length of service and then multiply that by the UB82 Total days billed.
If the UB82 total days billed greater than the DRG day Thres calculate Day outliner with basic DRG price on the claim divided by the DRG length of service times the DRG day perc and then multiply the value from UB82 total days billed minus the DRG day thres.
Calculate the cost outliner with the total claim charge on the claim minus the UB82 total non covered charge multiply that by reimbursement ratio and then subtract the value from basic DRG price times the DRG cost factor multiply then by DRG cost perc.
If the transfer DRG price greater than zero calculate the max transfer amount with the allowed DRG price on the claim plus the Cost Outliner calculated earlier.
Use the lesser of the two values transfer DRG price or Max transfer amount and move it to the allowed DRG price on the claim and to the reimbursement amount.
If transfer DRG price less than or equal to zero and there is not forced 439 error and the day outliner is greater than zero add the day outliner to the allowed DRG price on the claim but if the day outliner in zero or less and the cost outliner is greater than zero add the cost outliner to the allowed DRG price on the claim.

If the claim is UB82 outpatient and the 1st day of service on the claim is greater than 02/28/1999 and the bill type is 131 or 831 and the revenue code on the detail line is 360 thru 369 or 490 thru 499 , look up level 3 pricing and store on a table for later use set a switch ASC-TY-S to 'Y' to indicate there was a good pricing look up.

If ub82 home health claim and the bill type is 711 and the provider is 5000 thru 5999 and the 1st day of service on the claim is greater than 12/31/2001 and the revenue code is 951 or 521 or 522 find the provider rates where the 1st procedure service date on the detail ine is greater than or equal to the provider rate effective date on the provider file calculate the allowed charge on the detail line with the units of service times the provider accom fact p.

Perform Fee Comparison ([See FEE COMPARISON](#)).

If there is a good level 3 price and the revenue code is 360 thru 369 or 490 thru 499 and there is an allowed amount in the detail line this will be priced manual.

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If UB82 claim and this is not a IHS region look up revenue code pricing store for later use.

If inpatient claim and the claim is not a IHS regions with service code on the detail line of P, B, or Z and the region is developmentally disable;
Get the appropriate DD information the service code used will determine the correct DD rate and effective date to be using.
If the 1st procedure service date on the detail line is greater than or equal to the DD From date or the place the information is gotten from the table is index 35 or 04 use the submitted unit rate on the detail and move it to the provider charge fact p on the detail line.
If the 1st procedure service date on the detail line is greater than or equal to the DD From date or the place the information is gotten from the table is not index 35 or 04 use the DDP rate off the table based on the index determined by the service code and move it to the Provider charge fact p on the detail line.
If the provider charge fact p is \$999.99 calculate the allowed charge on the detail line with 15000.00 time the number on units of service on the detail line. If the submitted charge on the detail line less than or equal to the allowed charge on the detail line move the submitted charge on the detail line to the allowed charge on the detail line.
If the provider charge fact p is not \$999.99 calculate the allowed charge on the detail line with the provider charge fact p on the detail line times the number of unit of service on the detail line.
If allowed charge on the detail line is greater than the submitted charge move the submitted charge to the allowed charge.
Perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#))
Perform Fee Comparison ([See FEE COMPARISON](#)).

If inpatient claim and the claim is not a IHS regions with service code on the detail line of P, B, or Z and the region is not developmentally disable and there is a inpatient accommodation;
Get the assigned index to indicate the point on the provider file to look for the information specifically for a service code.
Perform Price Accommodation ([See PRICE ACCOMMODATION](#)).
Perform Fee Comparison ([See FEE COMPARISON](#)).

If inpatient claim and the claim is not a IHS regions with service code on the detail line of P, B, or Z and the region is not developmentally disable and there is not a inpat accommodation and the is ancillary service;
Based on the service code on the detail line find the appropriate position to look up information on the provider file.

If the service code is not 1 and not 2 and not 3 and not Q and not R and not S and not T and not U and not V and not W and not X and not Y or the provider file shows that they are authorized as long as the claim has not already been priced perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#)).
Perform Fee Comparison ([See FEE COMPARISON](#)).

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If UB82 inpatient claim and IHS region

Look at the first set of provider rate effective date if the 1st procedure service date on the detail line is not less than the provider rate effective date on the file calculate the allowed charge on the detail line with the units of service times the provider accum fact p then multiply the figure by the reimbursement ratio
Perform Fee Comparison ([See FEE COMPARISON](#))

If UB82 inpatient claim and not a IHS region and it's a valid revenue code Accom and there is DRG pricing perform Fee Comparison ([See FEE COMPARISON](#)).

If UB82 inpatient claim and it is not a IHS region and it's a valid revenue code and there is no DRG pricing look up the appropriate information on the provider file based on the service code on the detail line.
Perform Price Accommodation ([See PRICE ACCOMMODATION](#)).
Perform Fee comparison ([See FEE COMPARISON](#)).

If UB82 inpatient claim and it is not a IHS region and it's not a valid accommodation and there is a valid ancillary
If UB82 home health and the bill type is 711 or look up the appropriate information on the provider file based on the service code on the detail line and the provider file show authorized and as long as the claim in not already prices move the submitted charge to the allowed charge on the detail line, also perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#))
Perform Fee Comparison ([SEE FEE COMPARISON](#)).

If it is an outpatient claim and the service code is not 0 or the submitted charge on the detail line is zero or less and this claim is an ancillary service.
Based on the service code on the detail line find the appropriate position to look up information on the provider file.
If the service code is not 1 and not 2 and not 3 and not Q and not R and not S and not T and not U and not V and not W and not X and not Y or the provider file shows that they are authorized as long as the claim has not already been priced perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#)).
Perform Fee Comparison ([SEE FEE COMPARISON](#)).

If UB82 Outpatient and IHS region and the bill type is 131 and the revenue code is 987 and cpt4 code is 99221 thru 99239 or 99291 thru 99297 or 99429 thru 99440 or 99261 thru 99263
Perform Price UB82 Outpatient CPT4 Norm ([See PRICE UB82 OUTP CPT4 NORM](#)).
Perform Fee Comparison ([See FEE COMPARISON](#)).

If UB82 outpatient and IHS region, Look at the Second set of provider rate effective date if the 1st procedure service date on the detail line is not less than the provider rate effective date on the file calculate the allowed charge on the detail line with the units of service times the provider accum fact p then multiply the figure by the reimbursement ratio
Perform Fee Comparison ([See FEE COMPARISON](#)).

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- If UB82 outpatient claim or UB82 home health and R1RV allowed Outp Claim is C and the claim is already priced perform Price UB82 OUTP CPT4 Norm ([See PRICE UB82 OUTP CPT4 NORM](#)),
Perform Fee Comparison ([See FEE COMPARISON](#)).
- If UB82 outpatient or UB82 home health and R1RV allowed outp claim is C and it is not been already priced and the CPT4 code equals 3000, or 3001, or 3005 or 3006, or 97535 or 99078 or revenue code is not 982 and the cpt4 code is greater than spaces and one of the following two situations the bill type is 141 or the revenue code is 982 and the cpt4 code is 3000, or 3001 or 97535 or 99078 perform Price UB82 Outp Cpt4 Norm ([see PRICE UB82 OUTP CPT4 NORM](#))
Perform Fee Comparison ([See FEE COMPARISON](#)).
- If UB82 Outpatient or UB82 Home Health and R1RV allow Outp claim is C and it is not already priced and cpt4 code is 3000 or 3001 or 3005 or 3006 or 97535 or 99078 or the revenue code is not 982 and cpt4 code is greater than spaces and the bill type is not 141 and either the record code is not 982 or cpt4 code is not 3001 and not 3000 and not 97535 and not 99078
If UB82 outpatient claim or UB82 Home Health use cpt4 code on the detail line to look up lab file.
If not UB82 Outpatient claim and not UB82 Home Health use procedure code on the detail line to look up lab file.
If the 1st procedure service date on the detail line is not less than the current effective date on the lab file move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is greater than zero move the previous rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is zero or less move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If there was not a lab record found perform UB82 outp cpt4 norm ([See UB82 OUTP CPT4 NORM](#))
Perform Fee Comparison ([See FEE COMPARISON](#)).
- If there was a lab record found
 If main region or tape bill region and the last digits on CPT4 code is not 99 calculate allowed charge on the detail line with the current allowed charge on the detail line time the units of service on the detail line Perform Check Billed ([See CHECK BILLED](#))
 Perform Fee Comparison ([See FEE COMPARISON](#)).
- If not main region and this is also not a tape bill region calculate the allowed charge on the detail line with the current allowed charge on the detail line times the units of service on the detail line perform Check Billed ([See CHECK BILLED](#))
perform Fee Comparison ([See FEE COMPARISON](#)).

