

ACR - Adult Care Resident Case Management and Reassessments

This pricing methodology has been moved under ALF, Assisted Living Facilities. Providers of ALF, Assisted Living Facilities, bill on the CMS 1500 form using specified procedure codes. ALF was previously called ACR, Adult Care Resident Case Management and Reassessments. For general information regarding CMS 1500 claims processing, please reference the Practitioner pricing guidelines. For other assessment forms, please reference the Assessment pricing guidelines.

Pricing Method Criteria:	<p>Provider Class Types: See value set 'Prov Types ACR Pricing'</p> <p>073 (Case Management Waivers) 051 (Health Department Clinic)</p> <p>Specialty Codes: See value set 'Prov Specs ACR Pricing'</p> <p>30 (Area Agency on Aging) 31 (Communtiy Service Boards) 32 (Department of Health) 33 (Centers for Independent Living) 34 (Department of Social Services)</p> <p>Procedure Codes: See value set 'Procedures ACR Pricing'</p> <p>S0220 S0220 U1 T2022 Z8574 Z8577 Z8578</p>
Billing Form:	CMS 1500 form
Benefit Package:	Aid category of 12, 32, or 52

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits	Not applicable	Not applicable

Rate Description	Rate Criteria
ALFCases Management and Reassessments	N/A

<p>Rate:</p> <p>The Procedure Rate Table rate is the maximum rate allowed based on the From Date of Service of the claim. There is only one rate for these services. There are no separate rates for adults and children.</p>	
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Calculation Description	Calculation Criteria
<p>ALF Case Management and Reassessments Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate is the procedure specific rate in effect based on the From Date on the claim. Refer to the rates section above for more information. 2. Multiply #1 by units on the claim. 3. Determine the lesser of Billed Amount on the claim and the result of #2. 4. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3. 5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, #4 is the Amount to Pay. 	<p>N/A</p>

ALF - Assisted Living Facilities (Formerly ACR - Adult Care Resident Case Management and Reas- sessments)

Providers of ALF, Assisted Living Facilities, bill on the CMS 1500. ALF was formerly in the Pricing Manual under ACR, Adult Care Resident Case Management and Reassessments. For general information regarding CMS 1500 claims processing, please reference the Practitioner pricing guidelines. For other assessment forms, please reference the Assessment pricing guidelines.

Pricing Method Criteria:	<p>Provider Class Types: See value set 'Prov Types ACR Pricing'.</p> <p>073 (Case Management Waivers) 051 (Health Department Clinic)</p> <p>Specialty Codes: See value set 'Prov Specs ACR Pricing'.</p> <p>30 (Area Agency on Aging) 31 (Community Service Boards) 32 (Dept. of Health) 33 (Centers for Independent Living) 34 (Dept. of Social Services)</p> <p>Procedure Codes: See value set 'Procedures ACR Pricing'</p> <p>S0220 S0220 U1 T2022 Z8574 Z8577 Z8578</p>
Billing Form:	CMS-1500 Claim Form
Benefit Package:	Aid Category of "12", "32", or "52".

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>ALF Cases Management and Reassessments Rate:</p> <p>The Procedure Rate Table rate is the maximum rate allowed based on the From Date of Service of the claim. There is only one rate for these services. There are no separate rates for adults and children.</p>	<p>N/A</p>

Calculation Description	Calculation Criteria
<p>ALF Case Management and Reassessments Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate is the procedure specific rate in effect based on the From Date on the claim. Refer to the rates section above for more information. 2. Multiply #1 by units on the claim. 3. Determine the lesser of Billed Amount on the claim and the result of #2. 4. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3. 5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, #4 is the Amount to Pay. 	<p>N/A</p>

ANES - Anesthesia

Providers with DMAS provider class type 020 can bill on the CMS-1500 claim form for anesthesia services.

Pricing Method Criteria:	Procedure Codes: 00100 - 01999
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Anesthesia Procedure Rate:</p> <p>The Anesthesia Base Units on the Procedure Base Unit Table is multiplied by a conversion factor to determine the anesthesia rate. The CPA04001 System Parameter in the MMIS contains the current conversion rate for pricing anesthesia claims using the base units.</p> <p>If a provider wants to be paid extra for an anesthesia claim for any reason (age, condition of patient, heart disease, surgical field avoidance, etc.), the provider bills with DMAS modifier 22 for procedure codes (99100-99140). This will cause the claim to pend for manual review. The system should never allow the claim to pay for more than the Billed Amount on the claim. Refer to Value Set ANES PROCS PRICING for procedure codes applicable for anesthesia base units pricing.</p> <p>Note: Effective 01/01/2013, selected anesthesia procedure codes may be priced using the rate for the procedure code in MMIS. These procedures are in Value Set ANES PROCS FFS PRICING FLAT RT. These procedures do not use the base units for pricing.</p>	N/A

Calculation Description	Calculation Criteria
<p>Anesthesia Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. The base units in effect on the From Date of Service of the claim is retrieved from the Procedure Base Unit Table. 2. Retrieve the conversion factor from the System Parameter Table using 'CPA04001'. Multiply the conversion factor in effect on the From Date of Service by base units (from Procedure Base Unit Table) plus number of units billed on the claim. 3. System determines the lesser of Billed Amount on the claim and the result of #2. 4. Subtract the result of #3 from Billed Amount to determine Non-Covered Charges. If Non-Covered charges is less than \$0.00, move \$0.00 to Non-Covered Charges. Otherwise, move the result of #4 to Non-Covered Charges. 5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3. 6. Subtract Copay amount, if applicable, from the result of #5. 7. If the result of #6 is less than \$0.00, move \$0.00 to the Amount to Pay Otherwise, #6 is Amount to Pay. 	<p>N/A</p>

ASSES - Assessments

Assessments are form-based evaluations of the functional, physiologic and social characteristics of individuals. Assessments are most typically performed for Medicaid participants by Medicaid providers, although some assessments are completed for individuals who are not eligible for Medicaid. Only Level I and Level II Screeners are priced and paid in the automated Medicaid system for Assessments as claim type 96. Rates are based on procedure codes stored on the Procedure Rate Table for each type of assessment.

Pricing Method Criteria:	N/A
Billing Form:	DMAS-96 Nursing Home Assessment Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Not Applicable	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>Assessment Rate:</p> <p>This is a single procedure rate retrieved from Medical and Administrative Codes Database. Assessments are represented as procedure codes assigned within the Assessment sub-system. Claims processing will access the appropriate procedure code on the Procedure Rate Table in order to determine the assessment rate.</p>	N/A

Calculation Description	Calculation Criteria
<p>Assessments Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate on the Procedure Rate Table in effect based on the From Date of Service on the claim. 2. Multiply the rate by the number of units on the claim. 3. Move Results of #2 to Amount To pay and to allowed amount. 	N/A

DENT - Dental

There are three different rates for dental services. Procedures such as Orthodontics (see ORTHODONTICS value set) which require a PA pay the authorized amount or some portion of the authorized amount from the PA Database. Clinic visits (procedure code 00088 and provider type 041) pay the rate on the Provider Rate Table. Other dental procedures pay the lesser of the rate from the Provider Procedure Rate Table times the units billed and the rate from the Procedure Rate Table times the units billed if both rates exist. If both rates do not exist, the rate that does exist is the rate used. As part of Dental Carve out project(FIX ISR:2003-282-001-M), ortho payout claims (claim procedure = 'D8999' and claim from date of service = '07/01/2005') will pay authorized amt instead of in portions of authorized amt.

Pricing Method Criteria:	Provider Types:040 (Dentist)041 (Dental Clinic)042 (Dental Clinic MH/MR)052 (Federally Qualified Health Center)053 (Rural Health Clinic)097 (Out-of-State Dental)
Billing Form:	ADA Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
Dental Clinic Rate: This rate is from the Provider Rate Table.	Provider Class Types:041 (Dental Clinic)052 (Federally Qualified Health Center)053 (Rural Health Clinic) Procedure Codes: 00088 Rate Type: BA Rate Code: CLVS
Dental Procedure Rate: This is a single procedure rate retrieved from the Procedure Rate Table.	Region Type: DEN Region: Based on Provider's locality or 0007 Rate Code:



	OP
Provider Procedure Rate: This rate is from the Provider Procedure Rate Table.	N/A
PA Rate: This rate is the PA authorized amount.	If procedure requires a PA and there is an authorized amount greater than zero.

Calculation Description	Calculation Criteria
<p>Regular Dental Services Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate from the Procedure Rate Table based on the provider's locality code and in effect on the from date of service of the claim. 2. Multiply Rate from #1, if found, by the number of units on the claim. 3. Rate from the Provider Procedure Rate Table in effect on the from date of service of the claim. 4. Multiply Rate from #3, if found, by the number of units on the claim. 5. The lesser of the result of #2 and #4 is the Allowed Amount if both rates are found. If either rate is not found, use the rate that is found times the units to determine the Allowed Amount. If no rates are found, edit 0210 is set. 6. If billed charge < Allowed Amount, moved billed charge to Allowed Amount. 7. Subtract Primary Carrier Amount Paid, if applicable, from the result of #6. 8. If the result of #7 is less than \$0.00, move \$0.00 to the Payment. Otherwise, move the result of #7 to Payment. 	<ol style="list-style-type: none"> 1. If there is no rate found based on the provider's locality, use region 0007 to find a rate. If none is found, continue at #3.
<p>Dental Clinic Services Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate from the Provider Rate Table in effect on 	<p>Provider Types:041 (Dental Clinic)052 (Federally Qualified Health Center) 053 (Rural Health Clinic)</p> <p>Procedure Codes:</p>



<p>the from date of service on the claim. This rate is the Allowed Amount.</p> <p>2. Subtract Primary Carrier Amount Paid, if applicable, from the result of #1.</p> <p>3. If the result of #2 is less than zero, move zero to Payment. Otherwise, the result of #2 is the Payment.</p>	00088
<p>PA Calculation of Amount to Pay:</p> <p>1. If PA authorized amount > 0, move that amount to the Allowed Amount except for Orthodontics where the first claim pays 40% of the authorized amount and the remaining 3 claims each pay 20% of the authorized amount.</p> <p>2. Subtract Primary Carrier Amount Paid, if applicable, from the result in # 1.</p> <p>3. If the result of #2 is less than zero, move zero to Payment. Otherwise, the result of #2 is the Payment.</p>	N/A

DME - Durable Medical Equipment (DME)

DMAS Provider Class Types 062, 064, and 090 can bill CMS-1500 claims for DME services. The procedure codes are listed in Appendix B of the Billing Manual. Durable medical equipment (DME) rates are stored in the Medical and Administration Codes database. If the rate is equal to "IC", and the PA is not required, the claim will pend and the Pend Resolution Clerks manually price the claim. If the rate is equal to "IC", and the PA is required, the claim should price based upon the rate authorized on the PA file. Modifier RR identifies rental DME codes that have both rental and purchase rates. The fees will be used from the Procedure Rate Table with region type DME and region '0001' for Rental (procedure modifier RR) and Region '0002' for Purchases and rate type 'OP'.

Pricing Method Criteria:	N/A
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>DME Procedure Code Rate:</p> <p>This is a provider specific rate retrieved from Medical and Administrative Codes Database. The fees will be used from Procedure Rate Table with region type DME and region 0001 for Rental (any procedure modifier = RR) and region 0002 for Purchase and rate type 'OP' .</p>	<p>Provider Class Type: 062, 064, 090.</p>

Calculation Description	Calculation Criteria
<p>DME Calculation of Amount to Pay:</p> <p>1. Rate on the Procedure Rate Table in effect based on the From Date of Service on the claim. The rate will be found with region type 'DME' and region 0001 for Rental (any procedure modifier = 'RR'), and region 0002 for Purchase and rate type 'OP'.</p>	<p>Provider Class Type: 062, 064, 090</p>

2. Multiply the rate by the number of units on the claim.

3. System determines the lesser of Billed Amount on the claim and the results of #2.

4. Subtract the result of #3 from Billed Amount to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges. Otherwise, move the result of #4 to Non-Covered Charges.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.

6. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, #5 is Amount to Pay.

ECM - Elderly Case Management

Participants receiving these services must be over the age of 60 and are identified on the Eligibility File by having the Exception Indicator field equal to "G".

Pricing Method Criteria:	Provider Class Types: 073 (Case Management Waiver) Provider Specialty Codes: 090 (Elderly Case Management)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	Exception Indicator field equal to "G".

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
Elderly Case Management Rate: This is a single procedure rate retrieved from Medical and Administrative Codes Database. These procedure codes have the first position of the code equal to "Z" and have one of the Procedure file flags equal to "G".	N/A

Calculation Description	Calculation Criteria
Elderly Case Management Calculation of Amount to Pay: 1. Rate is Procedure File Rate in effect based on the From Date on the claim. 2. Rate is \$3.33/unit up to a maximum of \$100.00/month regardless of number of units billed on the claim. 3. Determine the lesser of Billed Amount on the claim and the result of #2.	N/A

4. Subtract the result from #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.

6. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, #5 is the Amount to Pay.

EPSDT - EPSDT Screenings and Immunizations

EPSDT screening and immunization services are rendered by providers that bill on the CMS-1500 claim form. Procedure codes for the EPSDT screening and immunizations are identified with an “S” or “I” in one of the Procedure Flag Codes Table. This flag is then moved into the claim record for reporting EPSDT services to CMS.

Pricing Method Criteria:	Procedure Flags: S (Screening) I (Immunizations)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>EPSDT Procedure Rate:</p> <p>EPSDT procedures are identified with an 'S' or 'I' in one of the Procedure Flag Codes Table.</p>	<p>Procedure Modifiers (Alpha Codes):</p> <p>H (No abnormalities found) K (Abnormality found, treatment, no referral) T (Abnormality found, treatment, referral) U (Abnormality found, no treatment, referral) W (Abnormality found, no treatment, referral) Y (Abnormality found, treatment/referral refused) Z (Abnormality found, no treatment, no referral)</p>
<p>RBRVS Rate:</p> <p>This rate is referred to as Resource Based Relative Value Scale (RBRVS). RBRVS rates are calculated from RBRVS weights and conversion factors prior to being loaded to the Procedure Rate Table. Hence, RBRVS rates are loaded and accessed like any other procedure specific rate in the system.</p>	<p>Procedure Modifiers:</p> <p>51 (Multiple Surgery)</p>

Calculation Description	Calculation Criteria
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EPSDT Calculation of Amount to Pay:

1. Rate is the rate defined above in effect for the From Date of Service on the claim.

2. Multiply #1 by units on the claim.

3. System determines the lesser of Billed Amount on the claim and the results of #2.

4. Subtract the result of #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.

5. Subtract Primary Carrier Amount Paid, if applicable, from result of #3.

6. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #6 is the Amount to Pay.

N/A

FAMIS - Family Access to Medical Insurance Security

Family Access to Medical Insurance Security or FAMIS is a separate aid category from Medicaid. It is not Medicaid, but, it is processed within the Medicaid System. Methods used are the same as Medicaid restrictions and differences are handled by Edits such as: A payment request cannot span both the Medicaid and FAMIS plans because FAMIS is not an expansion of Medicaid. Hence, if the dates of service of a payment request span an enrollee's eligibility in the Medicaid and FAMIS plans, set by Edit 452. Providers are required to split bill when an enrollee's eligibility changes during a hospital stay. For FAMIS enrollees, outpatient psychiatric services are limited to 26 sessions. If any of the listed procedure codes are billed more than 26 times, by any provider, alone or in conjunction with one another, and the place of treatment is not 21 (inpatient hospital), then set edit 963. All Medicaid Edits that apply to FAMIS are identified in the Edit Audit Manual including edits for recipients under 21. If there is an approved PA on file and the authorized PA units have not all been used, the payment request's units are deducted from the remaining authorized units. If there are not enough remaining authorized units, a cutback is taken and EOB 0639 is set. Outpatient Psychiatric Therapy Procedure Codes: 90845 90846 90847 90849 90853 90855 90857 90804 - 90815 Inpatient Psychiatric Services Diagnosis Code: 2990 – 319 (ICD-9) or F0150 – F99 (ICD-10) Except where identified by Edits, the pricing methods for FAMIS are the same as Medicaid, including Inpatient, Outpatient, DRG, etc... All FAMIS programs are supported including FAMIS Fee For Service, FAMIS Medallion, FAMIS Medallion II, and FAMIS Medallion III.

Pricing Method Criteria:	Program Code: 07 Procedure Code Flag: CS
Billing Form:	UB92, CMS-1500, ADA Claim Form, Pharmacy Claim
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
N/A	Not Applicable	Refer to Copay Section

Rate Description	Rate Criteria
Substance Abuse Rates: Only procedure codes Y0300-Y0312 are valid and Place of Service must be office.	Procedure Codes: Y0300-Y0312 Place of Treatment: 11 (Office) Provider Type: 071 (Substance Abuse Clinic FAMIS) 022 (Treatment Foster Care) 077 (Residential Treatment)

<p>Outpatient Psychiatric:</p> <p>Outpatient psychiatric services are limited to 26 sessions for FAMIS recipients. If a Prior Authorization exists and the authorized PA units have not all been used, the payment request's units are deducted from the remaining authorized units. If there are not enough remaining authorized units, a cutback is taken and EOB 0639 is set.</p>	<p>FAMIS Psych Procedure Codes:</p> <p>90845 90846 90847 90849 90853 90855 90857 90804 - 90815</p>
<p>DRG: Rates:</p> <p>[Hospital specific operating rate per case + IME (Indirect Medical Education) rate per case] * DRG relative rate. Capital Percentage * Per Diem is added to this.</p> <p>This rate is based on the through date of the claim.</p>	<p>Program Code: 07</p> <p>Procedure Code Flag: CS</p>

Calculation Description	Calculation Criteria
<p>Calculations:</p> <p>Substance Abuse and Psychiatric:</p> <p>1. FAMIS Calculation of Amount to Pay: (Y0300-Y0312 Substance Abuse) (90845, 90846, 90847, 90849, 90853, 90855, 90857, 90804 - 90815 Psychiatric) and flag code CS (FAMIS).</p> <p>2. Multiply the FAMIS Rate by the covered billed days on the claim.</p> <p>3. Subtract the result of #2 from the billed amount to determine non-covered charges, if non-covered charges is less than zero, move zero to non-covered charges.</p> <p>4. Subtract the Copay Amount Paid, if applicable, from the result of #3.</p> <p>5. If the result of #4 is less than zero, move zero to Amount to Pay. Otherwise, result of #6 is Amount to Pay.</p>	<p>Procedure Codes: Y0300-Y0312 (Substance Abuse) 90845, 90846, 90847, 90849, 90853, 90855, 90857, 90804 - 90815 (Psychiatric)</p> <p>Flag Code: CS (FAMIS)</p>

DRG:

DRG Calculation of Amount to Pay:

1. The Primary Rate is the Provider's rate per case in effect based on the Through Date of service on the claim. The DRG assignment is derived from the ICD diagnosis and procedures on the claim from the DRG Grouper. Each DRG is assigned a relative weight and ALOS Table.

2. Multiply the rate per case by the relative weight of the assigned DRG (Case rate * DRG weight). This result needs to be stored for reporting purposes.

3. Amount to Pay is the result of #2 unless there is a transfer, readmission, or Outlier case payment then refer to #4, 5, or 6.

4. If the case is a transfer case, then compute the Transfer Per Diem Case Rate amount, based on the Through Date of Service on the claim. Per diem payment is calculated based on the DRG case rate times the relative weight / Avg. L.O.S. from the DRG table of Relative weight times covered days. This becomes the Amount to Pay if lessor than or equal to the DRG case rate (amount in #2). This result needs to be stored for reporting purposes. It is possible for a transfer case to have an Outlier payment(See #6 below).

5. If the case is determined to be a Re-admission payment request (5 days with same or similar diagnosis code), the 1st inpatient hospital claim is to be voided and re-processed to show zero payment. The reason message on the Remittance Advice should be 'Patient re-admitted, claim to be re-priced'. The second inpatient hospital claim is voided and re-processed to create one claim/case (combining the 1st and 2nd claims) to have one claim processed through the DRG grouper (Steps #1 and # 2). This result needs to be stored for reporting purposes.

6. Compute the Outlier rate amount. This rate

Program Code:
07

Procedure Code Flag:
CS

Provider Type

001
014
085
091

<p>applies to claims with a higher than usual charges. The Outlier formula is stored with First Health's current payment logic. DMAS will update the Outlier threshold and other factors as needed. Refer to the current ISR and implementation for Outlier payment calculations.</p> <p>7. Add DRG Case rate # 2 or #5 + Outlier rate # 6 and this becomes Amount to Pay. If the DRG Case is a Transfer Case, add the Transfer Case Rate #4 + Outlier rate #6 and this becomes Amount to Pay. This result needs to be stored for reporting purposes.</p> <p>8. Compute Percentage and Multiply by Per Diem. Add to result obtained in number 7.</p> <p>9. Add Primary Carrier Amount Paid, Deductible, and Co-pay.</p> <p>10. Subtract the Primary Carrier Amount Paid, Deductible, and Co-pay from the result of #7.</p> <p>11. Move the results of #9 to the Amount to Pay.</p>	
<p>DRG Psych Per Diem Rate:</p> <p>This rate is bypassed from the DRG Pricing Methodology but uses a per diem rate for psych services.</p> <p>Refer to the Inpatient Per Diem Calculation of Amount to Pay.</p>	<p>Provider Class Types:001(Hospital)003(Private EPSDT Mental Hospital)007(State Mental Hospital < 21)091(Non-Enrolled Hospital)</p> <p>Bill Types:</p> <p>111 112</p> <p>ICD Diagnosis: Principal Diagnosis in the range of 290 - 319 (ICD-9) or F0150 – F99 (ICD-10).</p>

FQHC - Federally Qualified Health Centers (FQHC)/ Rural Health Clinics (RHC)

Dates of Service: Claims with dates of service on or before 5/31/94 with an override of timely filing limits are paid fee for service and are processed as described in the Practitioners Section of this document. Federally Qualified Health Centers and Rural Health Clinics are paid an encounter rate for Z codes, which are identified as clinic visits. These providers are also paid fee-for-service rates for other services such as EPSDT immunizations and screenings, lab and x-ray, and surgical procedures. Dental procedures are also provided in FQHC and RHC settings. Dental clinics are paid an encounter rate plus fee for service for all other dental procedures. Refer to the Dental pricing methodology section for more information on dental rates and calculations.

Pricing Method Criteria:	Provider Types: See value set 'Prov Types FQHC/RHC Pricing' CPA04014 052 (Federally Qualified Health Center) 053 (Rural Health Clinic)
Billing Form:	CMS-1500 Claim Form, ADA Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Encounter Rate:</p> <p>The provider is paid an encounter rate for procedure codes with a CV (Clinic Visit) indicator in one of the Procedure Flag Codes Table. The encounter rate is stored on the provider file with an effective date.</p>	<p>Provider Types:052 (Federally Qualified Health Center) 053 (Rural Health Clinic)</p> <p>Procedure Codes: Z8805 Z8806 Z8807 Z8808</p>
<p>Fee for Service Rate:</p> <p>This is a single procedure rate retrieved from Medical and Administrative Codes Database. These rates apply to particular services and pro-</p>	<p>Provider Types:052 (Federally Qualified Health Center) 053 (Rural Health Clinic)</p>

<p>cedures with Procedure Flag Code Table equal 'CF' (Clinic Fee). The Procedure Rate Table will be the maximum fee allowed based on the From Date of Service on the claim. This rate can be the Procedure Rate Table Region 1 rate or the Region 2 rate for participants under the age of 21.</p>	<p>Procedures: EPSDT Immunizations EPSDT Screenings VFC Administration Fees Babycare (Z9001 - Z9312, A0160)</p> <p>Procedure Flags: CF (Clinic Fee) S (Screenings) I (Immunizations)</p>
<p>Lab and X-ray Procedure Rate: These procedures are paid a rate of \$0.00.</p>	<p>Dates of Service: After 05/31/94</p> <p>Procedure Codes: 70000 - 89999 (Lab and X-ray Procedures)</p>
<p>Professional Component Rate: This procedure rate is retrieved from Medical and Administrative Codes Database.</p>	<p>Procedure Modifiers: 26 (Professional Component)</p> <p>Procedure Codes: 70000 - 89999 (Lab and X-ray Procedures)</p>
<p>Technical Component Rate: This procedure rate is retrieved from Medical and Administrative Codes Database.</p>	<p>Procedure Modifiers: TC (Technical Component)</p> <p>Procedure Codes: 70000 - 89999 (Lab and X-ray Procedures)</p>
<p>Dental Encounter Rate: This rate is for a provider specific rate for dental encounters.</p>	<p>Provider Types: 041 (Dental Clinic)</p>

Calculation Description	Calculation Criteria
<p>Encounters Calculation of Amount to Pay:</p> <p>1. Rate is the Provider's Encounter Rate in effect based on the From Date on the claim.</p> <p>2. Multiply #1 by units on the claim.</p>	<p>Procedure Codes: Z8805 Z8806 Z8807 Z8808</p>

<p>3. Subtract Primary Carrier Amount Paid, if applicable, from the result of #2.</p> <p>4. Subtract Copay, if applicable, from the result of #3.</p> <p>5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #4 is Amount to Pay.</p>	
<p>Fee for Service Calculation of Amount to Pay:</p> <p>1. Rate is the rate in effect based on the From Date on the claim. This is Region 1 or Region 2 rate on the Procedure Rate Table. If service requires a prior authorization and the rate on the Procedure Rate Table indicates 'IC' (Individual Consideration), the rate on the prior authorization will be used. Otherwise, when a prior authorization is not required, the claim is pended for manual review.</p> <p>2. Multiply #1 by units on the claim.</p> <p>3. System determines the lesser of Billed Amount on the claim and the results of #2.</p> <p>4. Subtract the result of #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.</p> <p>5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.</p> <p>6. Subtract Copay, if applicable, from the result of #5.</p> <p>7. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #6 is the Amount to Pay.</p>	<p>Provider Types:052 (Federally Qualified Health Center) 053 (Rural Health Clinic)</p> <p>Procedures:</p> <p>EPSDT Immunizations EPSDT Screenings VFC Administration Fees</p> <p>Procedure Flags:</p> <p>CF (Clinic Fee) S (Screenings) I (Immunizations)</p>

HH - Home Health

Revenue codes are submitted on the UB claim form for Home Health services. Rates are based on the provider's city/county code and are broken down into 3 geographic regions: Northern Virginia Urban and Rural Commonwealth of Virginia Department of Health Each provider is identified on a rate table by the MSA they are located in. The UB does not identify location but the provider number is used to reference the rate table and identify location.

Pricing Method Criteria:	Provider Class Types:058 (Home Health State) 059 (Home Health Private)
Billing Form:	UB-92 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Home Health Rate:</p> <p>This rate is based on the provider's specialty and the 3 geographical regions of the provider's city/county code. The provider's city/county code can be found on the Provider Table. Each provider is identified on a rate table by the MSA they are located in. The UB-92 does not identify location but the provider number is used to reference the rate table and identify location.</p>	<p>Provider Specialty:54 (Hospital Based)55 (Free Standing Hospital)</p> <p>City/County Codes:</p> <p>Northern Virginia Urban and Rural State of Virginia Department of Health (VDOH)</p>
<p>Home Health PT/OT/SLP Rates:</p> <p>This rate uses revenue codes to price Home Health physical therapy, occupational therapy, and speech language pathology visits. Pricing is based on the fee file in accordance with the provider geographical location. The same services for Outpatient Rehab are priced differently using provider specific rates. Revenue codes can also be different for the same service. Refer to the Outpatient Rehab Section.</p>	<p>Revenue Codes:</p> <p>420, 421, 423, 424, 430, 431, 433, 434, 441, 444, 542, 550, 551, 552, 571.</p>

Calculation Description	Calculation Criteria
Home Health Calculation of Amount to Pay:	N/A

1. Rate in effect based on the From Date of Service on the claim.
2. Multiply the rate by the number of covered days.
3. Subtract Primary Carrier Amount Paid, if applicable, from the result of #2.
4. Subtract Copay, if applicable. Copay is the lesser of [(covered days on the claim) or ((through date - from date)+ 1) times the copay amount] from the result of #3.
5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, #4 is Amount to Pay.

HMO - Health Maintenance Organizations (HMO)

HMO organizations submit encounter claims may be submitted at any time but not less than monthly. Encounter claims are adjudicated and priced as Medicaid fee-for-service. Subsequently, encounter claims are stored in claims history for cost-savings reporting purposes. However, payment requests are not generated for encounters.

Pricing Method Criteria:	N/A
Billing Form:	Electronic HMO Encounter Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Not Applicable	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
HMO Rates: HMO encounters use same rates as Medicaid fee-for-service. Refer to the applicable pricing methodology.	N/A

Calculation Description	Calculation Criteria
HMO Calculation of Amount to Pay: HMO encounters use the same payment calculations as Medicaid fee-for-service. Refer to the applicable pricing methodology.	N/A

HOSP1 - Hospice - DOS Prior to 1/1/2004

Providers with a DMAS provider class type 046 can bill CMS-1500 claims for Hospice services. There are five procedure codes that can be billed, Z9430 through Z9434. The rate to pay is based upon the MSA for the recipient's location (FIPS). Refer to the Nursing Home section of this manual for more information .

Pricing Method Criteria:	<p>Provider Class Types:</p> <p>See value set; 'Prov Types Hospice Pricing' - CPA04010 046 (Hospice)</p> <p>Procedure Codes:</p> <p>See value set; 'Procedures Hospice Pricing' - CPA04033 Z9430 - Z9434</p>
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>Procedure Rate:</p> <p>MSA Procedure rate retrieved from Medical and Administrative Codes Database. The region specific rate is determined by the MSA code (Urban, Rural, N. Va) also stored on The Medical Codes and Administrative database.</p>	<p>Procedure Codes:</p> <p>Z9430 - Z9434</p>
<p>Institutionalized Care Rate:</p> <p>This is a provider specific nursing facility per diem rate found on the Provider Rate Table. Providers are paid 95% of this rate. The Z9434 procedure must be billed in conjunction with Z9430 (routine home care) or Z9431 (continuous home care).</p> <p>1. Provider Specific Nursing Facility Rate in effect</p>	<p>Procedure Codes:</p> <p>Z9434</p> <p>Note: With the implementation of ISR 1998-246-003-M, claims with Z9434 will process the same as all other HOSPICE procedure codes. Rates for Z9434 were added to the rate table 6/22/2004, with a begin date of 10/01/1997.</p>

<p>for the referring provider from the Provider Rate Table based on the from date on the claim.</p> <p>2. Multiply Provider Specific Rate by 95% (percent) times number of units on claim. Ex. (Rate * 95 %) * Units</p> <p>3. Subtract Carrier paid amount if any from #2. Ex. ((Rate * 95%) * Units) - Carrier paid</p> <p>4. If result from 3 is less than zero move zero to amount to pay. Ex. Amount to Pay = ((Rate * 95%) * Units) - Carrier Paid. If Amount to pay is less than zero move zero to amount to pay.</p>	
<p>Continuous Home Care Rate:</p> <p>Continuous Home Care must have a minimum of eight (8) hours and a maximum of twenty-four (24) hours. All others must have one service per treatment date.</p>	<p>Procedure Codes:</p> <p>Z9431</p>

Calculation Description	Calculation Criteria
<p>Hospice Procedure Code Calculation of Amount to Pay:</p> <p>1. Rate in effect for the procedure code based on the MSA rate on the Procedure Rate Table on the From Date of the claim.</p> <p>2. Multiply rate by the number of units from the claim.</p> <p>3. System determines the lesser of the Billed Amount on the claim and the result of #2.</p> <p>4. Subtract the results of #3 from billed amount to determine Non-Covered charges. If Non-Covered Charges is less than zero, move zero to Non-Covered Charges. Otherwise, move the result of #4 to Non-Covered Charges.</p> <p>5. Subtract Primary Carrier Amount Paid, if applicable, from result of #3.</p> <p>6. If the result of #5 is less than zero, move zero to Amount to Pay. Otherwise, #5 is Amount to Pay.</p>	<p>Procedure Codes:</p> <p>Z9430 - Z9434</p>
<p>Institutionalized Care Calculation of Amount to</p>	<p>Procedure Codes:</p>

Pay:

1. Provider Specific Nursing Facility Rate in effect for the referring provider from the Provider Rate Table based on the from date on the claim. Note: The Z9434 procedure must be billed in conjunction with Z9430 (routine home care) or Z9431 (continuous home care).
2. Multiply (Provider Specific Rate by 95 percent) times the number of units from the claim.
3. Subtract Primary Carrier Amount Paid, if applicable, from the result of #2.
4. If the result of #3 is less than zero, move zero to Amount to Pay. Otherwise, #3 is Amount to Pay.

Z9434

Note: With the implementation of ISR 1998-246-003-M, claims with Z9434 will process the same as all other HOSPICE procedure codes. Rates for Z9434 were added to the rate table 6/22/2004, with a begin date of 10/01/1997..

HOSP2 - Hospice - DOS on or after 1/1/2004

Providers with a DMAS provider class type 046 must bill UB claims for Hospice services with DOS on or after 1/1/2004. Pricing is the same as for Hospice CMS-1500 claims with DOS prior to 1/1/2004 except that revenue codes are used instead of procedure codes. There are five revenue codes that can be billed, 651, 652, 653, 655, 656 and 658. The rate to pay is based upon the MSA rate based on the recipient's location (FIPS). Refer to the Nursing Home section of this manual for more information. .

Pricing Method Criteria:	<p>Provider Class Types:</p> <p>See value set; 'Prov Types Hospice Pricing' - CPA04010 046 (Hospice)</p> <p>Revenue Codes:</p> <p>651, 652, 653, 655, 656, 658</p>
Billing Form:	UB
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	N/A	N/A

Rate Description	Rate Criteria
<p>Revenue Code Rate:</p> <p>MSA revenue code rate retrieved from Medical and Administrative Codes Database. The region specific rate is determined by the MSA code (Urban, Rural, N. Va) also stored on The Medical Codes and Administrative database. The MSA rate is based on the recipient's location (FIPS).</p>	<p>Revenue Codes:</p> <p>651, 652, 653, 655, 656</p>
<p>Institutionalized Care Rate:</p> <p>Before 07/01/2015 the following pricing will be done for Hospice. After 07/01/2015 will be the RUG pricing.</p> <p>This is a provider specific nursing facility per diem</p>	<p>Revenue Codes:</p> <p>658</p>

rate found on the Provider Rate Table. This is the rate that is in effect for the UB92 first other provider based on the from date of service on the claim. Providers are paid 95% of this rate. The 658 revenue code must be billed in conjunction with 651 (routine home care) or 652 (continuous home care).	
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Calculation Description	Calculation Criteria
<p>Hospice Revenue Code Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate in effect for the revenue code based on the MSA rate on the Procedure Rate Table on the From Date of the claim. 2. Multiply rate by the number of units from the claim. 3. System determines the lesser of the Revenue Billed Amount on the claim and the result of #2. 	<p>Revenue Codes:</p> <p>651, 652, 653, 655, 656</p>
<p>Institutionalized Care Calculation of Amount to Pay:</p> <p>Before 07/01/2015 the following pricing will be done for Hospice. After 07/01/2015 will be the RUG pricing.</p> <ol style="list-style-type: none"> 1. Provider Specific Nursing Facility Rate in effect for the UB92 first other provider from the Provider Rate Table based on the from date of service on the claim. 2. Multiply (Provider Specific Rate by 95 percent) times the number of revenue units from the claim. <p>Hospice revenue '0658' pricing changes due to NPI implementation (effective from 03/26/2007 implementation date) which impacts only 1 above :</p> <ol style="list-style-type: none"> 1) If the claim is submitted with the NPI in the other provider id : <p>a] and that id has multiple provider type/location specific provider ids, the recipient's location</p>	<p>Revenue Codes:</p> <p>658</p>

details will be used to choose the specific provider id . This is done by comparing the recipient's address zip code from the recipient subsystem database and the provider servicing address zip codes. The provider id whose zip code matches the recipient's zip code is selected. If no match or more than one match, edit 1378 is set. The recipient's nursing home address is required to be captured in the recipient subsystem database in order for this pricing method to work.

b] or that id has a single provider type/location specific provider id, then there is no need to match the recipient address with the provider servicing address . The provider rates for the same provider type/location id will be used for the claim pricing purpose.

2) If the claim is submitted with the legacy provider id in the other provider id, there is no need to match the recipient address with the provider servicing address. The provider rates for the submitted legacy provider id will be used for the claim pricing purpose.

Hospice RUG Calculation of Amount to Pay – Effective with claim dates of service on or after 07/01/2015:

1. The per diem shall be calculated as the sum of the per diem rates for each revenue code 0022 line multiplied times the line-level revenue units.

- a. The RUG per diem rate for each revenue code 0022 line is calculated as follows, based on the from date of service: ((Direct rate X RUG weight) + Indirect rate + NATCEPS + Criminal Records + Plant Rate) rounded.
- b. Multiply the RUG per diem rate by the associated line-level revenue units.
- c. The final calculated RUG rounded amount will be multiplied by .95.