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If UB82 outpatient or UB82 home health and R1RV allow outp claim is not C and the rev valid ancillary

If UB82 home health and the bill type is 711 or look up the appropriate information on the provider file based on the service code on the detail line and the provider file show authorized and as long as the claim is not already priced move the submitted charge to the allowed charge on the detail line, also perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#))

Perform Fee Comparison ([see FEE COMPARISON](#)).

If nursing home claim and revenue code is not 022 and the Vocational rehabilitation provider is 1086 or 2435 or 50383 or 017553 and state hospital accom, review the accommodation code to reflect where on the provider file we will look for rate information;

Perform Price Accommodation ([See PRICE ACCOMMODATION](#)).

Perform Fee Comparison ([See FEE COMPARISON](#)).

If Nursing home claim and revenue code is not 022 and the vocational rehabilitation provider is not 1086 and not 2435 and not 50383 and not 017553 or this is not a state hospital accom and the service code is 1, 2, 3, Q, R, S, T, U, V, W, X, or Y or the service code is 4 and this claim is a basic care region; there will be a look up of the service code and based on what the service code is for the detail line that determines the type of information that will be taken from the provider file

Perform Price Accommodation ([See PRICE ACCOMMODATION](#)).

Perform Fee Comparison ([See FEE COMPARISON](#)).

If Nursing home claim and revenue code is not 022 and the vocational rehabilitation provider is not 1086 and not 2435 and not 50383 and not 017553 or this is not a state hospital accom and the service code is not 1, and not 2, and not 3, and not Q, and not R, and not S, and not T, and not U, and not V, and not W, and not X, and not Y and the service code is not 4 or the claim is not a basic care region.

If the service code is greater than zero move 1 to the reimbursement ratio and based on the service code on the detail line find the appropriate position to look up information on the provider file.

If the service code is not 1 and not 2 and not 3 and not Q and not R and not S and not T and not U and not V and not W and not X and not Y or the provider file shows that they are authorized as long as the claim has not already been priced perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#)).

Perform Fee Comparison ([See FEE COMPARISON](#)).

If UB82 Claims and there is a DRG price and as long as the 1st day of service is three years or less calculate the net claim charge with the allowed DRG price minus the total other insurance but if we are not a main region and the total other insurance is greater than 0 and the total patient liability is zero move zero to the net claim charge.

If UB82 Claims and there is a DRG price and the 1st day of service is past three years and the allowed DRG price is greater than the total other insurance calculate the net claim charge with the allowed DRG price minus the total other insurance.

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PAC APPLIED.

If not main region and not tape bill region or the 1st day of service on the claim is less than or equal to 08/31/1996 and provider is 50000 thru 59999 range and the total claim charge is less than 200 and the type of service code on the detail line is 9 and the allowed charge on the detail line is zero, move the submitted charge on the detail line to the allowed charge on the detail line.

If the 1st day of service on the claim is greater than 08/31/1996 and the claim is main region or tape bill region and the allowed charge on the detail line is zero and the prior authorization ctl no is spaces or zero and the durable medical equipment needs a prior approval and the DME max reimbursement is greater than zero and the DME max reimbursement is not less than the submitted charge on the detail line, move submitted charge on the detail line to the allowed charge on the detail line, indicate A pricing.

If the 1st day of service on the claim is greater than 08/31/1996 and the claim is main region or tape bill region and the allowed charge on the detail line is zero and the prior authorization ctl no is spaces or zero and the durable medical equipment needs a prior approval and the DME max reimbursement is greater than zero and the DME max reimbursement is less than or equal to the submitted charge on the detail line and the procedure code on the detail line is not on procedure list 110, indicate A pricing, move DME max reimbursement to the allowed charge on the detail line.

If 1st day of service on the claim is greater than 08/31/1996 and the claim has main region or tape bill region and the allowed charge on the detail line is greater than zero.

If the processing clerk number is MAS and the provider is 1058 or 1061 or 1063 or 1068 or 1324 or 1307 or 2331 or 1326 or 2333 or 2334 or 1328 or 2335 or 2372 or 1330 or 2400 or 1323 or 1332 or 1325 or 1329 or 1331 or 1312 or 54516 or 54517 or 54518 or 54519 or 54520 or 54521 or 54522 or 54523 or 33056 or 33057 or 33058 or 33059, move the allowed charge on the detail line to the submitted charge on the detail line

Check all modifiers and detail extra modifiers.

If the procedure code on the detail line is on procedure list 153 and the modifier is pay 8 dollars or procedure code on the detail line is 90782 and the revenue code is 983, move 8 dollars to the allowed charge on the detail line.

If modifier pay 20 percent calculate allowed charge on the detail line with the allowed charge on the detail line time .20.

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- If modifier 87 and the 1st procedure service date on the detail line greater than 12/31/1995 and the provider type code in the claim or on the provider file is 65 and the provider specialty code on the claim or on the provider file is 16 and the 1st procedure service date on the detail line is greater than 01/31/1999 calculate the allowed charge on the detail line with the allowed charge on the detail line time .17.
- If modifier 87 and the 1st procedure service date on the detail line greater than 12/31/1995 and the provider type code in the claim and on the provider file is are not 65 or the provider specialty code on the claim and on the provider file are not 16 or the 1st procedure service date on the detail line is less than or equals 01/31/1999 calculate allowed charge on the detail line with the allowed charge on the detail line times .15.
- If modifier 87 and the 1st procedure service date on the detail line less than or equals 12/31/1995 calculate allowed charge on the detail line with the allowed charge on the detail line times .15.
- If the modifiers are AL or AK or AU or AW or AY or the modifier is pay 75 percent and the procedure codes on the detail line is less than 70000 and greater than 89999 and the procedure code on the detail line is not in 90700 thru 90799 range and not in A0001 thru Z9998 range and the provider type code on the claim and provider file is not 65 or the provider specialty code on the claim and the provider file is not 16, calculate allowed charge on the detail line with the allowed charge on the detail line times .75.
- If the provider type code on the claim or on the provider file is 65 and the provider specialty code on the claim or on the provider file is 16 and the 1st procedure service date on the detail line is greater than 01/31/1998 and the procedure code on the detail line is less than 70000 or greater than 89999 and the procedure code on the detail line is not in 90700 thru 90799 range and not in A0001 thru Z9998 range and not a modifier 87 calculate the allowed charge on the detail line with the allowed charge on the detail line time .85.
- If the modifier is 86 or AN or AU and the 1st procedure service date on the detail line is less than 01/01/1996 calculate the allowed charge on the detail line with the allowed charge on the detail line times .5.
- If the modifier is pay half calculate the allowed charge on the detail line with the allowed charge on the detail line time .5.
- If modifier is 86 or AN or AU and the 1st procedure service date on the detail line is greater than or equal to 01/01/1996 and the provider type code on the claim and provider file is not 65 and the provider specialty code on the claim and the provider file is not 16 calculate the allowed charge on the detail line with the allowed charge on the detail line times .75.
- If the allowed charge on the detail line is greater than the submitted charge on the detail line and the revenue code on the detail line is not 951 and not 521 and not 522 or the provider is not in the 5000 thru 5999 range or the claim is not a UB82 home health move the submitted charge on the detail line to the allowed charge on the detail line, indicate pay as billed pricing.

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If the allowed charge is equal to the submitted charge and the modifier is pay half OR the modifier is 86 or AU or AN and the 1st procedure service date is less than 01/01/1996 calculate the allowed charge with the allowed charge times .5.

If allowed charge equals the submitted charge and the modifier is 86 or AN or AU and the 1st procedure service date is greater than or equal to 01/01/1996 calculate allowed charge with allowed charge times .75.

Subtract the allowed charge on the detail line from the submitted charge on the detail line giving other cutback amount on the detail line.

If the recipient has medicare coverage and the claim is not an adjustment and the patient liability is greater than zero and the patient liability is less than the allowed charge move patient liability to the allowed charge calculate other cutback amount with the submitted charge minus the allowed charge.

If the recipient has medicare coverage and the claim is not an adjustment and the patient liability is zero and the submitted charge minus other cutback(calculation made at the beginning of the program of the values that the claim came in with) is greater than zero and the submitted charge minus the other cutback (earlier calculation) is not equal to the current submitted charge and the submitted charge minus the other cutback(earlier calculation) is less than the allowed charge move the submitted charge minus the other cutback(earlier calculation) to allowed charge, calculate the other cutback again with the current submitted charge minus the allowed charge.

End of Pac Applied . ****

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APPLY REIMBURSEMENT RATE

If there is no DRG pricing and the claim is a UB82 Institutional claim calculate the allowed charge amount on the claim with the allowed charge amount that was on the claim minus the RC non covered charges minus the patient liability amount take that value and multiply it times the reimbursement ratio.

If there is no DRG pricing and the claim is not a UB82 institutional claim and is an institutional claim and IHS region and the provider is 1058 or 1061 or 1063 or 1068 or 1307 or 1312 or 1323, or 1324, or 1325 or 1326 or 1327 or 1328 or 1329 or 1330 or 1331 or 1332 or 2331 or 2333 or 2334 or 2335 or 2372 or 2400;

Select the correct rates on the provider file according to the service code.

If the 1st procedure service date on the detail line should equal or be greater than the provider rate effective date;

If the service code is A or B or Z calculate a rate with the provider accom fact p times the number of units of service on the detail line and move the new rate to the allowed charge on the detail line if it is less than the origin allowed charge.

If the service code is not A B and Z get the rate as if the service code is a H and calculate the rate with the provider accom fact p times a multiplier based on the actual service code move the new rate to the allowed charge on the detail line if the new rate is less than the allowed charge was originally

Calculate a new allowed charge with the current allowed charge on the detail line minus non covered charges on the detail line minus the patients liability on the detail line take that value and multiply it by the reimbursement ratio.

If there is no DRG pricing and the claim is not a UB82 institutional claim and is an institutional claim and not a IHS region or the provider is not 1058 and not 1061 and not 1063 and not 1068 and not 1307 and not 1312 and not 1323 and not 1324 and not 1325 and not 1326 and not 1327 and not 1328 and not 1329 and not 1330 and not 1331 and not 1332 and not 2331 and not 2333 and not 2334 and not 2335 and not 2372 and not 2400 Calculate a new allowed charge with the current allowed charge on the detail line minus non covered charges on the detail line minus the patients liability on the detail line take that value and multiply it by the reimbursement ratio.

If there is no DRG pricing and the claim is not a UB82 institutional claim and is an not an institutional claim calculate a new allowed charge with the current allowed charge times the reimbursement ratio.

If there is no DRG pricing calculate a reimbursement pct amount with the old reimbursement pct amount plus the old allowed charge minus the new allowed charge. Subtract the new allowed charge from the submitted charge to give a new other cutback amount.

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FEE COMPARISON

If the recipient has medicare coverage and the claim is not an adjustment and the patient liability is greater than zero and the patient liability is less than the allowed charge move patient liability to the allowed charge calculate other cutback amount with the submitted charge minus the allowed charge.

If the recipient has medicare coverage and the claim is not an adjustment and the patient liability is zero and the submitted charge minus other cutback(calculation made at the beginning of the program of the values that the claim came in with) is greater than zero and the submitted charge minus the other cutback (earlier calculation) is not equal to the current submitted charge and the submitted charge minus the other cutback(earlier calculation) is less than the allowed charge move the submitted charge minus the other cutback(earlier calculation) to allowed charge, calculate the other cutback again with the current submitted charge minus the allowed charge.

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CHECK BILLED

- If the processing clerk number is MAS and the provider is 1058 or 1061 or 1063 or 1068 or 1324 or 1307 or 2331 or 1326 or 2333 or 2334 or 1328 or 2335 or 2372 or 1330 or 2400 or 1323 or 1332 or 1325 or 1329 or 1331 or 1312 or 54516 or 54517 or 54518 or 54519 or 54520 or 54521 or 54522 or 54523 or 33056 or 33057 or 33058 or 33059, move the allowed charge on the detail line to the submitted charge on the detail line
Check all modifiers and detail extra modifiers.
- If the procedure code on the detail line is on procedure list 153 and the modifier is pay 8 dollars or procedure code on the detail line is 90782 and the revenue code is 983, move 8 dollars to the allowed charge on the detail line.
- If modifier pay 20 percent calculate allowed charge on the detail line with the allowed charge on the detail line time .20.
- If modifier 87 and the 1st procedure service date on the detail line greater than 12/31/1995 and the provider type code in the claim or on the provider file is 65 and the provider specialty code on the claim or on the provider file is 16 and the 1st procedure service date on the detail line is greater than 01/31/1999 calculate the allowed charge on the detail line with the allowed charge on the detail line time .17.
- If modifier 87 and the 1st procedure service date on the detail line greater than 12/31/1995 and the provider type code in the claim and on the provider file is are not 65 or the provider specialty code on the claim and on the provider file are not 16 or the 1st procedure service date on the detail line is less than or equals 01/31/1999 calculate allowed charge on the detail line with the allowed charge on the detail line times .15.
- If modifier 87 and the 1st procedure service date on the detail line less than or equals 12/31/1995 calculate allowed charge on the detail line with the allowed charge on the detail line times .15.
- If the modifiers are AL or AK or AU or AW or AY or the modifier is pay 75 percent and the procedure codes on the detail line is less than 70000 and greater than 89999 and the procedure code on the detail line is not in 90700 thru 90799 range and not in A0001 thru Z9998 range and the provider type code on the claim and provider file is not 65 or the provider specialty code on the claim and the provider file is not 16, calculate allowed charge on the detail line with the allowed charge on the detail line times .75.
- If the provider type code on the claim or on the provider file is 65 and the provider specialty code on the claim or on the provider file is 16 and the 1st procedure service date on the detail line is greater than 01/31/1998 and the procedure code on the detail line is less than 70000 or greater than 89999 and the procedure code on the detail line is not in 90700 thru 90799 range and not in A0001 thru Z9998 range and not a modifier 87 calculate the allowed charge on the detail line with the allowed charge on the detail line time .85.
- If the modifier is 86 or AN or AU and the 1st procedure service date on the detail line is less than 01/01/1996 calculate the allowed charge on the detail line with the allowed charge on the detail line times .5.
- If the modifier is pay half calculate the allowed charge on the detail line with the allowed charge on the detail line time .5.

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- If modifier is 86 or AN or AU and the 1st procedure service date on the detail line is greater than or equal to 01/01/1996 and the provider type code on the claim and provider file is not 65 and the provider specialty code on the claim and the provider file is not 16 calculate the allowed charge on the detail line with the allowed charge on the detail line times .75.
- If the allowed charge on the detail line is greater than the submitted charge on the detail line and the revenue code on the detail line is not 951 and not 521 and not 522 or the provider is not in the 5000 thru 5999 range or the claim is not a UB82 home health move the submitted charge on the detail line to the allowed charge on the detail line, indicate pay as billed pricing.
- If the allowed charge is equal to the submitted charge and the modifier is pay half OR the modifier is 86 or AU or AN and the 1st procedure service date is less than 01/01/1996 calculate the allowed charge with the allowed charge times .5.
- If allowed charge equals the submitted charge and the modifier is 86 or AN or AU and the 1st procedure service date is greater than or equal to 01/01/1996 calculate allowed charge with allowed charge times .75. Subtract the allowed charge on the detail line from the submitted charge on the detail line giving other cutback amount on the detail line.

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PRICE UB82 OUTP CPT4 NORM

- If not UB82 Outpatient or not IHS Region and the cpt4 code is 80002 thru 89399 or the revenue code is not 982 and there is a valid ancillary
- If UB82 home health and the bill type is 711 or look up the appropriate information on the provider file based on the service code on the detail line and the provider file show authorized and as long as the claim is not already priced move the submitted charge to the allowed charge on the detail line, also perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#))
- Perform Fee Comparison ([SEE FEE COMPARISON](#)).
- If UB82 outpatient and IHS region or CPT4 code is less than 80002 or greater than 89399 and the revenue code is 982, look up level 3 pricing for the pricing indicator that is on file determine what pricing to use based on that indicator on the level 3 pricing file.
- If pricing indicator is normal pricing.
- If there is an error on the provider file or the provide has type code of 65 and a specialty code of 16 or the provider has type code of 67 and a specialty code of 93 skip level 1 pricing.
- Set up key to look up level 1 pricing.
- If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 1 lookup otherwise use the type of service code that is coming in on the detail line.
- If UB82 Home Health or HCBC Elderly Disabled or the provider on the claim is with in 19000 thru 19099 range use the provider on the claim; But if it is not one of these three situations and the claim is a professional claim use the claims provider; but if this is not a professional claim and it is not one of the above three situations use the detail physician on the detail line to look up level 1 information.
- Look up level 1 information and store on a table for later use, if there is a bad price and the detail physician had not been used use that provider and relook up the level 1 pricing and store that information on a table for later use.
- If it is a UB82 Home Health claim and the bill type is 711 and the providers current or previous opt RR is greater than zero use revenue code to look up the price on the level 1 stored price table; if the revenue code matches the code on the table check the level 1 effective date if it is not greater than the detail 1st procedure date calculate the allowed charge on the detail line with the levell1 cust med charge times the unit of service on the detail line, but if the level 1 effective date is greater than the 1st procedure date calculate allowed charge on the detail line with the level 1 previous cust charge time the units of service on the detail line.