<p>2. The line-level per diem allowed amounts will be summed into the final reimbursement amount.</p> <p>3. The final reimbursement shall continue to be subject to copay, third party liability, patient pay, private room differential, and other payment calculations performed after the determination of the per diem rate.</p>	
<p>Total Claim Calculation of Amount to Pay:</p> <p>1. Add the calculated allowed amounts from all revenue lines.</p> <p>2. Subtract Primary Carrier Amount Paid, if applicable, from result of #1.</p> <p>3. Subtract Patient Pay, if applicable, from result #2.</p> <p>4. If the result of #3 is less than zero, move zero to Amount to Pay. Otherwise, #3 is Amount to Pay.</p>	<p>N/A</p>

IIPR - Inpatient Intensive Physical Rehabilitation

There are two types of inpatient intensive physical rehabilitation services: Intensive Physical Rehabilitation and Intensive Physical Rehabilitation - Special Contracts. Inpatient intensive physical rehabilitation services are billed on the UB claim form by the DMAS Provider Class Types 014 and 085 with the following Type of Bill codes: 111 (original claims), 116 (adjustments), 118 (voids). Special contracts within intensive physical rehabilitation services are available for a participant who qualifies for an intensive rehabilitation level of care. DMAS negotiates a per diem rate with the provider for these services for the participant. There are two types of special contract services and providers under intensive rehabilitation: In-State enrolled providers for ventilator dependent services and out-of-state providers for participants whose needs cannot be met by an in-state facility. These providers can be participating or non-participating out-of-state providers. Claims are paid automatically through the Claims Processing Subsystem, based on the negotiated amount contained on the prior authorization or a negotiated provider specific per diem rate on the Prior Authorization File. A prior authorization is always required for intensive physical rehabilitation services. Special negotiated rates for vent or other special rehab contracts will reside on the PA file. Z9992 code has been assigned for two existing special contracts: out-of-state and vents. Provider type 085 (Non-enroll Rehab Hospital) and 014 (Rehab Hospital) will bill for these special contracts. If the entire per diem is negotiated, the provider will bill using Z9992 with accommodation revenue code. If only a portion of the per diem is negotiated, the provider will bill for a normal inpatient rehab stay using the dates authorized on the PA plus procedure code Z9981 within the date authorized on the PA file.

Pricing Method Criteria:	Provider Class Types:014 (Rehab Hospital)085 (Non-Enroll Rehab Hospital)
Billing Form:	UB Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	N/A	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Primary Rehab Per Diem:</p> <p>This is a provider specific per diem rate for in-state rehab hospitals.</p>	<p>Provider Class Type:014 (Rehab Hospital)</p>
<p>Rehab Average State-Wide Per Diem Rate:</p> <p>This is a state-wide average inpatient rehab per diem rate for out-of-state providers. There is no DSA rate associated with this rate.</p>	<p>Provider Class Types:085 (Non-Enroll Rehab Hospital)</p>

<p>Rehab Average State-Wide Percentage</p> <p>Average State-Wide Percentage:</p> <p>This provider specific rate applies to out-of-state non-participating providers. Out-of-state providers are paid the lessor of the average statewide per diem rate or average statewide percentage.</p>	<p>Provider Class Types: 085(Non-enroll Rehab Hospital)</p>
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Calculation Description	Calculation Criteria
<p>Enrolled Rehab Hospital Calculation of Amount to Pay:</p> <p>Prior to 01/01/2000:</p> <ol style="list-style-type: none"> 1. Determine the provider's Per Diem Rate in effect based on the From Date on the claim. 2. Multiply #1 by the Payment Days on the claim to calculate the Per Diem Amount to Pay. 3. Add Primary Carrier Amount Paid, Patient Pay Amount and Copay. 4. Subtract the result of #3 from the result of #2. 5. If the result of #4 is less than \$0.00, then move \$0.00 to Amount to Pay and approve the claim. Otherwise, the result of #4 is the Amount to Pay. <p>As of 01/01/2000:</p> <ol style="list-style-type: none"> 1. Obtain operating rate from Rates database. 2. Multiply #1 by the number of Payment Days on the claim to calculate the Amount to Pay. 3. Multiply Capital Percentage by Amount to Pay Add to result obtained in number 2. 4. Add Primary Carrier Amount Paid, Patient Pay Amount and Copay. 5. Subtract the result of #4 from the result of #3. 	<p>Provider Class Types:014 (Rehab Hospital)</p>

<p>6. If the result of #5 is less than \$0.00, then move \$0.00 to Amount to Pay and approve the claim. Otherwise, the result of #5 is the Amount to Pay.</p>	
<p>Non-Enrolled Hospital Calculation of Amount to Pay:</p> <p>Prior to 01/01/2000:</p> <ol style="list-style-type: none"> 1. Determine the provider's Average Statewide Percent Rate in effect based on the From Date on the claim. 2. Multiply #1 by the allowed amount on the claim to calculate the Percent Amount to Pay. 3. Determine the provider's Average Statewide Per Diem Rate in effect based on the From Date on the claim. 4. Multiply #3 by the Payment Days on the claim to calculate Per Diem Amount to Pay. 5. Determine the lesser of #2 and #4. This result needs to be stored for reporting purposes. 6. Add Primary Carrier Amount Paid, Patient Pay Amount, Deductible, and Co-pay. 7. Subtract the result of #6 from the result of #5. 8. If the result of #7 is less than \$0.00, then move \$0.00 to Amount to Pay and approve the claim. Otherwise, the result of #7 is the Amount to Pay. <p>As of 01/01/2000:</p> <ol style="list-style-type: none"> 1. Obtain operating rate from Rates database. 2. Multiply #1 by the number of Payment Days on the claim to calculate the Amount to Pay. 3. Multiply Capital Percentage by Amount to Pay Add to result obtained in number 2. 4. Add Primary Carrier Amount Paid, Patient Pay Amount and Copay. 	<p>Provider Class Types:085 (Non-Enrolled Rehab Hospital)</p>

<p>5. Subtract the result of #4 from the result of #3.</p> <p>6. If the result of #5 is less than \$0.00, then move \$0.00 to Amount to Pay and approve the claim. Otherwise, the result of #5 is the Amount to Pay.</p>	
<p>DRG Calculation of Amount to Pay:</p> <p>This rate is by-passed from the DRG Pricing Methodology but uses a per diem rate for rehab services.</p> <p>Refer to the Inpatient Per Diem Calculation of Amount to Pay</p>	<p>Provider Class Types:014 (Rehab Hospital) 085 (Non-enroll Rehab) After DRG is fully implemented</p> <p>Bill Types:</p> <p>111 112</p>

IL - Independent Labs

DMAS Provider Class Types 001, 008, 009, 070, 091, and 098 bill on the CMS-1500 claim form.

Pricing Method Criteria:	Provider Class Types:001 (Hospital)008 (State MH med-surg)009 (Med-Surg MR)070 (Independent Lab)091 (Non-Enroll Hospital) 098 (Non-Enroll Lab) Invoice Type 08(Independent Lab)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Procedure Rate:</p> <p>This rate is retrieved from the Procedure Rate Table using the region type from the Reference Procedure Pricing Category Table, region 0001, and the rate type OP.</p>	<p>Region Type:</p> <p>From the Procedure Category Table</p> <p>Region:</p> <p>0001</p> <p>Rate Code:</p> <p>OP</p>
<p>CSB Rate:</p> <p>Effective 10/01/95, CSB (Community Service Board) Providers have a contract with an independent lab to pay at an agreed contract price.</p>	N/A
<p>Professional Component Rates:</p> <p>The Rate for Professional Component are obtained from the Procedure Rate Table using the region type from the Reference Procedure Pricing Category Table, region 0001, and rate type OPPC.</p>	<p>Procedure Modifier:</p> <p>26 (Professional Component)</p> <p>Procedure Codes:</p> <p>See value set CPA04021</p>
<p>Technical Component Rates:</p> <p>The Rates for Technical Component are</p>	<p>Procedure Modifier:</p> <p>TC (Technical Component)</p>

<p>obtained from the Procedure Rate Table using the region type from the Reference Procedure Pricing Category Table, region 0001, and rate types OP and OPPC. The difference in the two rates is the rate for technical component.</p>	<p>Procedure Codes: See value set CPA04021</p>
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Calculation Description	Calculation Criteria
<p>Independent Lab Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate is the rate in effect on the from date on the claim. 2. Multiply rate, if found, by units on the claim. 3. System determines the lesser of Billed Amount on the claim and the results of #2. 4. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3. 5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #5 is the Amount to Pay. 	<ol style="list-style-type: none"> 1. If procedure is in value set CPA04021 and the first procedure modifier is 26, the rate is read from the Reference Procedure Rate Table using the rate type OPPC. If the procedure is in value set CPA04021 and the first procedure modifier is TC, two rates are read from the Reference Procedure Rate Table; one uses the rate type OPPC (called min rate) and the other uses the rate type OP (called max rate). The difference between the max rate and the min rate is the rate in #2. If there is no procedure modifier 26 or TC, the rate type used is OP to obtain the rate used in #2.

INP - Inpatient

Inpatient services are billed on the UB claim form by the current DMAS Provider Class Types 001, 002, 003, 004, 005, 007, 008, 009, 012, 013, 014, 085, and 091 using the following Type of Bill Codes: 111(original claims) 112 (interim - first) 113 (interim - continuous) 114 (interim - last) 116 (adjustments) 118 (voids) This methodology uses the procedure and diagnosis on the claim to assign a DRG code and derive payment. First, the inpatient services are mapped into a common ICD coding scheme. Claims with bill type 111 and 112 are then grouped into cases and assigned a DRG code. Multi-claim stays will consist of bill type 112, 113, and 114. However, bill type 113 is not grouped and assigned a DRG code. Bill type 114 claims go to the grouper to ensure that the system will be able to identify the discharge date and status. Bill type 114 will have the discharge status and all the diagnosis and procedure codes. A daily adjudication cycle prices claims individually which are subsequently cost-settled once the claims can be assembled into cases, re-admission (inpatient admissions to same facility within 5 days from previous inpatient discharge date with the same or similar principal diagnosis), and implied transfers. As of 01/01/2000, the current billing cycle will be expanded from 21 to 120 days, for bill types 111, 112, and 113. For children (enrollees under 21), the current billing cycle of 31 days has expanded to 120 days. DRG is applied to only inpatient acute medical and surgical provider class types (PCT 001 and 091), effective as of 01/01/2000. Hospital (PCT 001,091) services with a primary diagnosis of mental health or rehabilitation, claims are priced at a per diem payment methodology. PCTs of 002, 003, 004, 005, 007, 008, 009, 012, 014, and 085 will be priced on the per diem payment methodology. Transplants are paid at a contracted or negotiated rate that is obtained from the PA File. For admissions on or after January 1, 2000, reimbursement is based on DRG for Medicaid and FAMIS.

Pricing Method Criteria:	Provider Class Types: 001 (Hospital) 002 (State Mental Hospital) 003 (Private EPSDT Mental Hospital) 007 (State Mental Hospital < 21) 008 (State MH Med-Surg) 009 (Med-Surg MR) 012 (Long Stay Inpatient Hospital – MH) 014 (Rehab Hospital) 085 (Non-Enroll Rehab) 091 (Non-Enroll Hospital)
Billing Form:	UB Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
Regular Per Diem and DSA Rate: This is a provider specific per diem rate. This secondary DSA rate has been discontinued effective 07/01/1996 for all hospitals except PCT 004 (Long Stay Hospital).	Provide Class Types: 001 (Hospital) 002 (State Mental Hospital) 003 (Private EPSDT Mental Hospital) 007 (State Mental Hospital < 21) 008 (State MH Med-Surg) 009 (Med-Surg MR) 012 (Long Stay Inpatient Hospital – MH) 014 (Rehab Hospital)

<p>Neonatal Intensive Care Unit (NICU) Per Diem Rate:</p> <p>The rate is for neonatal services and cannot be billed with any other room or board code effective with admission on or prior to December 31, 1999. The secondary NICU DSA rate has been discontinued effective 07/01/1996 for all hospitals with neonatal services.</p>	<p>Provider Class Types:</p> <p>001 (Hospital)</p> <p>Revenue Code:</p> <p>175 (Neonatal)</p>
<p>EPSDT Psych Per Diem Rate:</p> <p>This rate applies to EPSDT inpatient psych services.</p>	<p>Provider Class Types:003 (Private EPSDT Mental Hospital) 007 (State Mental Hospital < 21)</p>
<p>Average State-Wide Per Diem Rate:</p> <p>This is a statewide average inpatient per diem rate for out-of-state providers. There is no DSA rate associated with this rate. Out-of-state providers are paid the lessor of the average statewide per diem rate or average statewide percentage.</p>	<p>Provider Class Types:085 (Non-Enrolled Rehab) 091 (Non-Enrolled Hospital)</p>
<p>Average State-Wide Percentage:</p> <p>This rate applies to all out-of-state non-participating providers. Out-of-state providers are paid the lessor of the average statewide per diem rate or average statewide percentage.</p>	<p>Provider Class Types:085 (Non-Enroll Rehab) 091 (Non-Enroll Hospital)</p>
<p>DRG Rate:</p> <p>[Hospital specific operating rate per case + IME (Indirect Medical Education) rate per case] * DRG relative rate. Capital Percentage * Per Diem is added to this.</p> <p>This rate is based on the through date of the claim.</p>	<p>Provider Class Types:001 (Hospital) *091 (Non-Enrolled Hospital) Date specified with full DRG Implementation). *</p> <p>* PCT 001 and 091 will not be priced under DRG when the primary diagnosis is Rehab or Psych.</p> <p>Bill Types:</p> <p>111 112 114</p>
<p>Transplant Rate:</p> <p>This Contracted Amount will be located on the Prior Authorization Table. Transplants are paid the contracted amount found on the PA Table.</p>	<p>Provider Class Types: 001 (Hospital)091 (Non-Enroll Hospital)</p> <p>Procedure Codes in ICD-9 value set 328 (TRANSPLANT PROCEDURE CODE) or ICD-10 value set 20328 (ICD-10 TRANSPLANT PROCEDURES).</p>

	<p>DRG Codes:</p> <p>HEART: 103 LIVER: 480 LUNG: 795 BONE MARROW: 803 804 KIDNEY/PANCREAS: 805</p>
<p>DRG Transfer Case Rate:</p> <p>The sending hospital is paid per diem and the receiving hospital is paid the DRG Rate when a patient transfers to another hospital within 5 days with the same or similar diagnosis.</p> <p>[DRG payment / Avg. length of stay] * Covered days</p> <p>DRG codes 456, 639, and 640 are excluded from transfer case rate.</p> <p>Transfer cases are paid the lessor of full DRG or per diem rate based on DRG.</p>	<p>Provider Class Types:001 (Hospital)091 (Non-Enrolled Hospital) (date specific with full DRG implementation)</p> <p>Bill Types:</p> <p>111 112 114</p>
<p>DRG Outlier Rate:</p> <p>[[(Outlier threshold amount * Outlier labor percentage * Wage Index) + (Outlier threshold amount * Outlier non-labor percentage)] * DRG factor + [all of the above * Capital Percentage]]</p> <p>Outlier payments are applied to claims that have higher than usual charges.</p> <p>Refer to the current ISR related to the Outlier Formula.</p>	<p>Provider Class Types:001 (Hospital)091 (Non-Enrolled Hospital) date specific with full DRG implementation</p> <p>Bill Types:</p> <p>111 112 114</p>
<p>DRG Psych Per Diem Rate:</p> <p>This rate is bypassed from the DRG Pricing Methodology but uses a per diem rate for psych services.</p> <p>Refer to the Inpatient Per Diem Calculation of Amount to Pay.</p>	<p>Provider Class Types:001(Hospital)003(Private EPSDT Mental Hospital)007(State Mental Hospital <21)091(Non-Enrolled Hospital)</p> <p>Bill Types:</p> <p>111 112</p>



	<p>ICD Diagnosis: Principal Diagnosis in the range of 290 -319 (ICD-9 value set 314 – DIAG CODE PSYCH CLAIM) or F0150 – F99 (ICD-10 value set 20314 – ICD-10 DIAG CODE PSYCH CLAIM)</p>
<p>DRG Rehab Per Diem Rate:</p> <p>This rate is by-passed from the DRG Pricing Methodology but uses a per diem rate for rehab services.</p> <p>Refer to the Inpatient Per Diem Calculation of Amount to Pay</p>	<p>Provider Class Types: 001(Hospital)014(Rehab Hospital)085(Non-Enroll Hospital)091(Non-Enrolled Hospital)</p> <p>Bill Types:</p> <p>111 112 113 114</p> <p>ICD Diagnosis: Principal diagnosis V5721, V5722, V573, V528, V529, V571, V5789, V579 (ICD-9 value set 147 – REHAB CLAIM) or Z5189 (ICD-10 value set 20147 – ICD-10 REHAB DIAG)</p>
<p>DRG Re-Admissions:</p> <p>Re-admissions within a 5 day time period of discharge to the same facility with the same or similar diagnosis, will not span the 120 day billing cycle. They will be priced and paid the same as regular DRG claims.</p>	<p>Provider Class Types:001 (Hospital)091 (Non-Enrolled Hospital) (date specific with full DRG implementation)</p> <p>Bill Types:</p> <p>111 112 114</p>

Calculation Description	Calculation Criteria
<p>Inpatient Per Diem Calculation of Amount to Pay:</p> <p>1. Primary Rate is the provider’s Per Diem Rate in effect based on the From Date on the claim that is on the Provider Rate Table. Providers that are approved for a NICU per diem rate have this rate on the Provider Rate Table for claims with revenue codes 175.</p> <p>2. Multiply Primary Rate by Payment Days on the claim to calculate the Primary Rate Amount to</p>	<p>Provider Class Types:001 (Hospital)002 (State Mental Hospital)004 (Long Stay Hospital)007 (State Mental Hospital < 21)008 (State MH Med-Surg)009 (Med-Surg MR)012 (Long Stay Inpatient Hospital – MH)014(Rehab Hospital)</p>



<p>Pay. This result needs to be stored for reporting purposes.</p> <p>3. For claims with Dates of Service prior to 7/1/96, the secondary Rate is the provider's DSA Per Diem Rate in effect based on the From Date on the claim. This is the NICU DSA or regular DSA per diem rate as defined above. For claims with Dates of Service after 6/30/96, the DSA Per Diem Rate will not be applicable except for PCT of 004(Long Stay Hospital).</p> <p>4. Multiply Secondary Rate by Payment Days on the claim to calculate the DSA Rate Amount to Pay, if applicable. This result needs to be stored for reporting purposes.</p> <p>5. Add Primary Carrier Amount Paid, Patient Pay Amount and Co-pay</p> <p>6. Subtract the result of #5 from the result of #2 to calculate a new Primary Rate Amount to Pay. If this new Primary Rate Amount to Pay is less than \$0.00, hold this amount (unsigned) for #7 and move \$0.00 to the new Primary Rate Amount to Pay. This new Primary Rate Amount to Pay also needs to be stored on the system for reporting purposes.</p> <p>7. If applicable, subtract the held amount in #6 from #4 to calculate a new DSA Rate Amount to Pay. If this new DSA Rate Amount to Pay is less than \$0.00, approve the claim and move \$0.00 to the new DSA Rate Amount to Pay and the final Amount to Pay. This new DSA Rate Amount to Pay needs to be stored on the system for reporting purposes.</p> <p>8. Add the new DSA Rate Amount to Pay (#7) and the new Primary Rate Amount to Pay (#6). If the claim is approved, the result of #8 is the final Amount to Pay.</p>	
<p>EPSDT Calculation of Amount to Pay:</p> <p>1. Primary Rate is the provider's Per Diem Rate in effect based on the From Date on the claim.</p>	<p>Provider Class Types:003 (Private EPSDT Mental Hospital)</p>

<p>This is the EPSDT Psych Per Diem.</p> <p>2. Multiply #1 by Payment Days on the claim to calculate Amount to Pay. This result needs to be stored for reporting purposes.</p> <p>3. Add Primary Carrier Amount Paid, Patient Pay Amount and Co-pay.</p> <p>4. Subtract the result of #3 from the result of #2.</p> <p>5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay and approve the claim. Otherwise, the result of #4 is the Amount to Pay.</p>	
<p>Non-Enrolled Hospital Calculation of Amount to Pay:</p> <p>1. Determine the provider's Average Statewide Percent Rate in effect based on the From Date on the claim.</p> <p>2. Multiply #1 by the billed amount on the claim to calculate the Percent Amount to Pay.</p> <p>3. Determine the provider's Average Statewide Per Diem Rate in effect based on the From Date on the claim.</p> <p>4. Multiply #3 by the Payment Days on the claim to calculate Per Diem Amount to Pay.</p> <p>5. Determine the lesser of #2 and #4. This result needs to be stored for reporting purposes.</p> <p>6. Add Primary Carrier Amount Paid, Patient Pay Amount, Deductible, and Co-pay.</p> <p>7. Subtract the result of #6 from the result of #5.</p> <p>8. If the result of #7 is less than \$0.00, then move \$0.00 to Amount to Pay and approve the claim. Otherwise, the result of #7 is the Amount to Pay.</p>	<p>Provider Class Types:085 (Non-Enroll Rehab) 091 (Non-Enroll Hospital) Date specific with Full DRG implementation</p>
<p>DRG Calculation of Amount to Pay:</p>	<p>Provider Class Types: 001 (Hospital) 091 (Non-Enroll Hospital) date specific with full DRG implementation</p>

1. The Primary Rate is the Provider's rate per case in effect based on the Through Date of service on the claim. The DRG assignment is derived from the ICD diagnosis and procedures on the claim from the DRG Grouper. Each DRG is assigned a relative weight and ALOS Table.

2. Multiply the rate per case by the relative weight of the assigned DRG (Case rate * DRG weight). This result needs to be stored for reporting purposes.

3. Amount to Pay is the result of #2 unless there is a transfer, readmission, or Outlier case payment then refer to #4, 5, or 6.

4. If the case is a transfer case, then compute the Transfer Per Diem Case Rate amount, based on the Through Date of Service on the claim. Per diem payment is calculated based on the DRG case rate times the relative weight / Avg. L.O.S. from the DRG table of Relative weight times covered days. This becomes the Amount to Pay if lessor than or equal to the DRG case rate (amount in #2). This result needs to be stored for reporting purposes. It is possible for a transfer case to have an Outlier payment(See #6 below).

5. If the case is determined to be a Re-admission payment request (5 days with same or similar diagnosis code), the 1st inpatient hospital claim is to be voided and re-processed to show zero payment. The reason message on the Remittance Advice should be 'Patient re-admitted, claim to be re-priced'. The second inpatient hospital claim is voided and re-processed to create one claim/case (combining the 1st and 2nd claims) to have one claim processed through the DRG grouper (Steps #1 and # 2). This result needs to be stored for reporting purposes.

6. Compute the Outlier rate amount. This rate applies to claims with a higher than usual charges. The Outlier formula is stored with First Health's current payment logic. DMAS will

Bill Types:

- 111
- 112
- 113
- 114
- 116

Special Note:

Only claims with a bill type of 111 or 112 and 114 shall be passed to the Grouper software for DRG code assignment. Claims with bill type 111 reflect entire stay and should receive a DRG code that accurately reflects the stay. Total charges for the entire stay can also be obtained from a 111 bill type so outlier payments can also be calculated during the daily cycle. For multi-claim stays (bill type 112, 113, and 114) only the 112 bill type claim will be processed for DRG assignment.

This will provide timely payments to the facilities. The billing cycle will be 120 days. The longer billing cycle should eliminate most interim billing. Any 112 type bills submitted with the 120 billing cycle should group more accurately than the 21 day bills due to the increased time a facility has to get accurate coding on the claim. Since 112 type bills will usually receive the full DRG payment , most 113 and 114 bill types will not be grouped or priced by DRG.

Claims with Bill Type 116 are adjustment claims. These will be processed like 111s or 112s if the admission date is equal to the from date of service.

DRG Transfer Exclusions:

- 456
- 639
- 640

update the Outlier threshold and other factors as needed. Refer to the current ISR and implementation for Outlier payment calculations.

7. Add DRG Case rate # 2 or #5 + Outlier rate # 6 and this becomes Amount to Pay. If the DRG Case is a Transfer Case, add the Transfer Case Rate #4 + Outlier rate #6 and this becomes Amount to Pay. This result needs to be stored for reporting purposes.

8. Calculate Capital % Add-on by multiplying the results of #7 and the Capital Percentage.

9. Add Primary Carrier Amount Paid, Deductible, and Co-pay.

10. Subtract the Primary Carrier Amount Paid, Deductible, and Co-pay from the result of #7 plus #8.

11. Move the results of #10 to the Amount to Pay.

LHD - Local Health Departments

Local Health Departments (DMAS Provider Class Type 051) bill on the CMS-1500 for rendered services. For these claims, the rate from the Procedure Rate Table is the maximum rate allowed based on the From Date of Service of the claim. As described in the Practitioner Section of this document, this rate is found on the Procedure Rate Table, Region 2 rate, or the Region 1 rate for participants under the age of 21. HMOs are capitated effective 7/1/99 and no longer paid fee for service for claims with dates of service after 6/30/99.

Pricing Method Criteria:	Provider Class Types: See value set; 'Prov Types Local HD Pricing' CPA04013 051 (Health Department Clinic)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Procedure Rate:</p> <p>The Procedure file contains the Region 2 rate for adults and the Region 1 rate for participants under age 21. Immunization procedures are identified with an 'I' on the Procedure Flag Code Table and are paid a \$0.00 rate with these exceptions:</p> <ol style="list-style-type: none"> Hepatitis B Procedures Z9995, 90745, and 90746 if the enrollee is 19 or 20 years of age and the date of service is on or after 10/1/94. These are paid at Region 1 rate. Health departments can be paid for administration of the immunization. This is a single procedure rate retrieved from Medical and Administrative Codes Database. 	N/A
<p>Immunization Procedure Rate:</p> <p>Local Health Departments are paid the maximum fee allowed Region 1 Procedure Rate Table.</p>	<p>Procedure Codes:</p> <p>Y0013-Y0037</p>

<p>RBRVS Rate:</p> <p>This rate is referred to as Resource Based Relative Value Scale (RBRVS). RBRVS rates are calculated from RBRVS weights and conversion factors prior to being loaded to the Procedure File. Hence, RBRVS rates are loaded and accessed like any other procedure specific rate in the system.</p>	<p>Procedure Codes:</p> <p>11040 - 69799</p> <p>Procedure Modifiers:</p> <p>51 (Multiple Surgery)</p>
<p>HMO Capitated Rate:</p> <p>Procedures are capitated for HMO participants going to a Health Department provider as of 7/01/1999. All HMO claims with dates of service greater than 06/30/1999 are capitated.</p>	<p>Procedure Codes:</p> <p>90731 (prior to 4/01/96) 99211 Y0013-Y0037</p>
<p>Billed Amount Rate:</p> <p>For PCT 051 and a procedure modifier of 'U2', check value set 'Family Planning Code U2-PCT 51'. If procedure code is found in value set, price billed charges.</p>	<p>Procedure Codes for value set 'FAMILY PLANNING CODE U2-PCT 51'</p> <p>'J8499' '96110' THRU '96111' '99070' 'B4000' THRU 'B9999'</p> <p>Procedure Modifiers:</p> <p>'U2' Medicaid Level Of Care 2</p>

Calculation Description	Calculation Criteria
<p>Local Health Department Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate is the rate in effect based on the From Date on the claim. This is Region 1 or Region 2 Rate on the Procedure Rate Table or the PA rate. 2. Multiply #1 by units on the claim. 3. System determines the lesser of Billed Amount on the claim and the result of #2. 4. Subtract the result from #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges. 	<p>N/A</p>

<p>5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.</p> <p>6. Subtract Copay, if applicable, from the result of #5.</p> <p>7. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #6 is the Amount to Pay.</p>	
HMO Claims are capitated and paid monthly.	N/A
N/A	N/A
N/A	N/A

LS - Long Stay

Long Stay Hospitals are DMAS Provider Class Type 004 and bill on the UB for inpatient services using Type of Bill codes 111 (original claims), 116 (adjustments), 118 (voids). The (DRG) pricing methodology will not be used for Long Stay Hospitals.

Pricing Method Criteria:	Provider Class Types:004 (Long Stay Hospital)
Billing Form:	UB Claim Form
Benefit Package:	Exception Indicator equal to "L" .

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
Regular Per Diem and DSA Rate: This is a provider specific per diem rate. This secondary DSA rate has been discontinued for most hospitals.	N/A

Calculation Description	Calculation Criteria
Inpatient Per Diem Calculation of Amount to Pay:1. Primary Rate is the provider's Per Diem Rate in effect based on the From Date on the claim. 2. Multiply Primary Rate by Payment Days on the claim to calculate the Primary Rate Amount to Pay. This result needs to be stored for reporting purposes. 3. For claims with Dates of Service prior to 7/1/96, the secondary Rate is the provider's DSA Per Diem Rate in effect based on the From Date on the claim. This is the or regular DSA per diem rate as defined above. 4. Multiply Secondary Rate by Payment Days on the claim to calculate the DSA Rate Amount to Pay, if applicable. This result needs to be stored for reporting purposes.5. Add Primary Carrier Amount Paid, Patient Pay Amount and Copay 6. Subtract the result of #5 from the result of #2 to calculate a new Primary Rate Amount to Pay. If this new Primary Rate Amount to Pay is less than \$0.00, hold this amount (unsigned) for #7 and	N/A

move \$0.00 to the new Primary Rate Amount to Pay. This new Primary Rate Amount to Pay also needs to be stored on the system for reporting purposes.

7. If applicable, subtract the held amount in #6 from #4 to calculate a new DSA Rate Amount to Pay. If this new DSA Rate Amount to Pay is less than \$0.00, approve the claim and move \$0.00 to the new DSA Rate Amount to Pay and the final Amount to Pay. This new DSA Rate Amount to Pay needs to be stored on the system for reporting purposes.

8. Add the new DSA Rate Amount to Pay (#7) and the new Primary Rate Amount to Pay (#6). If the claim is approved, the result of #8 is the final Amount to Pay.

MEDCO - Medicaid Copay

There are two components that must be considered when calculating copay: 1.) Copay exemptions or rules indicate which services will be excluded from copay, and 2.) Copay calculation determines the amount of copay that is applied to rendered services. Copay is applied based on date of service, place of treatment, participant, provider, claim type, or type of bill. If more than one claim per dates of service, place of treatment, participant, provider, claim type or type of bill, copay will only be taken once. Dates may also be overlapping. Copay is not applied to SLH (Enrollee benefit program = '03') and TDO (Enrollee benefit program = '02') claims. Copay is not applied to enrollees enrolled in waiver services, LOC (DE3072). See value set 'ENR EXCEP IND NO COPAY'. Copay is not applied for American Indian/Alaskan Native enrollees in the FAMIS MOMS program.

Pricing Method Criteria:	Invoice Types: Practitioner Inpatient Outpatient Home Health Title XVIII Pharmacy
Billing Form:	Not Applicable
Benefit Package:	Not Applicable

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Not Applicable	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>Practitioner Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>1. If provider class type is 052 (FQHC) or 053 (RHC) and EPSDT Family planning indicator (field 24h) equals 2 (family planning related), copay is zero.</p> <p>2. If provider class type is 052 (FQHC) or 053 (RHC) and procedure code is in the range of 70000 to 89999 (lab or x-ray), copay is zero.</p> <p>3. If claim is a re-entered pend and copay is greater than zero, bypass copay calculation.</p> <p>4. If service is an emergency procedure (90500 - 90580, 99062, 99064, 99065, 99281 - 99285), copay is zero.</p> <p>5. If resolution reason code equals 648 (ER claim reduced document doesn't justify) or 699 (approved 223 - Review of ER documentation), copay is zero.</p> <p>6. If the recipient is less than 21, copay is zero.</p> <p>7. If the recipient excep-</p>

	<p>tion indicator is in value set 'ENR EXCEP IND NO COPAY' , copay is zero.</p> <p>8. If recipient is female and the primary or secondary diagnosis is pregnancy related (field 21 and 24e), copay is zero.</p> <p>9. If the emergency indicator (field 24i) equals 1, copay is zero.</p> <p>10. If CMS place of service (field 24b) equals 23, copay is zero.</p> <p>11. If the primary or secondary procedure modifier is TC (technical component), copay is zero.</p> <p>12. If claim type 01, provider type 014 or 085 and PA exists for INRHB, copay is zero. If claim type 05, provider type 046, and procedure code equal Z9430 - Z9434, and PA exists for HSPCE, copay is zero.</p> <p>13. If the procedure code flag not equal to 'CP', 'C1', 'FD', or 'FP', copay is zero.</p>
<p>Health Department Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>Provider Class Types:</p> <p>051 (Health Department Clinics)</p> <p>1. If copay is greater than zeros, bypass copay calculation.</p> <p>2. If the recipient is less that 21, copay is zero.</p> <p>3. If diagnosis is pregnancy related, copay is zero.</p> <p>4. If the procedure code flag not equal to 'CP', 'C1', 'FD', or 'FP', copay is zero.</p>
<p>Inpatient Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>1. If provider class type is not equal to 001 (hospital), 014 (rehab hospital), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital), copay is zero.</p> <p>2. If source of admission is equal to 4 (transfer from hospital), 6 (transfer from another health-care facility), or 7 (emergency room), copay is zero.</p>

	<p>3. If type of admission is equal to 1 (emergency), copay is zero.</p> <p>4. If admission date is not equal to from date, copay is zero.</p> <p>5. If recipient is less than 21, copay is zero.</p> <p>6. If special program indicator equals A4 (family planning related), copay is zero.</p> <p>7. If service is pregnancy related, copay is zero.</p> <p>8. If the procedure code flag not equal to 'CP', 'C1', 'FD', or 'FP', copay is zero.</p> <p>9. If enrollee exception indicator is in value set 'ENR EXCEP IND NO COPAY', copay is zero.</p>
<p>Outpatient Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>1. If provider class type is not equal to 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital), copay is zero.</p> <p>2. If service is performed in an emergency room, indicated by revenue codes 450 -459, copay is zero.</p> <p>3. If recipient is less than 21, copay is zero.</p> <p>4. If special program indicator equals A4 (family planning related), copay is zero.</p> <p>5. If service is pregnancy related, copay is zero.</p> <p>6. If the procedure code flag not equal to 'CP', 'C1', 'FD', or 'FP', copay is zero.</p> <p>7. If enrollee exception indicator is in value set 'ENR EXCEP IND NO COPAY', copay is zero.</p>
<p>Home Health Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>1. If recipient is less than 21, copay is zero. 2. If special program indicator equals 04 (family planning related), copay is zero. 3. If service is pregnancy related, copay is zero. 4. If the procedure code flag equal to 'FP', copay is zero. 5. If the Provider Class Type is not 057 (Rehab Agencies)</p>

	<p>and not 058(Home Health Agency State) and not 059(Home Health Agency Private) and not 094 (Out-of-State Home Health Agency) copay is zero.</p> <p>6. If enrollee exception indicator (LOC) is in value set 'ENR EXCEP IND NO COPAY', copay is zero.</p> <p>7. Emergency service, copay is zero.</p>
<p>Title XVIII Part A Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>1. If recipient is under 21, copay is zero.2. If enrollee exception indicator is in value set 'ENR EXCEP IND NO COPAY' , copay is zero.</p> <p>3. If Medicaid Part A and service is performed in an emergency room copay is zero.</p> <p>4. If the service is accident or emergency related (field 10), copay is zero.</p> <p>5. If procedure modifier (field 11a) is TC (technical component), copay is zero.</p> <p>6. If service is pregnancy related, indicated by the diagnosis code (field 9) copay is zero.</p> <p>7. If Medicare Part A and provider class type is equal to 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital) and from date (field 13) not equal to admit date (field 12), copay is zero.</p> <p>8. If the procedure code flag not equal to 'CP', 'C1', 'FD', or 'FP', copay is zero. For example, if the procedure or diagnosis is family planning related, copay does not apply.</p> <p>9.) If CMS Place of Treatment equals 23 (emergency room), copay is zero.</p>
<p>Title XVIII Part B Copay Exemptions:</p> <p>These claims will have a copay rate of \$0.00.</p>	<p>1. If recipient is under 21, copay is zero.</p> <p>2. If the service is accident or emergency related (field 10), copay is zero.</p> <p>3. If procedure modifier (field 11a) is TC (tech-</p>

	<p>nical component), copay is zero.</p> <p>4. If service is pregnancy related, indicated by the diagnosis code (field 9) copay is zero.</p> <p>5. If the procedure code flag not equal to 'CP', 'C1', 'FD', or 'FP', copay is zero. For example, if the procedure or diagnosis is family planning related, copay does not apply.</p> <p>6.) If CMS Place of Treatment equals 23 (emergency room), copay is zero.</p>
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Calculation Description	Calculation Criteria
<p>Practitioner Copay Calculation:</p> <p>1. If copay indicator equals C1, multiply by claim units or calculated through date minus the from date on the claim plus one (which ever is less) by \$1.00.</p> <p>2. If place of treatment is 11 (office) and provider class type is practitioner (020, 021, 023, 024, 025, 026, 030, 031, 032, 034, 049, 076, 095, or 102) and copay indicator equals CP, multiply by Claim Units or calculated through date minus the from date on the claim plus one (whichever is less) by \$1.00.</p> <p>3. If provider class type is clinic (050, 051, 052, 053, 056, or 093) and copay indicator equals CP, multiply by Claim Units or calculated through date minus the from date on the claim plus one (whichever is less) by \$1.00.</p> <p>4. If type of service is 7 (anesthesia) and copay indicator equals CP, copay is \$3.00.</p> <p>5. If place of treatment is 21 (inpatient), 22 (outpatient), 12 (home), or 32 (nursing home) and provider class type is practitioner (020, 021, 023, 024, 025, 026, 030, 031, 034, 076, 095, or 102) and copay indicator equals CP, multiply by claim units or calculated through date minus the from date on the claim plus one (whichever is less) by \$3.00.</p>	<p>1. Calculated Copay is \$1.00 * lessor of Units on claim or through date minus the from date on the claim plus one Procedure Flag = C1</p> <p>2. Calculated Copay is \$1.00 * Lessor of Claim Units or through date minus the from date on the claim plus one. Procedure Flag is CP Provider Class Type is Practitioner 020-021, 023-026, 030-031, 034, 076, 095, or 102. Place of Treatment is 11 Office</p> <p>3. Calculated Copay is \$1.00 * Lessor of Claim Units or through date minus the from date on the claim plus one Procedure Flag is CP Provider Class Type is Clinic 050-053, 056, or 093</p> <p>4. Calculated Copay is \$3.00 Procedure Flag is CP Type of Service is 7 Anesthesia</p> <p>5. Calculated Copay is \$3.00 * Lessor of claim units or through date minus the from date on the claim plus one Procedure Flag is CP Provider Class Types are 020- 021, 023-026,</p>