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If the claim is not a UB82 Home Health or the bill type is not 711 or the providers current and previous opt RR is zero use the revenue code if this is a UB82 Home Health to look up information on the level 1 stored price table or if this is not a UB82 Home Health claim use the procedure code to look up the information on the level 1 stored pricing table; If there is a match on the store level 1 pricing table and the level 1 Effective date is not greater than the 1st procedure service date on the detail line calculate level 1 cust med charge on the detail line with level 1 cust med charge on the table time the units of service on the detail line; If the Level 1 Effective date is greater than the 1st procedure service date calculate level 1 cust med charge on the detail line with previous cust charge time the units of service on the detail line.

If (not proc code A0425 or not A0428 and not A0429) and (not A0425 or A0428 or A0429 or A0426 or A0427) and (not A0425 or if it is not on the first detail line) and (not A0428 and not A0429) and (not A0426 and not A0427) and (not A0430) and (not A0431) and (not T2006 and not S4505) get level 2 information

Set up key to look up level 2 pricing.

If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 2 lookup otherwise use the type of service code that is coming in on the detail line.

Use 1 for location code on the level 2 key.

Use 0 for Specialty Code on the level 2 key.

Look up level 2 pricing and store on table for later use.

If level 2 effective date on the level 2 price table is not greater than the 1st procedure service date on the detail line calculate the level 2 prvl charge on the detail line with level 2 prvl charge on the pricing table times the unit of service on the detail line; If the level 2 effective date on the level 2 pricing table is greater than the 1st procedure service date on the detail line calculate level 2 prvl charge on the detail line with the previous level 2 prvl charge on the pricing table times the units of service on the detail lines.

If the type of service code on the detail line is 1 or H or J and the procedure code is 90585 thru 91999 or 92016 thru 99240 or 99275 thru 99499

OR

If the type of service code on the detail line is 2 or 9 and the procedure code is 10040 thru 69999 or 99201 thru 99499

OR

If the type of service code on the detail line is 3 and the procedure code on the detail line is 99241 thru 99274

OR

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- If the type of service code on the detail line is 4 or 6 or H or J and the procedure code on the detail line is 10000 thru 79999
Look up RVU Coeff and RVU Factor where the 1st procedure service date on the detail line is after the RVU date and also has a RVU type of service that matches the type of service code on the detail line.
- If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous rel val time the RVU Coeff times the RVU Factor time the units of service on the detail line.
- If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is zero or less and level 3 previous allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous allowed charge times units of service on the detail line.
- If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 rel val time the RVU Coeff time the RVU Factor times the units of service on the detail line.
- If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is zero and the level 2 allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 allowed charge on the price table time the units of service on the detail line.
- If the type of service code on the detail line is A and the level 3 rel val on the pricing table is greater than zero calculate level 2 allowed charge in the detail line with level 3 rel val on the price table time 15 plus the units of service on the detail line.
- If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table is greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times the units of service on the detail line.

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- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times the units of service on the detail line.
- If the provider on the claim is in 59000 thru 59999 range and the procedure code on the detail line is on procedure list 127
If UB82 outpatient claim or UB82 Home Health use cpt4 code on the detail line to look up lab file.
If not UB82 Outpatient claim and not UB82 Home Health use procedure code on the detail line to look up lab file.
If the 1st procedure service date on the detail line is not less than the current effective date on the lab file move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is greater than zero move the previous rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
If the 1st procedure service date on the detail line is less than or equal to the current effective date on the lab file and the previous effective date on the lab file is zero or less move the current rate on the lab file to the allowed charge on the detail line, mark as level 2 pricing.
- If Type of service code is G A or K move the level3 allowed charge on the detail line to the allowed charge on the detail line mark level 3 pricing. Done pricing.
- If level 1 cust med charge on the detail line is greater than zero and HCBC Elderly Disable Or the provider is 50000 thru 59999 or 19000 thru 19099 or 5000 thru 5999 and it's a professional claim.
If level 1 cust med charge on the detail line is greater than zero indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.
If level 1 cust med charge on the detail line is zero or less and level 2 prvl charge on the detail line is greater than zero, indicate level 2 pricing, move the level 2 prvl charge on the detail line to the allowed charge on the detail line. Done pricing.
If level 1 cust med charge on the detail line is zero or less and the level 2 prvl charge on the detail line is zero or less, indicate level 3 pricing, move level 3 allowed charge on the detail line to the allowed charge on the detail line. Done pricing.

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If level 1 cust med charge on the detail line is zero or less or not HCBC Elderly Disable and the provider is not 50000 thru 59999 and not 19000 thru 19099 and not 5000 thru 5999.
If level 2 prvl charge on the detail line greater than zero, indicate level 2 pricing, move level 2 prvl charge on the detail line to the allowed charge on the detail line. Done pricing.
If level 2 prvl charge on the detail line zero or less, indicate level 3 pricing, move level 3 allowed charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 2 prvl charge on the detail line is greater than zero and level 1 cust med charge on the detail line greater than the level 2 prvl charge on the detail line, indicate level 2 pricing, move level 2 prvl charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 2 prvl charge on the detail line is greater than zero and the level 1 cust med charge on the detail line less than or equal to the level 2 prvl charge on the detail line, indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 2 allowed charge on the detail line is zero, indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.

If level 3 allowed charge on the detail line greater than level 2 cust med charge on the detail line, indicate level 1 pricing, move level 1 cust med charge on the detail line to the allowed charge on the detail line. Done pricing.

If none of these situations are met than move level 3 allowed charge on the detail line to the allowed charge on the detail line and indicate level 3 pricing. Done pricing.

Perform Check Billed ([See CHECK BILLED](#)).

If pricing indicator is 1(level 1 pricing)
If there is an error on the provider file or the provide has type code of 65 and a specialty code of 16 or the provider has type code of 67 and a specialty code of 93 skip level 1 pricing.
Set up key to look up level 1 pricing.
If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 1 lookup otherwise use the type of service code that is coming in on the detail line.

If UB82 Home Health or HCBC Elderly Disabled or the provider on the claim is with in 19000 thru 19099 range use the provider on the claim; But if it is not one of these three situations and the claim is a professional claim use the claims provider; but if this is not a professional claim and it is not one of the above three situations use the detail physician on the detail line to look up level 1 information.

Look up level 1 information and store on a table for later use, if there is a bad price and the detail physician had not been used use that provider and relook up the level 1 pricing and store that information on a table for later use.

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- If it is a UB82 Home Health claim and the bill type is 711 and the providers current or previous opt RR is greater than zero use revenue code to look up the price on the level 1 stored price table; if the revenue code matches the code on the table check the level 1 effective date if it is not greater than the detail 1st procedure date calculate the allowed charge on the detail line with the levell cust med charge times the unit of service on the detail line, but if the level 1 effective date is greater than the 1st procedure date calculate allowed charge on the detail line with the level 1 previous cust charge time the units of service on the detail line.
- If the claim is not a UB82 Home Health or the bill type is not 711 or the providers current and previous opt RR is zero use the revenue code if this is a UB82 Home Health to look up information on the level 1 stored price table or if this is not a UB82 Home Health claim use the procedure code to look up the information on the level 1 stored pricing table; If there is a match on the store level 1 pricing table and the levell Effective date is not greater than the 1st procedure service date on the detail line calculate levell cust med charge on the detail line with level 1 cust med charge on the table time the units if service on the detail line; If the Level 1 Effective date is greater than the 1st procedure service date calculate level 1 cust med charge on the detail line with previous cust charge time the units of service on the detail line.
- If not UB82 home health and the level 1 cust med charge on the detail line is greater than zero and the provider is 50000 thru 59999 move the lvll cust med charge on the detail line to the allowed charge on the detail line.
- If this is a UB82 home health claim and the allowed charge on the detail line is not zero and the provider is within one of the following set of ranges 32000 thru 34999, or 38800 thru 39999 or 50000 thru 59999, or 19000 thru 19099, or 5000 thru 5999, go to Check Billed ([See CHECK BILLED](#)).
- If the pricing indicator is 2 (Level 2 pricing)
Set up key to look up level 2 pricing.
If the modifier on the detail line is 80 or 81 or 82 or 87 or AS or the three extra detail modifiers on the detail line are 80 or 81 or 82 or 87 or AS and the type of service is 8 use 2 for the type of service code on the level 2 lookup otherwise use the type of service code that is coming in on the detail line.
Use 1 for location code on the level 2 key.
Use 0 for Specialty Code on the level 2 key.
Look up level 2 pricing and store on table for later use.

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If level 2 effective date on the level 2 price table is not greater than the 1st procedure service date on the detail line calculate the level 2 prvl charge on the detail line with level 2 prvl charge on the pricing table times the unit of service on the detail line; If the level 2 effective date on the level 2 pricing table is greater than the 1st procedure service date on the detail line calculate level 2 prvl charge on the detail line with the previous level 2 prvl charge on the pricing table times the units of service on the detail lines.

If level 2 prvl charge in the detail line is greater than zero move the level 2 prvl charge on the detail line to the allowed charge on the detail line got to Check billed ([see CHECK BILLED](#)).

If pricing indicator is 3(level 3 pricing)

If the type of service code on the detail line is 1 or H or J and the procedure code is 90585 thru 91999 or 92016 thru 99240 or 99275 thru 99499

OR

If the type of service code on the detail line is 2 or 9 and the procedure code is 10040 thru 69999 or 99201 thru 99499

OR

If the type of service code on the detail line is 3 and the procedure code on the detail line is 99241 thru 99274

OR

If the type of service code on the detail line is 4 or 6 or H or J and the procedure code on the detail line is 10000 thru 79999

Look up RVU Coeff and RVU Factor where the 1st procedure service date on the detail line is after the RVU date and also has a RVU type of service that matches the type of service code on the detail line.

If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous rel val time the RVU Coeff times the RVU Factor time the units of service on the detail line.

If the 1st procedure service date on the detail line less than the level 3 effective date and the level 3 previous rel val is zero or less and level 3 previous allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 previous allowed charge times units of service on the detail line.

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- If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is greater than zero calculate level 3 allowed charge on the detail line with the level 3 rel val time the RVU Coeff time the RVU Factor times the units of service on the detail line.
- If the 1st procedure service date on the detail line is greater than or equal to the level 3 effective date and the level 3 rel val is zero and the level 2 allowed charge is greater than zero calculate level 3 allowed charge on the detail line with the level 3 allowed charge on the price table time the units of service on the detail line.
- If the type of service code on the detail line is A and the level 3 rel val on the pricing table is greater than zero calculate level 2 allowed charge in the detail line with level 3 rel val on the price table time 15 plus the units of service on the detail line.
- If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is not greater than the 1st procedure service date on the detail line and the level 3 allowed charge on the pricing 3 table is greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 allowed charge on the price 3 table times the units of service on the detail line.
- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is A0426 or A0427 or A0428 or A0429 or T2006 or S4505 or A0430 or A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times 1.
- If level 3 effective date on the pricing table is greater than or equal to the 1st procedure service date on the detail line and the level 3 previous allowed charge on the pricing table greater than zero and the procedure code is not A0426 and not A0427 and not A0428 and not A0429 and not T2006 and not S4505 and not A0430 and not A0431 calculate the level 3 allowed charge on the detail line with the level 3 previous allowed charge on the price 3 table times the units of service on the detail line.
- If level 3 allowed charge in the detail line is greater than zero move the level 3 allowed charge to the allowed charge on the detail line go to Check Billed ([see CHECK BILLED](#)).

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If pricing indicator is 9(do not pay).

Move zero to allowed charge on the detail line.

If pricing indicator is 5(priced as billed)

Indicate price as billed on the claim.

Calculate level3 allowed charge on the detail line with level3
allowed charge on the pricing table times the units of
service on the detail line.

Move submitted charge on the detail line to the allowed charge on
the detail line.

Go to Check Billed ([see CHECK BILLED](#)).

If any pricing indicator which did not price but is valid

Go to Check Billed ([see CHECK BILLED](#)).

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PRICE ACCOMMODATION

If the claim is already priced and the claim is a nursing home claim move 1 to reimbursement ratio.

Perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#))

Move the provider accom fact p from the provider file to the provider charge fact p on the detail line.

If it's a nursing home claim and a LTC region and the 1st procedure service date is greater than 12/31/1989 and the provider is 30000 thru 30699 and the provider is not 30225 and not 30423 and not 30394 and not 30396 and the providers location code is 1 and the service code is not Q and not S and not G and there was no error 087 on the claim and if the service code is R then the 1st procedure date must be greater than or equal to 09/01/1995 or there is not a service code of R but the 1st procedure date is less than 09/01/1995

(make sure client is eligible and also check for MDS rates or DDP rates)

If the service code is R and the new rate determined from Client Basic is less than the Provider charge fact p move the new rate to the provider charge fact p.

If this is a nursing home claim and a LTC region and the 1st procedure service date is greater than 12/31/1989 and the provider is 30000 thru 30699 range and provider is not 30225 and not 30423 and not 30394 and not 30396 and the service code is not Q and not R and not S and not 6 and as long as there wasn't a DDP or MDS rate found then move the submitted unit rate to the provider charge fact p.

If this is a nursing home claim,

If this is a LTC region and the Vocational Rehabilitation provider is not 1086 and not 2435 and not 50383 and not 017553 and the discharge was because of death and the service code and the discharge date equals the last procedure service date on the detail line calculate a non covered charge with the non covered days times the provider charge fact p before the calculation add 1 to the non covered days this is because the date of death in not paid for, then calculate the submitted charge on the detail line with the units of service times the provider charge fact p, move the provider charge fact p to the submitted unit rate on the detail line.

If this is a LTC region and the Vocational Rehabilitation provider is not 1086 and not 2435 and not 50383 and not 017553 and the discharge was not because of death or the service code is not R or the date of discharge is not equal to the last procedure service date and the submitted rate is not equal to the provider charge fact p calculate submitted charge with the unit of service times the provider charge fact P also calculate the non covered charge with the non covered days times the provider charge fact p move the provider charge fact p to the submitted rate.

Calculate the allowed charge on the detail line with the units of service times the provider charge fact p.

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- If the allowed charge on the detail line is greater than the submitted charge on the detail line move the submitted charge to the allowed charge if we are on the last detail line and the discharge was not because of death or the revenue code equals 160, 182 or 169 and they are not still a patient calculate a rate with the submitted charge divided by the units of service and subtract that rate from the allowed charge to represent that the last day will not be paid for.
- If the allowed charge on the detail line is not greater than or equal to the submitted charge move 1 to the reimbursement ratio Perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#)).
- If allowed charge on the detail line is equal to the submitted charge on the detail line and this is the last detail line on the claim and the discharge is not because of a death or the revenue code equals 160, 182 or 169 and they are not still a patient calculate and individual unit with the submitted charge divided by the units of service on the detail line and subtract that amount from the allowed charge on the detail line because we do not pay for that last day of service.
- If service codes are not 1 and not 2 and not 3 and not Q and not R and not S and not T and not U and not V and not W and not X and not Y just move the submitted charge on the detail line to the allowed charge on the detail line.
- If the claim is an inpatient claim or a UB82 inpatient claim
- If the provider charge fact p is \$999.99 calculate the allowed charge on the detail line with 15000.00 time the number on units of service on the detail line. If the submitted charge on the detail line less than or equal to the allowed charge on the detail line move the submitted charge on the detail line to the allowed charge on the detail line.
- If the provider charge fact p is not \$999.99 calculate the allowed charge on the detail line with the provider charge fact p on the detail line times the number of unit of service on the detail line.
- If allowed charge on the detail line is greater than the submitted charge move the submitted charge to the allowed charge.
- Perform Apply Remb Rate 3000 ([See APPLY REIMBURSEMENT RATE](#))

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Eligibility

Medicaid eligibility is entered in the TECS and/or TEEM systems. MMIS eligibility (SB620010) is entered for anyone the state pays a benefit on who is not Medicaid eligible. These type of clients are WW, VR, CSHS, and some DD as well as any others that do not have Medicaid eligibility.

A recipient's PCN is used to look up eligibility information. This information is retrieved from SB150030(TECS and TEEM eligibility file) or it is retrieved from SB620010(MMIS eligibility file) or it can also be on SB640010(QMB eligibility).