<p>6. Multiply Provider Fee's by Claim Units or calculated through date minus the from date on the claim plus one (whichever is less) by \$3.00.</p>	<p>030- 031, 034, 076, 095, or 102 Practitioner Place of Treatment is 21 (inpatient), 22 (outpatient), 12 (home), or 32 (nursing home)</p> <p>6. Calculated Copay is \$3.00 * Lessor of claim units or through date minus the from date on the claim plus one</p>
<p>Health Department Copay Calculation:</p> <p>1. Multiply Procedure File's UVS by \$1.00.</p>	<p>Provider Class Types:</p> <p>051 (Health Department Clinic)</p>
<p>Inpatient Copay Calculation:</p> <p>1. Set copay to \$100.00.</p>	<p>N/A</p>
<p>Outpatient Copay Calculation:</p> <p>1. Multiply covered days by \$3.00.</p>	<p>N/A</p>
<p>Home Health Copay Calculation:</p> <p>1. Multiply covered days by \$3.00.</p>	<p>N/A</p>
<p>Title XVIII Part A Copay Calculation:</p> <p>1. If provider class type is equal to 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital), and place of treatment is 21 (inpatient hospital), set copay to \$100.00.</p> <p>2. If Provider Class Type is equal to 001 (hospital), 014 (rehab hospital), 091 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital) and place of treatment is 22 (outpatient hospital), multiply Procedure file's UVS or calculated 'number of days stay' (whichever is less) by \$3.00.</p> <p>3. If Provider Class Type is equal to 052 (Federally Qualified Health Center), 053 (Rural Health Clinic) and bill type in the first position is a '7', pass parameter 'CPA04813' to obtain rate from RF_SYS_PARAMETER.</p>	<p>1. Copay is \$100.00 Provider Class Types are 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital) Place of Treatment is 21 (inpatient hospital)</p> <p>2. Copay is \$3.00 * (lesser of) Units or number of days stay Provider Class Types are 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital) Place of Treatment is 22 (outpatient hospital)</p> <p>3. Copay is \$1.00 when Provider Class Type is equal to 052 (Federally Qualified Health Center), 053 (Rural Health Clinic) and bill type in the first position is a '7'. This is obtained by passing parameter CPA04813 to the RF_SYS_PARAMETER table.</p>
<p>Title XVIII Part B Copay Calculation:</p>	<p>1. Copay to \$3.00 Procedure Flag is CP</p>

<p>1. If type of service is 7 (anesthesia) and Procedure file's copay indicator equals CP, set copay to \$3.00.</p> <p>2. If provider class type is equal to 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital) and place of treatment is 21 (inpatient hospital) or 22 (outpatient hospital), multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 3.00.</p> <p>3. If provider class type is equal to 052 (FQHC) or 053 (RHC), multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 1.00.</p> <p>4. If the Procedure File's copay indicator equals C1, multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 1.00.</p> <p>5. If provider class type is equal to 058 (state home health), 059 (private home health), or 094 (non-enrolled home health) and Procedure file's copay indicator equals CP, multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 3.00.</p> <p>6. If provider class type is practitioner (020, 021, 023, 024, 025, 026, 030, 031, 034, 076, 095, 099, or 102) and place of treatment is 11 (office) and Procedure file's copay indicator equals CP (or FD with non-fertility DX code), multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 1.00.</p> <p>7. If provider class type is 050 (renal unit), 051 (health dept clinic), 056 (MH clinic), or 093 (non-enrolled clinic) and Procedure file's copay indicator equals CP (or FD with non-fertility DX code), multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 1.00.</p> <p>8. If provider class type is practitioner (020, 021, 023, 024, 025, 026, 030, 031, 034, 076, 095, 099,</p>	<p>Type of Service is 7 (anesthesia)</p> <p>2. Copay is 3.00 * (lesser of) Units or number of days stay Procedure Flag is CP Provider Class Types are 001 (hospital), 014 (rehab hospital), 019 (CORF), 057 (rehab agency), 085 (non-enrolled rehab hospital), or 091 (non-enrolled hospital) Place of Treatment is 21 (inpatient hospital) or 22 (outpatient hospital)</p> <p>3. Copay is \$1.00 * (lesser of) Units or number of days stay Procedure Flag is CP Provider Class Types are 052 (FQHC) or 053 (RHC)</p> <p>4. Copay is \$1.00 * (lesser of) Units or number of days stay Procedure Flag is C1</p> <p>5. Copay is 3.00 * (lesser of) Units or number of days stay Procedure Flag is CP Provider Class Types are 058 (state home health), 059 (private home health), or 094 (non-enrolled home health)</p> <p>6. Copay is 1.00 * (lesser of) Units or number of days stay CP (or FD with non-fertility DX code) Provider Class Types are practitioner (020-021, 023-026, 030-031, 034, 076, 095, 099, or 102) Place of Treatment is 11 (office)</p> <p>7. Copay is \$1.00 * (lesser of) Units or number of days stay Procedure Flag is CP (or FD with non-fertility DX code) Provider Class Type is 050 (renal unit), 051 (health dept clinic), 056 (MH clinic), or 093 (non-enrolled clinic)</p> <p>8. Copay is 3.00 * (lesser of) Units or number of days stay CP (or FD with non-fertility DX code)</p>
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<p>or 102) and place of treatment is 21 (inpatient hospital), 22 (outpatient hospital), 12 (patient's home), 31-32 (nursing home), or 41-42 (ambulance) and Procedure file's copay indicator equals CP (or FD with non-fertility DX code), multiply Procedure file's UVS or calculated "number of days stay" (whichever is less) by \$ 3.00.</p>	<p>Provider Class Type is practitioner (020-021, 023-026, 030-031, 034, 076, 095, 099, or 102) Place Of Treatment is 21 (inpatient hospital), 22 (outpatient hospital), 12 (patient's home), 31-32 (nursing home), or 41-42 (ambulance)</p>
<p>Pharmacy Co-pay Calculation:</p> <p>Copay is equal to \$1.00 for generic prescriptions and \$3.00 for brand prescriptions. The determination of brand versus generic is based on the following:</p> <p>If the GPI is 1 or CMS Drug Category is I or N (innovator multi-source or non-innovator multi-source), classify the drug as 'generic'; otherwise, classify the drug as 'brand'.</p> <p>Only DAW 5 drugs will pay as generic drugs for co-pays. Other DAWs will pay based on whether they are truly a generic or a brand.</p> <p>Exceptions:</p> <p>Currently, certain enrollees are exempt from copay. They include:</p> <ul style="list-style-type: none"> children (based on age) nursing home enrollees (exception indicator 1, 2, or 7) pregnant enrollees (as indicated on the incoming claim) <p>As of Release 21 (05/27/2006), the exception indicator exemption will be handled by the 'Drug Copay Exempt' value set.</p>	<p>DAW 5 will pay as generic drugs for co-pays.</p>

MHC - Mental Health Clinics (CSB)

Mental Health clinics, also known as Community Service Boards (CSB), are DMAS Provider Class Type 056. These providers can submit mental health services for Medicaid participants, State Plan Only services (SPO), and MR Waiver services. This section addresses mental health services and SPO services for these providers. Refer to the Waiver Section of this document for additional information on waiver services of these providers.

Pricing Method Criteria:	<p>Provider Class Types:</p> <p>056 (Mental Health Clinics)</p> <p>Provider Specialty: See value set; 'Prov Specs CSB Pricing' - CPA04016</p> <p>042 (CSB Mental Health) 043 (CSB MR State Plan) 044 (MR Waiver) 045 (DRS Community Services) 046 (MR Contractor)</p> <p>041 (CSB Clinic) is priced using practitioner logic.</p>
Billing Form:	CMS-1500 Claim Form
Benefit Package:	Exception Indicator Y.

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Procedure Rate:</p> <p>This procedure rate is retrieved from Medical and Administrative Codes Database. For these services, the Procedure Rate is the maximum rate allowed based on the From Date of Service of the claim. The Region Rate will be determined based on one of the following categories below: Category 1 - The Region 1 Rate, if present for SPO services, is the rate for providers in Northern Virginia, and the Region 2 Rate is the rate for providers in the rest of the state.</p>	<p>Region 1 Rate - Northern Virginia.(city county codes) 510, 013, 043, 047, 059, 600, 610, 061, 630, 685, 153, 177, 179, 187, 099, 107, 683.</p> <p>Region 1 Rate - Urban Virginia. (city county codes) Value set - Urban Region Localities 013, 023, 036, 041, 045, 059, 085, 087, 095, 107, 127, 153, 161, 199, 510, 550, 600, 610, 630, 650, 683, 685, 700, 710, 735, 740, 760, 770, 775, 810, 830</p>

<p>Category 2 - The Region 1 (Urban) Rate, is the rate for providers included in the Urban locality and the Region 2 (Rural) Rate is the rate for providers in the rest of the state. These rates only apply for procedures included in MHCS Specific Proc Codes value set.</p> <p>There is no difference in rates for adults and children.</p>	
<p>RBRVS Rate:</p> <p>This rate is referred to as Resource Based Relative Value Scale (RBRVS). RBRVS rates are calculated from RBRVS weights and conversion factors prior to being loaded to the Procedure File. Hence, RBRVS rates are loaded and accessed like any other procedure specific rate in the system.</p>	N/A
<p>Substance Abuse Services</p> <p>The rate is calculated based on the modifier to indicate a percentage based reimbursement method. The system parameter used to calculate the percentage is given along with the modifier.</p>	<p>Modifier HO = 100% of the Procedure Code rate - System parameter - CPA040HO. HN = 75% of the Procedure Code rate - CPA040HN. HM = 56.2% of the Procedure Code rate - CPA040HM. HQ = 20% of the Procedure Code rate - CPA040HQ. HP = 0% of the Procedure Code rate - CPA040HP (for future use).</p>

Calculation Description	Calculation Criteria
<p>Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate is the Procedure Rate in effect based on the From Date on the claim or the PA rate, as defined above. 2. Multiply #1 by units on the claim. 3. System determines the lesser of Billed Amount on the claim and the result of #2. 4. Subtract the result from #3 from the Billed Amount on the claim to determine Non-Covered 	N/A

Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.

6. Subtract Copay, if applicable, from the result of #5.

7. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the results of #6 is the Amount to Pay.



NH - Nursing Home

Revenue codes are submitted on the UB form for Nursing Home services. Tracking claims activity throughout the system requires accumulation of the billed amounts from providers for all routine accommodation services (room and board) and ancillary charges. The total payment received by the provider from other sources of revenue (patient pay, insurance, or Medicare) also is reported at the summary level, as well as the “net” Medicaid payment amount. This data is required for cost report processing and settlement of the report for rate setting purposes. PIRS will continue to be the basic nursing home rate methodology for routine care. However, Resource Utilization Groups (RUGS) is used for the cost-settlement pricing methodology for nursing home specialized care. RUGS rates are accessed using the provider number, rate code, rate type, and claim begin date of service. PIRS rates are still available for specialized care claims whose service dates are prior to the effective date of RUGS.

Pricing Method Criteria:	Provider Class Types: 006 (Skilled Nursing Home MH) 010 (Skilled Nursing Home non-MH) 011 (Skilled Nursing Home MR) 015 (Intermediate Care Facility) 016 (Intermediate Care Facility - MH) 017 (ICF – MR – State Owned) 018 (ICF – MR – Community Owned) 028 (Skilled Nursing Facility –State) 029 (Intermediate Care Facility – State) 086 (Non-Enroll Intermediate Care Facility) 092 (Non-Enroll Skilled Care Facility)
Billing Form:	UB Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Determined by DSS edits.	Refer to Copay Section.

Rate Description	Rate Criteria
Specialized Care Rate: This is a provider specific rate for those providers that have been approved for participation in the Specialized Care Program. This pricing methodology uses the Resource Utilization Groups (RUGS) for rate determination.	Provider Class Types: 010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility) Provider Specialties: 086 (Ventilator) 087 (AIDS)

<p>The 'Provider Specialties' are really the change source values obtained from the enrollee benefit package table. The change source is used to determine which provider rate to use for pricing.</p> <p>If the change source = 86, rate code on provider rate table is VENT, 87 = AIDS, 89 = COMP, 92 = RHAB.</p> <p>For Therapeutic Bed Use, revenue code 2109, calculate daily amount add-on.</p>	<p>089 (Complex) 092 (Rehab)</p>
<p>Regular Per Diem Rate:</p> <p>This is the regular per diem rate of payment determined after processing the provider's cost report for settlement with no adjustment to the rate for provider case mix score.</p>	<p>Provider Class Types:</p> <p>006 (Skilled Nursing Home MH) 011 (Skilled Nursing Home MR) 016 (Intermediate Care Facility MH) 017 (ICF – MR – State Owned) 018 (ICF – MR – Community Owned) 028 (Skilled Nursing Facility –State) 029 (Intermediate Care Facility – State) 086 (Non-Enroll Intermediate Care Facility) 092 (Non-Enroll Skilled Care Facility)</p>
<p>Private Room Differential Rate:</p> <p>The is a provider specific rate paid in addition to the routine per diem rate amount.</p> <p>For Therapeutic Bed Use, revenue code 2109, calculate daily amount add-on.</p>	<p>Recipient Indicators:</p> <p>1 (Nursing ICF) 2 (Nursing SNF)</p> <p>Provider Class Types:</p> <p>010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility)</p> <p>Provider Specialties:</p> <p>091 (NF Private Room)</p>
<p>PIRS Rate:</p> <p>This rate is a provider specific per diem rate based on cost settlement. Cost settlement is determined by the application of the service intensity index identified through the use of a given facility's patient mix relative to the needs of other nursing facilities.</p>	<p>Provider Class Types:</p> <p>010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility)</p>
<p>NATCEP Rate (Nurse Aide Training and Competency Evaluation Program):</p>	<p>Provider Class Types:</p> <p>010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility)</p>

<p>This is a component rate that is included in the provider specific per diem rate.</p>	
<p>RUG Rate (Resource Utilization Groups) – Effective with claim dates of service 11/1/2014:</p> <p>This is a component rate used for a price-based perspective payment methodology based on weights and provider-specific rates.</p>	<p>Claim Type:</p> <p>02 (Skilled Nursing Facility) 10 (Intermediate Care Facility) 09-A (Crossover Part-A, but processed as claim type 02 or 10)</p> <p>Provider Class Types:</p> <p>010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility)</p> <p>Provider Specialties EXCLUDED:</p> <p>86 (Ventilator) 87 (AIDS) 89 (Complex) 92 (Rehabilitation)</p>

Calculation Description	Calculation Criteria
<p>Nursing Home (RUG Excluded) Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Total Per Diem Rate in effect based on the from date of service on the claim. The Total Per Diem Rate includes the total of all applicable component rates for a provider. 2. Multiply the Total Per Diem Rate by the number of days covered. 3. Multiply the Private Room Differential by the number of days (as indicated by the Authorization File). 4. Add the results of #2 and #3. 5. Subtract Primary Carrier Amount Paid, if applicable, from result of #4. 6. Subtract Patient Pay, if applicable, from result of # 5. 7. For Therapeutic Bed use and Private Room Dif- 	<p>N/A</p>

<p>ferential Rates, multiply the 2109 revenue code daily rate by the number of days (as indicated by the Authorization File). and add it to the result of #6.</p> <p>8. If the result of #7 is less than zero, move zero to Amount to Pay. Otherwise, #7 is Amount to Pay.</p>	
<p>Nursing Home RUG Calculation of Amount to Pay – Effective with claim dates of service 11/1/2014:</p> <p>1. The per diem shall be calculated as the sum of the per diem rates for each revenue code 0022 line multiplied times the line-level revenue units.</p> <p style="padding-left: 40px;">a. The RUG per diem rate for each revenue code 0022 line is calculated as follows, based on the from date of service: ((Direct rate X RUG weight) + Indirect rate + NATCEPS + Criminal Records + Plant Rate) rounded.</p> <p style="padding-left: 40px;">b. Multiply the RUG per diem rate by the associated line-level revenue units.</p> <p>2. The line-level per diems will be summed into the final reimbursement amount.</p> <p>3. The final reimbursement shall continue to be subject to copay, third party liability, patient pay, private room differential, and other payment calculations performed after the determination of the per diem rate.</p>	<p>Claim Type:</p> <p>02 (Skilled Nursing Facility) 10 (Intermediate Care Facility)</p> <p>Provider Class Types:</p> <p>010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility)</p> <p>Provider Specialties EXCLUDED:</p> <p>86 (Ventilator) 87 (AIDS) 89 (Complex) 92 (Rehabilitation)</p>
<p>For Nursing Home Specialized Care Calculation of Amount to Pay:</p> <p>1. Total Per Diem Rate in effect based on the from date of service on the claim. The Total Per Diem Rate is comprised of the specialized care rate for the provider, including NATCEP.</p> <p>2. Multiply the Total Per Diem Rate by the number of days covered.</p> <p>3. Subtract Primary Carrier Amount Paid, if applicable</p>	<p>Provider Class Types:</p> <p>010 (Skilled Nursing Home non-MH) 015 (Intermediate Care Facility)</p> <p>Provider Specialties:</p> <p>086 (Ventilator) 087 (AIDS) 089 (Complex) 092 (Rehab)</p>

able, from the result of #2.

4. Subtract Patient Pay, if applicable, from the result of # 3.

5. For Therapeutic Bed use, multiply the 2109 revenue code daily rate by the number of days (as indicated by the Authorization File). and add it to the result of #4.

6. If the result of #5 is less than zero, move zero to Amount to Pay. Otherwise, #5 is the Amount to Pay.

OASC - Outpatient Ambulatory Surgical Centers

These providers are Provider Class Type 049 and bill on the CMS-1500 claim form. SLH enrollees will be billed on UB92 forms by Provider Type '001' or '091'. The procedure billed on the CMS-1500 claim form must contain a procedure code flag of 'AP1' through 'AP9' or 'AS1' through 'AS9'. The rates will be determined by the AP or AS flag. The UB92 claims will identify Ambulatory Surgical with a revenue code of '490' and a procedure code on the same revenue line. The procedure code will require the ASC level flags the same as the CMS-1500 billed procedures.