If the recipient is just on TECS or TEEM then the most recent eligibility record from ES150030 will be formatted as a MMIS base record. Other information is gathered for the base record when the recipient is on TECS or TEEM only. The last name, first name, middle initial, birthdate, sex, race, and date of death are found on the ES100000 file. The address information for TEEM is located on ADDRESS DB2 table and for TECS it is on ADDRESS adabas file. Living arrangement is found on CLIENT BASIC DBF file for TECS and LVNG_ARRNGMNT_INFO for TEEM(currently all living arrangements are being gathered from the CLIENT BASIC DBF; because the TEEM living arrangement is being posted back to TECS and the old information on TECS does not get posted to TEEM).

For a MMIS recipient, the base record information is on the SB620010 file.

Once the base record has been built then the remaining eligibility periods are stored on a table. The eligibility information for a TECS or TEEM recipients are all found on the ES150030 file. The information off the ES150030 will just need to be moved into the MMIS eligibility format so the program can utilize the data.

If this is a MMIS recipient, all the information on the SB620010 file is ready to move into the table.

If there is a record on the SB640010 file, the eligibility information is reviewed for QMB. The information generated for SB640010 comes from the TECS eligibility files for QMB.

The dates from the file are compared with the service dates on the claim to determine if the detail is QMB eligible.

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Recipient Liability

Recipient Liability is the amount of money that the recipient can afford to pay for their own medical expenses each month.

If the record is a UB82-Inpatient claim and a DRG claim with a net claim charge of zero, then no amount can be applied to recipient liability.

If the claim is a valid record on SB681010 (Basic Care ADABAS file) and if the basic care payment is not less than the net claim charge, the net claim charge becomes the total patient liability.

Nursing Home claims may have liability entered by the provider on the turnaround document, if so the amount has been deducted from the net charge and has to be added back before any liability is applied.

UB82 Inpatient, Medicare Crossover, State Hospital, and Swing Bed claims which span more than 1 month, we must allow a status of 'ML' (met liability) when checking client-status-ma on the CASE-COMPOSITION-DBF ADABAS file. If a client-status-ma of "ML" is found, we no longer continue processing for that month, but we compute the next month in the span and start over processing for that month of the claim until we find a client-status-ma of "AU". If none is found, no recipient liability is applied.

The client is looked up on the ME_SIXTY_FREE_DAY DB2 file and checked to see if they have any 60 free day periods. If so, each period will be entered into a table of begin and end dates. Each table entry will be set to 'Y' to indicate that liability has been met for the period. The CASE-LIABILITY-DBF ADABAS file is read and all of the case liability records will be tabled with all the other clients or buddies who are in the same liability records, because when a client meets his liability for a month it may cause others in the case to have their liability met also.

If the client had no entries loaded in the above table, all case liability records are read that have him in it and all the other clients who are in the same liability records are tabled. Each of these client's DB2 rows must be read and their date range placed into the table. Rather than adding other clients full 60 day spans, we cut the span end date to the last day of the first month in the entry. These short spans are to preclude letting this client meet liability between the date of birth and the end of the month. This would erroneously set a 60 free day period in effect even though this client is neither the mother or the newborn.

After all entries are placed into the table, then the status for the month of all begin dates in the table will be read and if the client status is 'AU', then that entry will be changed from 'Y' to 'N' to indicate that liability was not met for that entry. Claims will be passed against this table to see if they should be paid, pended or processed against liability.

If the entry is a 'Y' liability has been met between the date of birth and the end of the month for the 60 free ma days.

If the entry is a 'N' liability has not been met between the date of birth and the end of the month for the 60 free ma days.

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If the entry is a ' ' there are no clients or buddies with 60 free ma days.

All of the records on the ME_CLNT_BILL_APPLD DB2 file are read until we find the record with the lowest liability, then the sequence is saved to the lowest to use later.

If the entire claim was satisfied from liability then the record is updated on the CASE-LIABILITY-DBF ADABAS file and the claim is written to the client bill file. In this case, the client has remaining liability in this case liability record so leave the process switch on so the next claim for this client will be processed.

If this is a DRG claim and the RL is greater than or equal to the billed amt we will deduct the RL from the billed amt. If the RL is less than the billed amt and the billed amt is less than the DRG amt we will deduct the RL from the billed amt. Otherwise, we deduct RL from the DRG amt.

When the claim charge is reduced by recipient liability for a NON-TECS client, rows are created on the following two DB2 files: ME_CLNT_BILL and associated ME_CLNT_BILL_APPLIED, using data from the claim to record the claims used to satisfy liability.

The current claim record is updated to reflect the recipient liability used to satisfy part of the payment amount.

If the claim is a UB82 Inpatient, Crossover, State Hospital, or Swing Bed claim, we will initialize total patient liability to zero because we will be adding patient liability to total patient liability for each month processed in the month span.

If UB82 Inpatient claim or Crossover claim or Swing Bed or VR provider is equal to '001086' or '002435' or '050383') the claim applied amount is added to the total patient liability amount.

If not UB82 Inpatient claim or Crossover claim or Swing Bed or VR provider is not equal to '001086' or '002435' or '050383') the claim applied amount is moved to the total patient liability amount.

If Crossover claim and the recipient aid category is 028, or 029, or 030, or 031 and the procedure code is equal to '09990' or '09991' or '09992' or '09994' or '09995' or '09996' then zero will be moved into the patient liability amount.

If none of these checks apply to the claim, then the allowed charge is checked against the patient liability amount. If the allowed charge is greater than the patient liability amount, then the patient liability amount remains the same and the next detail is checked repeating this process until the allowed charge is less than the patient liability amount, then the allowed charge is moved into the patient liability amount. This process is repeated until there is no liability left.

If the claim's recipient legal county is equal to a 55 or 56, then the recipient liability is figured out by taking the total patient liability and multiplying it by the SPED (Special Program for the Elderly and Disabled) total allowed amount. The SPED total allowed amount is figured out by adding together all of the allowed charges for the details.

A credit claim (adjustment) reverses any recipient liability.

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INDIVIDUAL ADJUSTMENT PROCESSING

Week 1 of Checkwrite:

- 1) Request for individual adjustment goes into checkwrite via data entry
- 2) Request matches with history file. System makes a credit claim out of the history record and makes an adjustment claim.
- 3) Credit claim reverses any recipient liability.
- 4) Credit claim goes onto a 'hold' file until matching claim goes to pay.

Week 2 of Checkwrite:

- 1) Adjustment from Week 1 enters into MMIS as a claim.
- 2) It automatically suspends for the auditor to work.

Week 3 of Checkwrite:

- 1) If the individual adjustment has been worked by an auditor, it will enter MMIS and process as a regular claim.
- 2) If it processes without errors, it will match with the claim credit and both will appear on the RA.

HIPAA 837 ADJUSTMENTS

Week 1 of Checkwrite:

- 1) Adjustment comes in via the translator on an 837
- 2) Two separate records are created. One is the adjustment claim which contains the provider's corrections and the other record is similar to a paper adjustment request which goes onto the 'rolling transaction' file.
- 3) The 'rolling transaction' record goes into a job which matches the ICN with the history records. If a history record is found, a claim credit is created.
- 4) If the adjustment claim from step 2 has a matching credit from step 3, the system makes a claim record to go into the next checkwrite. The matching credit reverses any recipient liability and goes onto the negative claim 'hold' file.

Week 2 of Checkwrite:

- 1) The adjustment claim from week 1 enters checkwrite. If it has no errors, it will match up with the claim credit and both will appear on the RA.

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MASS ADJUSTMENT PROCESSING

Week 1 of Checkwrite:

- 1) Mass adjustment request goes into front end jobs via data entry and gets put on the 'rolling transaction file'.
- 2) Rolling transaction file goes into the job that creates mass adjustments. This job creates two files. One with the adjustment records and one with the claim credits. A report is created so the requestor can view the results to see if they are correct.
- 3) If the results are not correct, a job is run which deletes the files created above.
- 4) If the results are correct, a job is run which copies the files to ones which will enter the next checkwrite.
- 5) Claims enter checkwrite and automatically suspend. The auditor can then correct or recycle them.
- 6) The claim credits reverse recipient liability and are added to the claim credit 'hold' file to wait for the matching adjustment.

Week 2 of Checkwrite:

- 1) If claims are worked or recycled and have no errors, they will match with the claim credit and both will show on the RA.

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Financial Processes in the MMIS system

Financials are changes to present claims or other payments the state makes on behalf of recipients or providers. They are for the most part input into the MMIS system by Data Entry and create a record on the SB102010 file (rolling transaction file). At month end all financials are copied to the Master Financial File SB205010.

Reasons for a Financial being created.

1. Recoupment: This is to recover funds that were over paid to a Provider. These recoupments can be settled with a check from a provider or the system will deduct future payments from the provider until the Recoupment is settled. If the recoupment is large and it is a nursing home the MMIS system will take 10% per cycle until the recoupment is settled.
Transaction code 00.
2. Repayment: This financial is produced when an over payment is settled by a provider paying a check to the state to settle the over payment.
Transaction code 04.
3. Payouts: these are payments the state can make to a provider that needs operating capital on an emergency basis. The payout (Transaction code 06) will be created to cover the payout. Then a recoupment would be issued to recover the payout over the next MMIS cycles.
4. Cash Receipts: These financials are created for returned state checks that weren't cashed or personal checks received for overpayments or duplicate payments.
Transaction code 20 for state checks
Transaction code 30 for personal checks
5. Refunds: These are payouts for over charges of the system when more was owed to the provider. The system requires a cash receipt (Transaction code 20) financial before issuing the refund.
Refund transaction codes:
Transaction code 22 for refunds with History
Transaction code 24 for refunds without History
6. Void claims: If a claim needs to be voided a financial is created for that claim that voids the transaction. This is done when checks are not cashed or lost.
Transaction code 3
7. After processing these claims could become Transaction codes 26 (Credit Paid) 32 (Regular Financial Suspended) or 36 (Regular Financial Paid (State check))
8. Transaction code (50) are financial collection records.
9. Transaction code (80) system generated refund financial.

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Claims are processed through the MMIS system and accounted based on their Federal, State and County Share of the Medicaid funds paid using match codes for the types of claims. When the Federal Government or the Counties send money to the state a financial is created using the Financial Input Form and a "V" in the Action code to indicate that this isn't claim related. These transactions use the following codes:

Transaction code "70" for County payments
Transaction code "72" for state payments
Transaction code "74" for Federal payments

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Basic Processing of Financials

Financial records are produced in Job SB1J500 program SB1500 from Data Entry records input to the rolling transaction File SB102010 and SB683070 file for Buy in clients from Job ES3J300 program. These financials are placed on the SB150010 file. Report SB1-500-AA is created that shows all financial input records processed.

The financials are processed against the Master Provider Account file SB150050 in SB1550 where the adjustments and recoupments are added or deducted from the provider totals on file TP.SB150050 these transactions are reported on the SB1-550-CC report. This program also produces the Financial Status report SB1-550-BB.

These financials are added to the History File for medical claims and drug claims in SB1J065 the following MMIS run. For HMO financials they are added to History in SB1J069 the following MMIS run.

The county voucher is produced in SB1J510 program SB1580 which shows all the financial adjustments, recoupments, refunds that were processed each week on report SB1-580-AA. This shows the Federal, State, and county share of these activities based on the match code system.

Each Claim processed through the MMIS system produces a record of payments. Those that are not suspended are shown on the Remittance Advice in Job SB1J520 program SB1570 and a check for paid services is sent to each provider weekly. This is recorded on the Master Provider Account file SB150050. These Payments are totaled and the state then issues a payout financial. Those claims that suspend are reported on the Resolution Worksheet JOB SB1J086 program SB1390 and are reprocessed through the MMIS system after correction records that apply to each claim are produced.

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Other programs and their Actions

Program SB1020 JOB SB1J001 and SB1J001A formats the date for Financial records.

SB1210 JOB SB1J065 updates the history file with financials created in Job SB1J500 from the previous checkwrite run.

SB1220 Job SB1J066 updates the Master Provider Account file SB150050 with the financial transactions for the production of the 1099's at year end. Also shows if any recoupments are due to over payments.

SB1230 Job SB1J066 and SB1J069 reports financials with errors for recipients. SB1J066 for all types other than HMO which are processed in SB1J069.

Program SB1330 Job SB1J085 checks for financial records that are Void Check records. If the amount of the check has been added to the clients family subsidy amounts the check is subtracted from this amount and the Adabas file SS880010 is update accordingly.

Program SB1335 Job SB1J085 checks financial record for type writes those that qualify to file DF.SB133510 and adds a count of financial records that meets the criteria.

Program SB1370 has no processing of Financials but writes those present to the output file DF.SB137010(+1).

Program SB1565 checks the legal county and match code assigned to each financial. If the codes are inconsistent with correct procedures the claim is placed on a sort file and written to report SB1-565-AA.

Program SB1590 places all qualified financials (those other than collections) on file TP.SB159020(+1).

Program SB1595 JOB SB1J700 checks all claims and financials for proper sequencing and split claim codes. If they are found in error the program willabend.

Program SB1598 Job SB1J598 uses a Data Entry file DE.SB159805 to delete financial transactions from the Master Provider Account File SB150050.

Program SB1608 job SB1J608 creates refund financials for Drug claims paid by Blue Cross Blue Shield.

SB1661 Job SB1J661 Process only claims and skips financials.

SB1746 Job SB1J749 Process only claims and skips financials.

SB1747 Job SB1J745 Process HMO claims only and skips financials.

SB1749 Job SB1J749 Process HMO or PCP claims only and skips financials.

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SB1780 Job SB1J890 This program selects the Home and Community Base Care for the elderly/disabled and Home Health case claims from the MMIS monthend file and reformats them into the Home and Community Base Care for the elderly/ disabled master. This includes editing and transferring related financials to file TP.SB178010(+1) from TP.SB179010.

SB1800 Job SB1J920 THIS PROGRAM TAKES THE FINANCIAL TRANSACTIONS BATCH NUMBER 700 THRU 713 OFF THE SB179010 FILE AND PRINTS THEM ON MICROFICHE. The claim transaction codes selected are 00, 04, 06, 20, 22, 24, 26, 30, 32, 36 that are (FINR-ACTION-CODE = 'C' OR 'V' OR 'W' OR 'Y') and are in batch Range 700 to 713. This includes all Mass adjustments and Mass adjustment header records. Uses the last 6 TP.SB179010 files.

SB1806 Jobs SB1J805, SB1J806 and SB1J806A. CAPITATION REPORT - THIS PROGRAM PRODUCES A CAPATITATION EPURT FOR THE COUNTY AND DATES SELECTED ON THE SETUP RECORD. Uses the last 13 TP.Sb179010 files and selects claims based on the setup card. This program skips financial processing.

Financial reports are produced in Job SB1J700 program SB1850 with sub programs that produce the reports from the monthly claims file SB179010.

- SB185A - UPDATE 18-MONTH ARCHIVAL HISTORY EXTRACT
- SB185C - PAID CASE EXTRACTS
- SB185D - INSTITUTIONAL REASONABLE CHARGE REPORT
- SB185E - NON-INSTITUTIONAL REASONABLE CHARGE REPORT
- SB185F - LAST SERVICE OR SCREENING FILE
- SB185G - TOTAL CLAIMS REPORT
- SB185H - STATISTICAL ABSTRACT FILE
- SB185I - SUSPECT TPL/OI PULL LISTING
- SB185J - TPL/OI REDUCTIONS REPORT
- SB185K - CATEGORY OF SERVICE BY AID CATEGORY REPORT
- SB185L - FEDERAL MATCHING FUNDS DISTRIBUTION REPORT
- SB185M - COUNTY MONTHLY VOUCHER
- SB185N - CCS MONTHLY VOUCHER

The SUB Programs called for the MMIS system are SB185H, SB185K and SB185L. SB185H produces the Statistical Abstract file that contains the financial data for all claims and financials processed.

SB185K reports all financial data for claims and financials processed.

SB185L sets the match code and Group for Financial records.

For mass adjustments programs SB1870 and SB187A in Job SB1J870 produce adjustment records based on input from the SB102010 rolling transaction file. Adjustment records are produced for all claims for each provider listed based on procedure code price adjustments. These can be either increased or decreased amounts and can result in a recoupment or a refund being created for each provider that qualifies.

Program SB1895 Job SB1J895 creates a report for all adjustments by cost center and match code for each provider. This can produce a recoupment or payout.

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SB1900 processes financial costs and claim costs for INPATIENT AND OUTPATIENT CLAIM FROM MONTH END TAPE AND CREATES A RECORD FOR EACH DETAIL PER CLAIM AND WRITES TO file TP.SB190020(+1). The input is from TP.SB159020(0).

SB1905 JOB SB1J785 processes the inpatient and outpatient claims and financials for the State hospitals, with processing similar to SB1900.