Pricing Method Criteria:	Provider Class Type: 049 (Ambulatory Surgical Center)
Billing Form:	CMS-1500 Claim Form, UB92 Claim Form (SLH)
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Outpatient Surgical Center Rate; Dates of Service (DOS) prior to 04/05/2010 for FFS and any date for Encounters: :</p> <p>This rate is determined by the procedure code flags.</p> <p>Flags 'AS1' and 'AP1' use ASC Level One Rate Flags 'AS2' and 'AP2' use ASC Level Two Rate Flags 'AS3' and 'AP3' use ASC Level Three Rate Flags 'AS4' and 'AP4' use ASC Level Four Rate Flags 'AS5' and 'AP5' use ASC Level Five Rate Flags 'AS6' and 'AP6' use ASC Level Six Rate Flags 'AS7' and 'AP7' use ASC Level Seven Rate Flags 'AS8' and 'AP8' use ASC Level Eight Rate Flags 'AS9' and 'AP9' use ASC Level Nine Rate</p> <p>DOS on or after 04/05/2010 for FFS: State Wide EAPG Rate (from the RF_SYS_PARAMETER).</p>	<p>The ASC Level Rates are stored on the System Parameter Table.</p> <p>ASC Level One Rate = \$277.44 ASCLEVEL1 ASC Level Two Rate = \$371.52 ASCLEVEL2 ASC Level Three Rate = \$426.05 ASCLEVEL3 ASC Level Four Rate = \$524.83 ASCLEVEL4 ASC Level Five Rate = \$599.14 ASCLEVEL5 ASC Level Six Rate = \$680.40 ASCLEVEL6 ASC Level Seven Rate = \$869.14 ASCLEVEL7 ASC Level Eight Rate = \$801.09 ASCLEVEL8 ASC Level Nine Rate = \$1,106.46 ASCLEVEL9</p> <p>\$86.58</p>

Calculation Description	Calculation Criteria
<p>Outpatient Ambulatory Surgical Center Calculation of Amount to Pay; DOS prior to 04/05/2010 for FFS and any date for Encounters::</p> <ol style="list-style-type: none"> 1. Rate is the rate in effect based on the From Date on the claim. Rate is determined by ASC Levels and ASC Flags. 2. Multiply #1 by units on the claim. 3. System determines the lesser of Billed Amount on the claim and the results of #2. 4. Subtract the result from #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges. 5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3. 6. Subtract copay, if applicable from the result of #5. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #6 is the Amount to Pay. 	<p>For procedures billed on CMS-1500 forms, if one of the procedure modifiers is equal to '50', the procedure is paid at 150% of the ASC Level Rate.</p> <p>For procedures billed on UB92 forms that contain more than one 0490 revenue line, each non surgical procedure is paid at 100% of the ASC Level Rate. However, if more than one surgical procedure code, the highest ASC Level Rate will be paid at 100% and all other surgical procedures will be paid at a reduced rate of 50% of the ASC Level Rate.</p>
<p>Outpatient Ambulatory Surgical Center Calculation of Amount to Pay: DOS after 04/04/2010 for FFS:</p> <ol style="list-style-type: none"> 1. The EAPG Code is derived from diagnoses and procedures on the claims from the 3M EAPG grouping software. 2. The EAPG weight associated with the EAPG Code is multiplied by the State Wide Rate \$86.58 (from the RF_SYS_PARAMETER table using the key EAPG-RATE) to get the EAPG Total Payment. 3. Subtract Primary Carrier Amount Paid, if applicable, from the result of #2. 4. Subtract the copay, if applicable from the result of #2. 5. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of 	<p>N/A</p>

#4 is the Amount to Pay.

OSIS - Out-of-State Inpatient Services

Deleted per DMAS This Pricing Method not needed in New VA MMIS as it is covered in Inpatient section 5.1.14.

Pricing Method Criteria:	N/A
Billing Form:	N/A
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
Deleted per DMAS not needed in VA MMIS. Covered in Inpatient section 5.1.14	N/A

Calculation Description	Calculation Criteria
Deleted per DMAS not needed in VA MMIS. Covered in Inpatient section 5.1.14	N/A

OUTP - Outpatient

Providers with the provider class type of 001, 002, 004, 005, 008, 009, 012, 013, 014, 019, 057, 085 and 091 can bill on the UB claim form for outpatient services. These providers are paid a percentage of charges billed on the claim form, as defined on the Provider Table. After 6/30/2009, PT 019 and 057 are billed on the CMS 1500 claim format.

Pricing Method Criteria:	Provider Class Types:001 (Hospital)002 (State Mental Hospital)004 (Long Stay Hospital)005 (T B Hospital)008 (State MH Med-Surg)009 (Med-Surg MR)012 (Long Stay Inpatient MH)013 (Long Stay Inpatient MR)019 (CORF)- prior to 07/01/2009 057 (Rehab Agency) - prior to 07/01/2009 085 (Non-Enroll Rehab Hospital)091 (Non-Enroll Hospital)
Billing Form:	UB Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Outpatient Percentage Rate:</p> <p>This rate is a provider specific percentage that is applied to covered charges.</p>	N/A
<p>Outpatient Rehab PT/OT/SLP Rates:</p> <p>This rate uses revenue codes to price Outpatient Rehab physical therapy, occupational therapy, and speech language pathology visits. Pricing is based on the provider rate file. The same services for Home Health are priced differently using the procedure fee file. Revenue codes can also be different for the same service. Refer to the Home Health Section.</p>	<p>Revenue Codes:</p> <p>421, 423, 424, 431, 433, 434, 441, 443, 444</p>
<p>Non-Emergency Reduction Rate:</p> <p>Payment is set to \$30.00 when an emergency room revenue code is billed and the principal diagnosis is not in the ICD-9 value set 319 (PAYABLE ER DIAGNOSIS CODE TABLE) or ICD-10 value set 20139 (ICD-10 DX EMERGENCY PAY CODES) and not in the</p>	<p>Revenue Codes:</p> <p>450 - 459</p> <p>Diagnosis:</p> <p>Non-emergency diagnosis</p>

ICD-9 value set 320 (PEND ER DIAGNOSIS CODE TABLE I) or ICD-10 value set 20320 (ICD-10 DX EMERGENCY PEND CODES) and the from date of service is < 06/01/2001 and the payment amount is > \$30.00. If the payment amount <= td service.

Calculation Description	Calculation Criteria
<p>Outpatient Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Outpatient Percentage Rate in effect based on the from date of service on the claim. This percentage rate is found on the Provider Master file. 2. Multiply the Outpatient Percentage Rate by the Billed Amount on the claim. 3. Subtract the result of #2 from the billed amount to determine non-covered charges, if non-covered charges is less than zero, move zero to non-covered charges. 4. Subtract Primary Carrier Amount Paid, if applicable, from the result of #2. 5. Subtract the Copay Amount Paid, if applicable, from the result of #4. 6. Subtract the Patient Pay Amount Paid, if applicable, from the result of #5. 7. If the result of #6 is less than zero, move zero to Amount to Pay. Otherwise, result of #6 is Amount to Pay. 	<p>N/A</p>

PACE - Program of All-inclusive Care for the Elderly (PACE)

PACE is a contract specific service that designates a particular provider and particular participants within certain city/county codes and/or zip codes.

Pricing Method Criteria:	Provider Class Types: 104 (PACE)
Billing Form:	UB-04 Claim Form
Benefit Package:	PACE 01-05-2001

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable	Not Applicable.

Rate Description	Rate Criteria
<p>PACE Rate:</p> <p>The rate is billed on a monthly basis by the provider. Claims are submitted on a monthly basis.</p>	<p>Provider Class Types: 104 (PACE)</p> <p>PACE Benefit Plan 01-05-2001</p> <p>Revenue Codes: 3103 - Adult Care -Medical & Social, Daily</p> <p>Rate Type: 'PD' (Per Diem) Rate Code: 'PC1' (Dual Eligible) 'PC2' (Not Dual Eligible)</p> <p>If Medicare Part-A or Medicare Part-B - the rate on the 'PC1' row is used for pricing the claim.</p> <p>If neither Medicare Part-A nor Medicare Part-B exists, then the rate on the 'PC2' is used for pricing the claim.</p>

Calculation Description	Calculation Criteria
Calculation of Amount to Pay for PACE claims:	N/A

Description

A claim is determined to be eligible for the PACE rate calculation when all of the following is true:

- a. PCT is '104'
- b. Enrollee is enrolled into the PACE benefit plan (01-05-2001)
- c. The revenue code on the revenue line is '3103'

The rates are associated with each Provider ID. The rate type is PER DIEM (PD) and the rate codes are 'PC1' (Dual Eligible) and 'PC2' (Not Dual Eligible).

If the Payment request has Medicare Part-A or Medicare Part-B, then the rate on the rate code 'PC1' is used. Otherwise, the rate on the rate code 'PC2' is used.

Calculation

- 1. The calculated rate amount is derived by multiplying the appropriate rate amount by the number of units on each revenue line (Revenue Code of '3103').
- 2. The cutback amount on each revenue line (if any exists) is subtracted from the respective revenue line billed amount.
- 3. The amount calculated in steps 1 and 2 are then compared with each other for each revenue line and the lesser of the two will be the allowed amount for the revenue line.
- 4. Any billed amount on a revenue line that does not have a PACE revenue code is not used for pricing.
- 5. Any Non-Covered amounts on the revenue lines are ignored and are not considered for pricing.

PHAR - Pharmacy

The Pharmacy Drugs pricing methodology uses drug type to derive rates and calculations.

Pricing Method Criteria:	Legend Drugs Non-Legend Drugs Unit Dose Drugs Brand Necessary Drugs Hemophilia Drugs Pandemic Relief Drugs
Billing Form:	Not Applicable
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Carrier Amount subtracted from Provider Payment.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>This rate relates to drugs that require a pre-prescription.</p> <p>Through 09/30/04 Legend drugs are priced at Drug Cost which is the lowest of the following rates: - Reference Cost (AWP minus 10.25%) - Federal Upper Limits (FMAC) - State MAC</p> <p>Beginning 10/01/04 The drug unit price will be determined by POS (Point of Sale). It will be the lower of these: - Reference Cost (AWP minus 10.25%) - Federal Upper Limits (FMAC) - V60/V75 *</p> <p>* Beginning 12/01/04 : The Vendor MAC will be used in place of the V60/V75 .</p> <p>* Beginning 07/01/2008 and 06/30/2010 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the</p>	Legend Drug Type

lowest (non-zero) of these:

- Reference Cost (AWP minus 10.25%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Between 07/01/2010 and 09/30/2010 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

- Reference Cost (AWP minus 13.1%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Between 10/01/2010 and 06/30/2011 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

- Reference Cost (AWP minus 10.25%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Beginning 07/01/2011 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

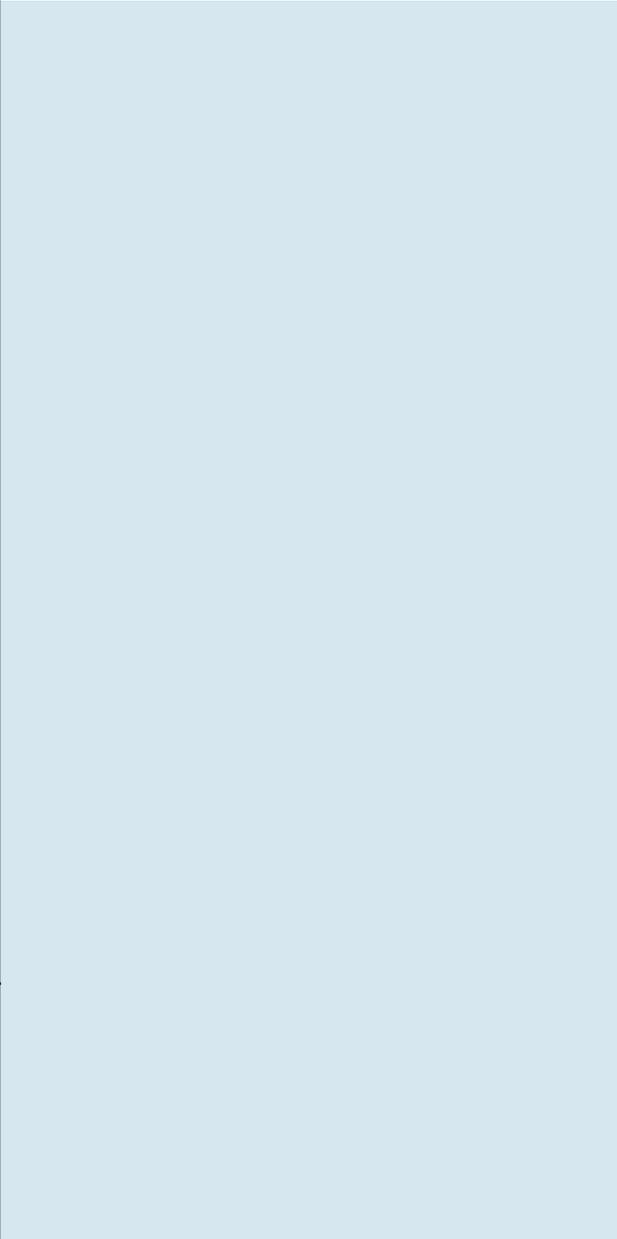
- Reference Cost (AWP minus 13.1%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Non-Legend Drug Rate:

Through 09/30/04
 Non-Legend drugs are priced at Drug Cost which is the lowest of the following rates:

- Reference Cost (AWP minus 10.25%)
- Federal Upper Limits (FMAC)
- State MAC

Beginning 10/01/04
 The drug unit price will be determined by POS



Non-Legend Drug Type

(Point of Sale). It will be the lower of these:

- Reference Cost (AWP minus 10.25%)
- Federal Upper Limits (FMAC)
- V60/V75 *

* Beginning 12/01/04 : The Vendor MAC will be used in place of the V60/V75 .

* Between 07/01/2008 and 06/30/2010 - The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

- Reference Cost (AWP minus 10.25%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Between 07/01/2010 and 09/30/2010 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

- Reference Cost (AWP minus 13.1%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Between 10/01/2010 and 06/30/2011 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

- Reference Cost (AWP minus 10.25%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

Beginning 07/01/2011 – The Specialty MAC price (SMC) will be used in logic to determine lowest price. Drug unit price is determined by POS (Point of Sale). It will be the lowest (non-zero) of these:

- Reference Cost (AWP minus 13.1%)
- Federal Upper Limits (FMAC)
- Vendor MAC (VMC)
- Specialty MAC (SMC)

<p>Unit Dose Drug Rate: For claims with a date of service after 12/31/2003, Legend Drug Rate pricing logic applies. Providers will receive a monthly fee of \$5.00 per LTC enrollee.</p> <p>Effective 7/1/11 providers will no longer receive a \$5.00 monthly administration fee for each LTC enrollees (LOC 1 or 2) for claims with a date of service after 06/30/2011.</p> <p>For claims with a date of service prior to 01/01/2004:</p> <p>This rate is associated with drugs that are packaged in a manner such that a single package provides one dose.</p> <p>The Unit Dose Drug Rate is equal to one of the following:</p> <p>1) If the Unit Dose Indicator is equal to '1', the Unit Dose Rate is equal to the lesser of the State or Federal Upper Limits plus an add-on amount, or the Reference Cost (this rate already has the add-on included in the rate). This rate can be found in the Unit Dose Rate field.</p> <p>2) If the Unit Dose Indicator is equal to '0', the Unit Dose Rate is equal to the lesser of the Federal Upper Limits, State MAC, or Reference Cost, plus an add-on amount. This rate can be found in the Unit Dose Rate field.</p> <p>3) If the Unit Dose Indicator is equal to '0', the claim is priced at the Unit Dose Rate. If the Unit Dose Indicator is equal to '1', the claim can only be a unit dose and is priced using the Unit Dose Rate.</p>	<p>Unit Dose Drug Type</p>
<p>Brand Necessary Drug Rate (DAW1)</p> <p>Through 09/30/04 Is a Dispensed As Written (DAW) drug rate, where the provider designates that the Brand only drug must be dispensed. A DAW override code of '1', (entered by the provider) will cause</p>	<p>Brand Drug Type</p>

<p>the claim to pay the Brand Necessary price which is the Reference price.</p> <p>Between 10/01/2004 and 06/30/2010 Use the Reference cost (AWP minus 10.25%).</p> <p>This indicator is found in field #11 of the drug claim form.</p> <p>Between 07/01/2010 and 09/30/2010 Use the Reference cost (AWP minus 13.1%).</p> <p>Between 10/01/2010 and 06/30/2011 Use the Reference cost (AWP minus 10.25%).</p> <p>Beginning 07/01/2011 Use the Reference cost (AWP minus 13.1%).</p>	
<p>Hemophilia Drugs Rate: For NDCs under GCN20174, GCN23382, and GCN 91942: Effective September 2, 2004, the Drug Costs and Brand Necessary prices are calculated at AWP minus 25%.</p> <p>For NDC 00944294004 under GCN20174: Effective September 2, 2004, the Drug Costs and Brand Necessary prices are calculated at AWP minus 25%.</p> <p>For NDCs 00169706101 and 3284902138 under GCN 23382: Effective September 2, 2004, the Drug Costs and Brand Necessary prices are calculated at AWP minus 25%.</p> <p>For NDC 58394001101 under GCN 91942: Effective September 2, 2004, the Drug Costs and Brand Necessary prices are calculated at AWP minus 25%.</p> <p>03/29/13 Hemophilia drugs defined in Value Set HEMOPHILIA DRUGS were all closed.</p> <p>Effective from 03/30/2013, calculate allowed amount at the current drug reimbursement rate of AWP-13.1% and uses the lesser of logic as does all pharmacy drug pricing.</p>	<p>Hemophilia drugs identifiable by the following GCNs 09628 09629 09634 20174 23381 23382 23383 25121 25123 25124 25125 25127 25130 25136 25139 25140 25141 25142 25143 25144 25145 25146 25147 25220 25221 25152 25153 25154 50050 50056 50057 50058 89260 89434 89435 89436 91942 91671 91672 91673 91674. They can also be identified by value set named HEMOPHILIA DRUGS</p>
<p>Pandemic Relief Drugs Rate: Effective 10/01/2009</p>	<p>Tamiflu and Relenza Drugs administered for the Pandemic Relief Program (Recipients with Bene-</p>

	fit Program 99) will show no dispensing fee, co-payment, or payment.
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Calculation Description	Calculation Criteria
<p>Legend Drugs Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Multiply cost/unit by number of units to get the Billed Amount. 2. Add dispensing fee and/or Clozaril monitoring fee if applicable. 3. Subtract copay when copay applies. (See Medicaid Copay section) 4. Move calculated maximum reimbursement per claim. 	<p>CMS1500 IV Infusion Rates</p> <p>Service day rates by type of therapy*:</p> <p>Pharmacy - Hydration Therapy \$ 8.00 S9373 thru S9377</p> <p>Pharmacy - Chemotherapy 25.00 S9329 thru S9331</p> <p>Pharmacy - Pain Management Therapy 12.00 S9325 thru S9328</p> <p>Pharmacy - Drug Therapy 27.00 S9338, S9348, S9490, S9494, S9497, S9501 thru S9504</p> <p>Pharmacy - TPN Therapy 150.00 S9364 thru S9368</p> <p>* only one code paid by therapy type per day</p> <p>Note: There is a separate dispensing fee for brand and generic drugs. A generic drug is determined by either the Generic Price Indicator and/or the Va Generic Override Indicator. This change is effective July 1, 2005</p>
<p>Compound Drugs:</p> <ol style="list-style-type: none"> 1. Each individual NDC ingredient will be priced as rate times metric decimal quantity. NOTE: For compound claims only, OTC ingredients are payable when at least one prescription ingredient is also payable. All other claim edits apply to individual ingredient components and will pay or deny based on the edit disposition. If all prescription ingredients are set to deny, then the OTC ingredient components are not payable. 2. Add all amounts to give Total Amount to Pay. 	<p>Note: There is a separate dispensing fee for brand and generic drugs. A generic drug is determined by either the Generic Price Indicator and/or the Va Generic Override Indicator. This change is effective July 1, 2005</p>

<p>3. Add dispensing fee if applicable.</p> <p>4. Subtract copay when copay applies. (See Medicaid Copay section)</p> <p>5. Move calculated maximum reimbursement per claim.</p>	
<p>Professional Service Transactions:</p> <p>Professional Services billed through the Pharmacy Claims adjudication system are priced at a flat rate, depending on the service. The claim will price at the rate found on the Benefit Service Code Table, for the given DOS.</p> <p>Dispensing Fee, Copay, and Other Payer Paid Amounts will not be taken into consideration when pricing the claim.</p>	<p>Note: Rate is determined by the combination of PPS Codes and Service Code (NDC or HCPCS) submitted on the claim. If NDC is submitted on the claim, the system will use its associated HICL Sequence Code when attempting to find an applicable rate.</p> <p>Service Codes stored on the Benefit Service Code Table consist of either HCPCS or HICL Sequence Code.</p>

PRACT - Practitioners

Providers are paid the lesser of the billed amount or the calculated amount to pay (maximum fee of the Procedure Rate Table, times units on the claim). Region 2 of the Procedure Rate Table, is usually used for obtaining the rate based on the From Date of Service on the claim. The rate in Region 1 of the Procedure Rate Table, is used if the participant is less than 21 years old. If the participant is less than 21 years old and the Region 1 rate is "IC" or \$0.00, Region 2 is used for pricing the claim. The exception to this is for screening and immunization procedure codes which are always priced using Region 1 rates. For these services, if there is no Region 1 rate (\$0.00 or "IC"), the claim will pend. Exception: All claims for routine childhood immunizations pend. Resource Based Relative Value Scale (RBRVS) is treated as a single procedure specific rate in the new system. Logic is not required to derive RBRVS using base rates and conversion factors.