SB1960 JOB SB1J840 produces the Paid admissions report (Does not process financials)

SB1970 JOB SB1J810 processes SB179010 claims for provider range 90000 to 99999 into the DDS format for both Claims and Financials that qualify.

SB2006 JOB SB2J006 reads the month end tape SB179010 and processes the DSH financial records into the DSH Report.

SB2050 Job SB2J001 and SB2J004 THIS PROGRAM PERFORMS PREPROCESSING FUNCTIONS FOR CLAIMS USED AS INPUT TO THE MARS (SB2050) AND SURS (SB3010) PROGRAMS: The financials that are processed are refunds and voids. Produces the Financial Master file SB205010.

SB2060 Job SB2J060 Formats dates on claims. Skips financial records.

SB2100 JOB SB1J001 THE EDIT, ALLOCATE AND FORMAT PROGRAM SEQUENTIALLY READS THE MONTHLY FINANCIAL WORKFILE (SB205010) Created in SB2050 FOR AN ENTIRE MONTH AND EDITS CERTAIN FIELDS IN THE RECORD FOR VALIDITY. DEFAULTS ARE PLUGGED AS REQUIRED.

OUTPUT FILES ARE:

ACCEPTED CLAIMS FILE	SB210010
2082 EXTRACT FILE	SB210030
CCS CLAIMS	SB210040
EPSDT SCREENING CLAIMS	SB210050
RECIPIENT COST SHARING	SB210060
CAT SVC PART C EXTRACT	SB210070

FIVE REPORTS ARE ALSO PRODUCED:

CLAIMS PAYMENT SUMMARY	SB2100AA
CLAIMS PAYMENT STATISTICS	SB2100BB
TRANSACTION REGISTER	SB2100CC
STERILIZATION REPORT	SB2100DD
PROCESS SUMMARY	SB2100FF

SB2210 HCFA processing. Deleted by HIPAA.

SB2255 moves the Recipient Base ID to Drug claims Original PCN field. Writes Financials without processing.

SB2260 Job SB1J260 and SB1J700 THIS PROGRAM WILL CREATE THE QUARTERLY 2082 TAPE TO TAPE CLAIM FILE AND THE TOTAL PROVIDER PAYMENT FILE. THE 3 MONTH END CLAIMS FILES (SB179010) FOR THE CURRENT QUARTER WILL BE USED FOR INPUT. Creates Quarterly file in SB2J260. Creates weekly in SB1J700.

SB2295 Job SB2J295 process claims and financials for the Human Service Centers.

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SB2940 JOB SB2J016 creates a report for financial records that meet the following criteria. IF (ACTION-CODE = 'C' (setup) OR 'V' (dispense void) OR 'W' (change) OR 'Y' (delete) AND ((TRANS-CODE = '22' (refund with history) OR '24' (refund no History) OR '26' (Over refund pay) OR '32' (Void claim) OR '36' (paid) OR '50' (Collection) OR FINR-REASON-CODE = '99' (Drug Rebate) This program then determines the proper collections, cancellations and refunds for each provider.

Program SB3010 Job SB3J005 THIS PROGRAM REFORMATS THE FINANCIAL WORK FILE FORM THE CLAIMS PROCESSING SUBSYSTEM INTO THE FORMAT REQUIRED FOR SUR PORCESSING. Files used for input TP.SB205010(0),TP.SB205010(-1),TP.SB205010(-2).

Program SB1990 Job SB1J990 creates the end year 1099's for each provider from the Master Provider Account file SB150050. This file is then copied and deleted for the next years records. This job must be run after the last checkwrite of the year and before the first checkwrite of the next year.

Program SB1991 Job SB1J991 READS THE Master Provider Account file SB150050 and reports EARNINGS FOR THE YEAR AND PREPARES AN EARNINGS DETAIL LIST.

SB4411 Job SB4J411 creates the file to use in the drug rebate programs that produce financial rebates to clients.

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Codes and Meaning

FINANCIAL REASON CODES

<u>CODE</u>	<u>DESCRIPTION</u>
91	Third Party - Medicare
92	Third Party - Health Insurance
93	Third Party - Casualty Insurance
94	Third Party - Reimbursements received from responsible relations
95	Probate collections - all types
96	Fraud and abuse
97	Voluntary repayments - all types
98	Other collections - Overpayments, payments to wrong vendor and collections
99	Drug rebates

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FINANCIAL INPUT ERROR CODES

<u>CODE</u>	<u>MESSAGE</u>
E01	Not Valid Action Code
E02	Not Valid Transaction Code
E03	Amounts Do No Crossfoot
E04	Action Code Setup - Transaction Not
E05	Action Code Disposition - Transaction Code Not
E06	Disposition Against A/R Requires A/R Number
E07	Invalid Case Number
E08	Setup with Number Already on File
E09	CTL Number Matches File, BUT Not Disposition, Change, Delete
E10	CTL Number Not on File for this Provider
E11	Disposition Original Amount Not Equal Setup Original Amount
E12	Transaction Amount Greater than Remaining Amount
E13	No Outstanding A/R's for this Provider on File
E14	A/R Control Number does not Match any File Items
E15	A/R Transaction Amount Greater than Remaining Amount on A/R
E16	More than 10 Dispositions Against this A/R this Cycle
E17	Duplicate Transaction this Cycle
E18	Provider not on File
E19	Sequence Detail Blank
E20	A Numeric ICN Must be Entered (This may be 0)
E21	Valid Numeric Date Must be Submitted
E22	A Valid Aid Category Must be Submitted on the Financial Input Form
E23	Action Code, Type Claim Invalid
E24	Incorrect Match Code
E25	Incorrect Category of Service
E26	Sequence Detail Must be Greater 00
E27	Invalid 'A/R Number ICN' for a Drug Rebate Collection/Payout
E28	MATCH-CODE equals 41 and ICN-REGION not equal 94 or MATCH-CODE equals 42 and ICN-REGION not equal 21.
E29	TRANSACTION-CODE equals 70 and REMAINING AMOUNT not equal zero
E30	Invalid Social Security
**	The following Financial (Input Error Codes (E31-E38)) are for VR an Supportive Employment Financials.
E31	Authorization Number not Numeric or Equal to Zeros
E32	Region 94 with Authorization Number Present but Procedure Code not Equal to 00052, 00053 or 00054
E33	Biennium (Last 2 Positions in Comments Field) not Numeric, or Equal to Zeroes, or an Even Year
E34	Authorization Record not Found on VR Authorization File
E35	Transaction Amount Greater than Total Actual Paid on VR Authorization File
E36	Transaction Amount Greater than the Current Paid Amount for the Biennium Entered in the Last 2 Positions of the Comments Field
E37	Transaction Amount is Greater than (Total Paid Amount - Total Credit Amount) from VR Authorization Payment Record which is Read when the Number is Entered on the Financial Form

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E38 Transaction Code must be a '20', '30', '22', '24', or '32'

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CASH DISPOSITION ERROR CODES

(Reported on the SB1230AA Recipient Data Sheets)

- H1: Base Soc Sec # and ICN # don't match. (Thru "MMIS", Enter "E" on CRT, and Soc Sec # off of input transaction. This code indicated Soc Sec # & ICN do not match).
- H2: Adjustment on original claim ICN #. (Enter "K" on CRT - Check for Auth # = if not on CRT look at backup on paid case report - microfiche). (Check history status (Claim Adj 20) Recip Data Sheet)
This code indicates ID # and ICN # match but original ICN # has been adjusted - look for new ICN #.
- H3: Sequence detail is less than amount refunded or has been used already. (Enter "K" on CRT - May have to check printout for collected refunds. Cancel or go to paid case report or remittance advice). This code indicates the refund amount is greater than the amount on the sequence detail line.
- H4: Wrong detail # to wrong amount.
(Check Backup on setup). This code indicates the sequence detail listed on the transaction is not out on the system - sequence detail line has to be changed.
- H5: Financial transaction case number does not match the related history record case number.

CASH DISPOSITION ERROR CODES

For DRG Related Financials in SB1210

- H1: Base Soc Sec # and ICN # don't match. (Thru "MMIS", enter "E" on CRT, and Soc Sec # off of input transaction. This code indicates Soc Sec # & ICN do not Match).
- H2: Original ICN # has been fully refunded.
- H3: Financial transaction amount greater than original reimbursement amount or the total amount refunded will be greater than the original amount. On a state check void the transaction amount does not equal the original amount of the check.
- H4: Claim detail number greater than those in history file.
- H5: Financial transaction case number does not match the related history record case number.

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