Pricing Method Criteria:	N/A
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Refer to Copay Section.

Rate Description	Rate Criteria
<p>Procedure Rate:</p> <p>This is a procedure specific rate retrieved from Medical and Administrative Codes Database.</p> <p>If a provider procedure rate is found use that rate; exceptions Assessment, Capitation, Management Fee and Administrative Fee Claims.</p>	N/A
<p>RBRVS Rate:</p> <p>This rate is referred to as Resource Based Relative Value Scale (RBRVS). RBRVS rates are calculated from RBRVS weights and conversion factors prior to being loaded to the Procedure Rate Table. Hence, RBRVS rates are loaded and accessed like any other procedure specific rate in the system.</p>	<p>Procedure Codes:</p> <p>11040 - 69970</p> <p>Procedure Flag: R</p>
<p>Mental Health Clinic:</p> <p>This is a procedure specific rate retrieved from Medical and Administrative Codes Database.</p>	<p>Provider Type 056</p> <p>Specialty 041</p>
<p>Professional Component Rate:</p>	<p>Procedure Modifiers:</p>

<p>This procedure rate is retrieved from Medical and Administrative Codes Database. Claims history is checked for components already paid on the service for the same service date. If a paid claim is found, the system will price the claim based on the component that has not been paid. For example, if the professional component has already been paid, the claim will price at the technical component rate.</p>	<p>26 (Professional Component)</p>
<p>Technical Component Rate:</p> <p>This procedure rate is retrieved from Medical and Administrative Codes Database. Claims history is checked for components already paid on the service for the same service date. The claim will not pay if the technical component has already been paid.</p>	<p>Procedure Modifiers:</p> <p>TC (Technical Component)</p> <p>Procedure Codes:</p> <p>59020 - 59025 70000 - 89999 91000 - 91299 92541 - 92599 92950 - 92984 93000 - 93999 94010 - 94799 95000 - 95999</p>
<p>Assistant Surgeon Rate:</p> <p>This procedure specific rate is retrieved from Medical and Administrative Codes Database and multiplied by .20.</p>	<p>Provider Class Types:</p> <p>020 (Physician) 023 (Nurse Practitioner) 024 (Licensed Psychologist) 030 (Podiatrist) 031 (Optometrist) 035 (Nurse Midwife) 052 (FQHC) 053 (Rural Health Clinic) 095 (Non-Enroll Physician)</p> <p>Procedure Modifiers:</p> <p>80 (Assistant Surgeon) 81 (Minimum Assistant Surgeon) 82 (Assistant Surgeon)</p>
<p>Bilateral Procedure Rate:</p> <p>This procedure rate is retrieved from Medical and Administrative Codes Database and multiplied by 150%.</p>	<p>Procedure Modifiers:</p> <p>50 (Bilateral Procedure)</p> <p>Procedure Codes in value set 'Bilateral Procedure'.</p>

<p>Percentage Pricing Rate:</p> <p>This rate is applied to certain providers who are priced at a percentage of the total rate.</p>	<p>Provider Class Types:</p> <p>021 (Counselor - 67.5 % rate) 025 (Psychologist - 90% rate) 034 (Clinic Nurse - 67.5% rate) 076 (LCSW - 67.5% rate) 101 (School Psychologist - 67.5 % rate) 102 (Marriage & Family Therapist - 67.5 % rate) 103 (Substance Abuse Practitioner - 67.5 % rate) 105 (Certified Professional Midwife - 75 % rate)</p>
<p>Co-Surgeon Rate (NEW):</p> <p>This procedure rate is retrieved from Medical and Administrative Codes Database and multiplied by .60.</p>	<p>Provider Class Types:</p> <p>020 (Physicians) 095 (Out-of-State Physicians)</p> <p>Procedure Modifiers:</p> <p>62 (Two Surgeons) 66 (Surgical Team)</p>
<p>Reduced Outpatient Rate:</p> <p>The 'Reduced Outpatient Rate' pricing logic does not apply for claims with DOS on or after 7/1/08, due to the new pricing logic implemented for 'Physician Payment by Site of Service'.</p> <p>This rate is reduced 50% when the service is not rendered in the office. Applies to specific procedure codes indicated by a flag on the Procedure Flag Table.</p>	<p>Provider Class Types:</p> <p>020 (Practitioner) 023 (Nurse Practitioner) 030 (Podiatrist) 031 (Optometrist) 033 (Nurse Anesthetist - Medicaid Crossover Only) 035 (Nurse Midwife) 038 (Hearing Aid) 040 (Dentist) 043 (Speech Language Pathologist) 044 (Audiologist)</p> <p>Procedure Flag: RD</p>
<p>Reduced Emergency Room Rate:</p> <p>Payment is set to \$20.00 when an emergency procedure is billed and the primary diagnosis code is not in the ICD-9 value set 319 (PAYABLE ER DIAGNOSIS CODE TABLE) or ICD-10 value set 20139 (ICD-10 DX EMERGENCY PAY CODES) and not in the ICD-9 value set 320 (PEND ER DIAGNOSIS CODE TABLE I) or ICD-10 value set 20320 (ICD-10 DX EMERGENCY PEND CODES) and the from date of service is < 06/01/2001 and the payment amount is > \$20.00. If the payment amount </= td</p>	<p>CMS Place of Treatment:</p> <p>23 (Emergency Room)</p> <p>Provider Class Types:</p> <p>020 (Practitioner)</p> <p>Procedure Codes:</p> <p>Listed in 'Emergency Procedure' value set.</p>

<p>service.</p>	<p>90500 - 90580 99281 - 99285 99062 99064 - 99065</p> <p>CMS Type of Service:</p> <p>Not 2 (Surgery) Not 7 (Anesthesia) Not 6 (Radiation Therapy) Not 8 (Diagnostic Lab)</p>
<p>Multiple Procedure RVU Rate:</p> <p>The system prices the procedure with the highest RVU rate at 100% of the Medicaid Allowed Amount. Lower RVUs are priced at 50% of the Medicaid Allowed Amount. There are some exceptions to this pricing rule where the procedure is paid at 100% regardless of the RVU. These are identified by procedure code as shown in the rate criteria.</p>	<p>CMS Modifiers:</p> <p>Rendered Services:</p> <p>Surgery claims for a recipient with same dates of service.</p> <p>Procedure Codes that always pay 100% regardless of RVU:</p> <p>11101 11201 11732 15101 15121 15201 15221 15241 15261 15787 16042 17001 17002 22103 22116 22216 22226 22328 22585 22614 22632 27692 29850 29851 29855 29856 29888 29889 32501 33530 33533 33534 33535 33536 33924 44955 47001 58611 61712 61795 63035 63048 63057 63066 63076 63078 63082 63086 63088 63091 63308 64727</p>
<p>Outpatient Rehab Services</p>	<p>Effective 07/01/2009, the following applies for Provider Class Type 019 and 057</p> <p>Rehabilitation Services:</p> <p>Physical Therapy - Allowed amount is 100% of the OUP REHAB Region Rate Procedure Codes 97001, 97110, 97150</p> <p>Occupational Therapy - Allowed amount is 100% of the OUP REHAB Region Rate Procedure Codes 97003, 97530, S9129</p> <p>Speech Therapy - Allowed amount is 100% of the OUP REHAB Region Rate Procedure Codes 92506, 92507, 92508</p>

<p>Special Education Services</p>	<p>Provider Class Type 072</p> <p>Rehabilitation Services:</p> <p>Procedure Codes - in value sets School Rehab Services and School Psych Procedures</p> <p>Skilled Nursing - Allowed amount is 100% of the Region Rate Procedure Codes T1001, T1002, T1003</p> <p>Physical Therapy - Allowed amount is 100% of the Region Rate Procedure Codes 97001, 97110, 97150</p> <p>Speech Language Pathology Modifiers Q or U6 - Allowed amount is 100% of the Region Rate Procedure Codes 92506, 92507, 92508</p> <p>Occupational Therapy - Allowed amount is 100% of the Region Rate Procedure Codes 97003, 97530, S9129</p> <p>Psychology Services 90801-90802, 90804-90815, 90845-90847, 90853, 90857, 90885, 96100-96103, 96116, 96118-96120 Modifiers Q or U6 - Allowed amount is 100% of the Region Rate Modifiers R or AH - Allowed amount is 90% of the Region Rate Modifiers S or AJ - Allowed amount is 67.5% of the Region Rate</p> <p>Audiology - Allowed amount is 100% of the Region Rate 92553, 92555-92557, 92559, 92560-92565, 92567- 92569, 92571-92573, 92575-92577, 92579, 92582-92583, 92587-92588, 92592-92593, 92597, 92601-92604, 92620-92621, 92625-92627, 92630, 92633</p> <p>Medical Evaluations - Allowed amount is 100% of the Region Rate</p>
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	<p>T1024</p> <p>Transportation - Allowed amount is 100% of the Region Rate</p> <p>T2003</p> <p>Personal Care Services - Allowed amount is 100% of the Region Rate</p> <p>T2027, S5125</p> <p>Paid amount for all the above services is determined by multiplying the allowed amount by either the MEDIC-FFP% (Medicaid) or FAMIS-FFP% (Medicaid Expansion and FAMIS).</p> <p>EPSDT Services:</p> <p>Procedure Codes - not in value sets School Rehab Services or School Psych Procedures.</p> <p>Allowed amount is 100% of the Region Rate. Paid amount is based upon the allowed amount.</p>
<p>Baby Care:</p>	<p>Provider Class Type:</p> <p>020 (Physician) 023 (Nurse Practitioner) 035 (Nurse Midwife) 036 (Case Management) 051 (Health Department Clinic) 052 (Federally Qualified Health Center) 053 (Rural Health Clinic)</p> <p>Provider Specialty:</p> <p>036 (Case Management) 037 (Nutrition) 038 (Patient Education) 039 (Homemaker Services)</p> <p>Procedure Codes: Old procedure codes effective thru DOS 12/31/2003: (Z9001, Z9010, Z9104, Z9105, Z9106, Z9300, Z9301, Z9302, Z9310, Z9311, Z9312)</p>

	<p>A0160 New procedure codes effective beginning DOS 06/20/03: (99420, G9001, G9002, S9442, S9446, 97802, 97803, S5131)</p>
<p>Department of Social Services(DSS):</p> <p>Paid amount is determined by multiplying the allowed amount by the VA-DSS% system parameter value depending on claims date of service.</p>	<p>Provider Class Type:</p> <p>073 (Case Management Waiver)</p> <p>Procedure Codes: See value set 'Department of Social Services' for ranges</p>
<p>Virginia Department of Health(VDH):</p> <p>Paid amount is determined by multiplying the allowed amount by the VA-VDH% system parameter value depending on claims date of service.</p>	<p>Provider Class Type:</p> <p>051 (Health Department Clinic) 053 (Rural Health Clinic)</p> <p>Procedure Codes: See value set 'Virginia Department of Health' for ranges</p>
<p>Psychiatric Nurse Practitioner Rates</p> <p>Procedures associated with this specialty are priced at 67.5% or 100% of the total rate depending on the procedure.</p>	<p>Effective 08/01/2007, the following combination will be used to price claims at 67.5%</p> <p>Provider Class Type :</p> <p>023 (Nurse Practitioner)</p> <p>Provider Specialty :</p> <p>111 (Psychiatric Nurse Practitioner)</p> <p>Procedures to be priced at 67.5% of the total rate. These are listed in 'Psych Nurse Practitioner - 67.5 ' value set</p> <p>90801-90802, 90804-90819, 90821-90824, 90826-90829, 90845-90847, 90853, 90857, 90899, 96101-96103, 96118-96120</p>

<p>Physician Payment by Site of Services.</p> <p>If the maximum fee applies, pay the IP rate if found, else pay OP rate. The 'Physician Payment by Site of Service' logic applies only for claims with DOS on or after 7/1/08.</p> <p>The professional component rate will be the OPPC rate as no IPPC rate is currently available.</p> <p>The technical component rate will be the OP rate minus the OPPC rate even if an IP rate is on file.</p>	<p>Claim Types:</p> <p>05 (Practitioner) 09 (Title 18 XOVB)</p> <p>Provider Class Types:</p> <p>020 (Practitioner) 021 (Licensed Professional Counselor) 023 (Nurse Practitioner) 025 (Clinical Psychologist) 026 (Chiropractor) 030 (Podiatrist) 031 (Optometrist) 032 (Optician) 033 (Nurse Anesthetist - Medicaid Crossover Only) 035 (Nurse Midwife) 038 (Hearing Aid) 040 (Dentist) 041 (Dentist Clinic) 043 (Speech Language Pathologist) 044 (Audiologist) 051 (Health Department Clinic) 056 (Mental Health Mental Retardation) 071 (Substance Abuse Clinic-FAMIS) 072 (Education Services) 076 (Licensed Clinical Social Worker) 077 (Psych Residential Inpatient Facility) 078 (Licensed Social Worker) 095 (Out-of-State Phys) 097 (Out-of-State Dental) 099 (Medicare Crossover) 101 (School Psychologist) 102 (Marriage and Family Therapist) 103 (Substance Abuse Practitioner) 105 (Certified Professional Midwives)</p> <p>See value set IP Provider Class Type</p> <p>Place of Services:</p> <p>21 (Inpatient Hospital) 22 (Outpatient Hospital) 23 (Emergency Room Hospital) 24 (Ambulatory Surgical Center) 31 (Skilled Nursing Facility)</p>
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	<p>51 (Inpatient Psychiatric Facility) 61 (Comprehensive Inpatient Rehabilitation Facility)</p> <p>See value set IP Place of Service</p>
<p>Mental Health Assessment (effective 08/01/2009)</p> <p>This procedure rate is retrieved from Medical and Administrative Codes Database using the region type MHAS. Rates are obtained based on the procedure modifier associated with the procedure.</p> <p>If any procedure modifier is U6, the region used is 0001. If any procedure modifier is U7, the region used is 0002. If any procedure modifier is U8 and the provider locality is rural, the region used is 0003. If any procedure modifier is U8 and the provider locality is urban, the region used is 0004. If any procedure modifier is U9 and the provider locality is rural, the region used is 0005. If any procedure modifier is U9 and the provider locality is urban, the region used is 0006. If any procedure modifier is UA, the region used is 0007.</p>	<p>Claim type: 05 (Practitioner)</p> <p>Provider types: 020 (Practitioner) 056 (Mental Health Mental Retardation) 073 (Case Management) 095 (Non-Enroll Physician)</p> <p>Procedure code: H0032</p> <p>Provider locality in value set 'Urban Region Localities' is considered urban.</p>

Calculation Description	Calculation Criteria
<p>Calculation of Amount to Pay:</p> <p>The system calculates the Amount to Pay as follows for services not reduced by emergency room edits. Note: If there are two or more units on a multiple surgery claim, different percentages could apply to the Rate, as defined above. The first unit must have Amount to Pay calculated separately from the remaining units on the claim.</p> <p>1. Rate is the rate in effect for the From Date of Service on the claim. This is the Region 1 or 2 rate on the Procedure Rate Table or the PA rate, as defined in the PA section or the provider procedure rate. The system should multiply this rate</p>	N/A

by all percentages if applicable, as defined above.

2. Multiply #1 by units on the claim.

3. System determines the lesser of Billed Amount on the claim and the results of #2.

4. Subtract the result of #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.

6. Subtract Copay, if applicable, from the result of #5.

7. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #6 is the Amount to Pay.

RESID - Residential Treatment Center

Providers with DMAS provider class type 022 and 077 can bill for RESID Pricing services. Included in these services are services that are associated with Prior Authorizations (PAs) for Treatment Foster Care Case Management (TFC-CM, PA Service Type 0700), Residential CSA (RESICSA, PA Service Type 0750), Residential Non CSA (RESINON, PA Service Type 0751), Children's Group Home Level A (Level A, PA Service Type 0752), and Therapeutic Group Home Level B (Level B, PA Service Type 0753).

Pricing Method Criteria:	Provider Class Type:022 (Treatment Foster Care-Case Management)077 (Residential Treatment Center) Bill Form: UB04 Claim Form (RESICSA and RESINON) CMS-1500 Claim Form (TFC-CM, Level A, and Level B)
Billing Form:	UB04 Claim Form (RESICSA and RESINON)
Benefit Package:	01-Medicaid , 07-FAMIS

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL Edits	N/A	Refer to Copay Section

Rate Description	Rate Criteria
TFC-CM Procedure Rate (CMS-1500): This is a procedure specific rate retrieved from Medical and Administrative Codes Database (Procedure T1016, Procedure Type F).	Provider Type 022
Level A Procedure Rate (CMS-1500): This is a procedure specific rate retrieved from Medical and Administrative Codes Database (Procedure H2022, Procedure Type 1).	Provider Type 077
Level B Procedure Rate (CMS-1500): This is a procedure specific rate retrieved from Medical and Administrative Codes Database (Procedure H2020, Procedure Type 1).	Provider Type 077
RESICSA Rate (UB-04): The standard RESICSA rate is established annually each State FY by DMAS's Provider Reimbursement. The Rate is recorded in the MMIS as the System Parameter RESICSA starting 10/01/2007 and effective 07/01/2008 and later; this rate is viewable online in an inquiry mode and is not additionally included in this Pricing Manual.	Provider Type 077 Effective 10/01/2007, the RESICSA rate is recorded in the approved PA Line Cost Field based on the lower of 1) the rate submitted by the provider with the PA request or 2) the standard RESICSA rate in the MMIS for the PA Authorized Dates.

Prior to 10/01/2007, the RESICSA rate was used to price RESICSA claims manually. The rates for the manual pricing process were:

Effective 07/01/2007 – 06/30/2008 – \$393.20
 Effective 07/01/2006 – 06/30/2007 – \$376.98
 Effective 07/01/2005 – 06/30/2006 – \$357.67
 Effective 07/01/2004 – 06/30/2005 – \$340.64
 Effective 07/01/2003 – 06/30/2004 – \$330.72

RESINON Rate (UB-04):
 The RESINON rate is established annually each State FY by DMAS’s Provider Reimbursement for each provider based on annual evaluations with the providers. The Rate is recorded in the MMIS for each provider as Rate Code RESN for the provider’s rate information and effective 07/01/2008 and later; this rate is viewable online in an inquiry mode and is not additionally included in this Pricing Manual.

Prior to 10/01/2007, the RESINON rate for each associated provider was used to price RESINON claims manually. The rates for the manual pricing process were:

Effective 07/01/2007 – 06/30/2008:

Provider NPI-----Provider Legacy-----	Rate
1033178033-----0000728 -----	\$222.84
1043280951-----N/A -----	\$228.16
1053404533-----10050014-----	\$363.57
1083702229-----0207055-----	\$344.95
1093740482-----0207012-----	\$289.88
1124051701-----10079659-----	\$390.71
1235238320-----10000556-----	\$0.00
1275564361-----0000701-----	\$289.88
1497751135-----N/A-----	\$348.57
1629172838-----0000752-----	\$348.63
1659333045-----10135435-----	\$375.13
1730239922-----0207039-----	\$385.47
1740245117-----0207306-----	\$357.38
1750304044-----0207292-----	\$357.08
1871507699-----0207241-----	\$338.60
1932218864-----0207101-----	\$385.16
1942231063-----0207021-----	\$289.88

Effective 07/01/2006 – 06/30/2007:

Provider Type 077
 Effective 10/01/2007, the RESINON rate is recorded in the approved PA Line Cost Field is based on the lower of 1) the rate recorded in the MMIS for the provider’s RESN rate or 2) the standard RESICSA rate in the MMIS for the PA Authorized Dates.

N/A

Provider NPI	Provider Legacy	Rate
1033178033	0000728	\$213.65
1053404533	10050014	\$348.58
1083702229	0207055	\$330.73
1093740482	0207012	\$277.93
1124051701	10079659	\$374.61
1235238320	10000556	\$0.00
1275564361	0000701	\$277.93
1629172838	0000752	\$334.25
1659333045	10135435	\$359.67
1730239922	0207039	\$369.58
1740245117	0207306	\$342.64
1750304044	0207292	\$342.36
1871507699	0207241	\$324.64
1932218864	0207101	\$369.28
1942231063	0207021	\$277.93
N/A	0207195	\$330.73
N/A	10157293	\$334.20

Effective 07/01/2005 – 06/30/2006

Provider NPI	Provider Legacy	Rate
1033178033	0000728	\$202.71
1053404533	10050014	\$330.72
1083702229	0207055	\$313.79
1093740482	0207012	\$263.69
1124051701	10079659	\$355.41
1235238320	10000556	\$0.00
1275564361	0000701	\$263.69
1629172838	0000752	\$317.13
1659333045	10135435	\$341.24
1730239922	0207039	\$350.64
1740245117	0207306	\$0.00
1750304044	0207292	\$325.09
1871507699	0207241	\$308.01
1932218864	0207101	\$350.36
1942231063	0207021	\$263.69
N/A	0207195	\$313.79

N/A

Effective 07/01/2004 – 06/30/2005

Provider NPI	Provider Legacy	Rate
1033178033	0000728	\$193.05
1053404533	10050014	\$314.97
1083702229	0207055	Not Elig
1093740482	0207012	\$251.13
1235238320	10000556	\$0.00

N/A

1275564361----0000701-----\$251.13	
1629172838----0000752-----\$302.03	
1730239922----0207039-----\$333.95	
1740245117----0207306-----\$0.00	
1750304044----0207292-----\$309.61	
1932218864----0207101-----\$333.68	
1942231063----0207021-----\$251.13	
N/A-----0000233-----Not Elig	
N/A-----0000671-----Not Elig	
N/A-----0000744-----\$338.49	
N/A-----0207004-----\$319.33	
N/A-----0207071-----\$293.34	
N/A-----0207217-----\$251.13	

Effective 07/01/2003 – 06/30/2004	
Provider NPI----Provider Legacy---- Rate	
1033178033----0000728 -----\$187.43	
1083702229----0207055-----\$0.00	
1275564361----0000701-----\$243.82	
1629172838----0000752-----\$293.23	
1730239922----0207039-----\$324.225	N/A
1750304044----0207292-----\$300.59	
1932218864----0207101-----\$323.96	
N/A-----0000233-----\$311.62	
N/A-----0000671-----Not Elig	
N/A-----0000744-----\$328.63	
N/A-----0207004-----\$310.03	
N/A-----0207071-----\$284.80	

Calculation Description	Calculation Criteria
<p>TFC-CM, Level A, and Level B Services Calculation of Amount to Pay:</p> <p>1. Rate is the rate in effect for the From Date of Service on the claim. This is the Region 1 or 2 rate on the Procedure Rate Table.</p> <p>2. Multiply #1 by units on the claim.</p> <p>3. System determines the lesser of Billed Amount on the claim and the results of #2.</p> <p>4. Subtract the result of #3 from the Billed Amount on the claim to determine Non-Covered</p>	N/A

<p>Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.</p> <p>5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.</p> <p>6. Subtract Copay, if applicable, from the result of #5.</p> <p>7. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #6 is the Amount to Pay.</p>	
<p>RESICSA Services Calculation of Amount to Pay:</p> <p>1. For Services on or after 10/01/2007, multiply the PA Cost Field for the appropriate PA Line by the claim payment days to determine the calculated amount (allowed amount), and if the billed charges of the claim are less than the calculated amount, then move the billed charge to the allowed amount.</p> <p>2. The allowed amount will be reduced by any Primary Carrier Amount Paid and/or Copay, if applicable. If the allowed amount is less than \$0.00 after any reductions, move \$0.00 to the Amount to Pay; otherwise, the result after the reductions is the Amount to Pay.</p> <p>3. Effective 10/01/2007 claims will no longer Pend (Edit 0705) for manual pricing.</p>	N/A
<p>RESINON Services Calculation of Amount to Pay:</p> <p>1. For Services on or after 10/01/2007, multiply the PA Cost Field for the appropriate PA Line by the claim payment days to determine the calculated amount (allowed amount), and if the billed charges of the claim are less than the calculated amount, then move the billed charge to the allowed amount.</p> <p>2. The allowed amount will be reduced by any Primary Carrier Amount Paid and/or Copay, if applicable. If the allowed amount is less than</p>	N/A

\$0.00 after any reductions, move \$0.00 to the Amount to Pay; otherwise, the result after the reductions is the Amount to Pay.

3. Effective 10/01/2007 claims will no longer Pend (Edit 0705) for manual pricing.

RIAL - Regular and Intensive Assisted Living

An enrollee must have Aid Category of “12”, “32”, or “52” to receive these services. An enrollee must also have an Exception Indicator “F” for Regular Assisted Services or “J” for Intensive Assisted Services. The enrollee receiving these services can not co-exist in any other waiver program. Recipients participating in the Regular Assisted Living program can co-exist in any Managed Care program. Recipients participating in the Intensive Assisted Living program can not co-exist in any Managed Care program. Note that providers can bill 31 days BUT maximum payments are \$90.00 or \$180.00.

Pricing Method Criteria:	Provider Class Types: See value set; 'Prov Types Asst Living Pricing' - CPA04017 079 (Assisted Living) Provider Specialties: 048 (Regular Assisted Living) 049 (Intensive Assisted Living)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
Regular Assisted Living Rate: The provider may bill this rate no more than one per day not to exceed 31 days per month. There is a monthly maximum for procedure Z8575. This is \$90.00/month for Z8575.	Provider Class Types: 079 (Assisted Living) Provider Specialties: 048 (Regular Assisted Living) Procedure Codes: Z8575
Intensive Assisted Living Rate:	Provider Class Types:

<p>The provider may bill this rate no more than one per day not to exceed 31 days per month.</p> <p>There are specific Monthly maximum rates. For Procedure Code Z8576 the maximum is \$180.00/month.</p>	<p>079 (Assisted Living)</p> <p>Provider Specialties:</p> <p>049 (Intensive Assisted Living)</p> <p>Procedure Codes:</p> <p>Z8576</p>
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Calculation Description	Calculation Criteria
<p>Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Rate is the Procedure file rate in effect based on the From Date on the claim. There are monthly maximums for procedures Z8575 and Z8576. Refer to the rates section above for more information. 2. Multiply #1 by units on the claim. 3. Determine the lesser of Billed Amount on the claim and the result of #2. 4. Subtract the result of #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges. 5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3. 6. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise #5 is the Amount to Pay. 7. Do not allow rate for procedure Z8575 to exceed \$90.00 a month and do not allow rate for Z8576 to exceed \$180.00 monthly maximum. If calculated rate exceeds the monthly maximum cutback to monthly maximum for these procedures. 	<p>N/A</p>

SLH - State and Local Hospitalization (SLH)

The State and Local Hospitalization Program (SLH) is a separate state funded Accountable Health Care Plan for which medical claims are paid for the indigent population. Eligibility is based on a number of need criteria, including ineligibility for the Medicaid Program. Claims for SLH are paid fully in order of receipt of the claim based on the claim's from date of service and the SLH participant's city/-county code on the participant's eligibility file (SLH participants may have services rendered at any facility regardless of whether the facility is in the participant's city/county). Claims go to the history file as disallowed if the funds for a particular locality have been exhausted. However, if the funds are replenished during the fiscal year, claims are recycled from the History File and paid based on the oldest claim by dates of receipt.

Pricing Method Criteria:	N/A
Billing Form:	UB Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>DRG Rehab Per Diem Rate:</p> <p>This rate is by-passed from the DRG Pricing Methodology but uses a per diem rate for rehab services.</p> <p>Refer to the Inpatient Per Diem Calculation of Amount to Pay</p>	<p>Provider Class Types: 001(Hospital)091(Non-Enrolled Hospital)</p> <p>Bill Types:</p> <p>111 112 113 114</p> <p>ICD Diagnosis: Principal diagnosis = V5721, V5722, V573, V528, V529, V571, V5789, V579 (ICD-9 value set 147 – REHAB CLAIM) or Z5189 (ICD-10 value set 20147 – ICD-10 REHAB DIAG)</p>
<p>DRG Rate:</p> <p>[Hospital specific operating rate per case + acute psych IME (Indirect Medical Education) rate per case] * DRG relative rate + (all of the above *</p>	<p>Provider Class Types:001 (Hospital)091 (Non-Enrolled Hospital)</p> <p>Bill Types:</p>

<p>Capital Percent)</p> <p>This rate is based on the through date of the claim. The factor is multiplied by the DRG payment and outlier payment.</p>	<p>111 112 113* 114*</p> <p>*For Full DRG implementation</p>
<p>State and Local Hospital Rates:</p> <p>This rate is determined based on the Medicaid per diem rates for providers.</p>	<p>Provider Class Types:</p> <p>001 (Hospital)</p>
<p>Non-Enrolled Hospital Rates:</p> <p>These rates are based on rates established for non-enrolled providers in the Medicaid program. These rates are found on the Provider Master file.</p>	<p>Provider Class Types:091 (Non-Enrolled Hospital)</p>
<p>Hospital Outpatient Rates:</p> <p>These services are billed on UB-92 claim form as revenue codes are converted in the current system to procedure codes. The services include: Emergency Room, Hospital Outpatient Clinic, and Hospital Outpatient Surgery.</p>	<p>Provider Class Types:</p> <p>001 (Hospital)</p> <p>Procedure Codes:</p> <p>99283 99214 M0050-M0054</p>
<p>Ambulatory Surgery Center Rate:</p> <p>This rate is for services from Free-Standing Ambulatory Surgery Centers.</p>	<p>Provider Class Types:049 (Ambulatory Surgical Center)</p> <p>Procedure Codes: DOS less than 1/1/2004 M0050-M0054</p> <p>Revenue Code: 0490, with revenue procedure that has a flag code of ASC.</p>
<p>Health Department Clinic Rate:</p> <p>This rate is for services from Health Department Clinics.</p>	<p>Provider Class Types:</p> <p>051 (Health Department Clinics)</p> <p>Procedure Codes:</p> <p>99214 or m0050 - m0054</p>
<p>DRG Transfer Case Rate:</p> <p>[DRG payment / Avg. length of stay] * Covered days</p> <p>DRG codes 456, 639, and 640 are excluded from</p>	<p>Provider Class Types:001 (Hospital)091 (Non-Enrolled Hospital) (date specific with full DRG implementation)</p> <p>Bill Types:</p>

transfer case rate.	111 112 114
Transfer cases are paid the lessor of full DRG or per diem rate based on DRG.	
DRG Outlier Rate:[(Outlier threshold amount * Outlier labor percentage * Wage Index) + (Outlier threshold amount * Outlier non-labor percentage)] * DRG factor Outlier payments are applied to claims that have higher than usual charges.Refer to the current ISR related to the Outlier Formula.Provider Class Types:001 (Hospital)091 (Non-Enrolled Hospital) date specific with full DRG implementation	Bill Types: 111 112 114
DRG Psych Per Diem Rate:This rate is bypassed from the DRG Pricing Methodology but uses a per diem rate for psych services.Refer to the Inpatient Per Diem Calculation of Amount to Pay.Provider Class Types:001(Hospital)091(Non-Enrolled Hospital)	Bill Types: 111 112 ICD Diagnosis: Principal Diagnosis in the range of 290 -319 (ICD-9 value set 314 – DIAG CODE PSYCH CLAIM) or F0150 – F99 (ICD-10 value set 20314 – ICD-10 DIAG CODE PSYCH CLAIM)

Calculation Description	Calculation Criteria
<p>Non-Enrolled Inpatient Calculation of Amount to Pay:</p> <p>1. Rate in effect based on the from date of service on the claim. This rate is found on the SLH Program provider rate table.</p> <p>2a). Multiply the Inpatient Per Diem Rate by number of covered days.</p> <p>2b). Multiply the Inpatient Percentage Rate by the Billed Amount on the claim.</p> <p>3. System determines the lesser of the two calculated Amounts to Pay as a result of the calculations in #2a and #2b.</p> <p>4. Subtract the result of #3 from the billed amount to determine non-covered charges. If non-covered charges is less than \$0.00, move \$0.00</p>	<p>Provider Class Types:091 (Non-Enrolled Hospital)</p>

<p>to non-covered charges.</p> <p>5. Subtract the Primary Carrier Amount Paid, if applicable, from the result of #4.</p> <p>6. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, move the result of #5 to Amount to Pay.</p>	
<p>Inpatient Calculation of Amount to Pay:</p> <p>1. Rate in effect based on the from date of service on the claim. This rate should be found on the SLH Program provider rate table.</p> <p>2. Multiply the rate by number of covered days.</p> <p>3. Subtract the result of #2 from the billed amount to determine non-covered charges. If non-covered charges is less than \$0.00, move \$0.00 to non-covered charges.</p> <p>4. Subtract the Primary Carrier Amount Paid, if applicable, from the result of #2.</p> <p>5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, move the result of #4 to Amount to Pay.</p>	<p>Provider Class Types:</p> <p>001 (Hospital)</p>
<p>Hospital Outpatient Calculation of Amount to Pay:</p> <p>1. Rate in effect based on the date of service on the claim. This rate is determined based on the outpatient service billed as defined above.</p> <p>2. Multiply the rate by the number of units.</p> <p>3. System determines the lesser of billed amount on the claim and the result of #2.</p> <p>4. Subtract the result of #3 from the billed amount to determine non-covered charges. If non-covered charges is less than \$0.00, move \$0.00 to non-covered charges.</p> <p>5. Subtract the Primary Carrier Amount Paid from the result of #3.</p>	<p>N/A</p>

6. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, move the result of #5 to Amount to Pay.

Inpatient Per Diem Calculation of Amount to Pay:

1. Primary Rate is the provider's Per Diem Rate in effect based on the From Date on the claim that is on the Provider Eligibility File. Providers that are approved for a NICU per diem rate have this rate on the provider eligibility file for claims with revenue codes 175.

2. Multiply Primary Rate by Payment Days on the claim to calculate the Primary Rate Amount to Pay. This result needs to be stored for reporting purposes.

3. For claims with Dates of Service prior to 7/1/96, the secondary Rate is the provider's DSA Per Diem Rate in effect based on the From Date on the claim. This is the NICU DSA or regular DSA per diem rate as defined above. For claims with Dates of Service after 6/30/96, the DSA Per Diem Rate will not be applicable except for PCT of 004(Long Stay Hospital), 008(State MH Med-Surg), and 012(Long Stay Inpatient Hospital-MH).

4. Multiply Secondary Rate by Payment Days on the claim to calculate the DSA Rate Amount to Pay, if applicable. This result needs to be stored for reporting purposes.

5. Add Primary Carrier Amount Paid, Patient Pay Amount and Co-pay

6. Subtract the result of #5 from the result of #2 to calculate a new Primary Rate Amount to Pay. If this new Primary Rate Amount to Pay is less than \$0.00, hold this amount (unsigned) for #7 and move \$0.00 to the new Primary Rate Amount to Pay. This new Primary Rate Amount to Pay also needs to be stored on the system for reporting purposes.

7. If applicable, subtract the held amount in #6

Provider Class Types:001 (Hospital)002 (State Mental Hospital)003(Private EPSDT Mental Hospital)004 (Long Stay Hospital)007 (State Mental Hospital < 21)008 (State MH Med-Surg)009 (Med-Surg MR)012 (Long Stay Inpatient Hospital – MH)014(Rehab Hospital)

<p>from #4 to calculate a new DSA Rate Amount to Pay. If this new DSA Rate Amount to Pay is less than \$0.00, approve the claim and move \$0.00 to the new DSA Rate Amount to Pay and the final Amount to Pay. This new DSA Rate Amount to Pay needs to be stored on the system for reporting purposes.</p> <p>8. Add the new DSA Rate Amount to Pay (#7) and the new Primary Rate Amount to Pay (#6). If the claim is approved, the result of #8 is the final Amount to Pay.</p>	
<p>DRG Calculation of Amount to Pay:</p> <p>1. The Primary Rate is the Provider's rate per case in effect based on the Through Date of service on the claim. The DRG assignment is derived from the ICD diagnosis and procedures on the claim from the DRG Grouper. Each DRG is assigned a relative weight and ALOS Table.</p> <p>2. Multiply the rate per case by the relative weight of the assigned DRG (Case rate * DRG weight) + (Rate * Weight * Capital Percent). This result needs to be stored for reporting purposes.</p> <p>3. Amount to Pay is the result of #2 unless there is a transfer, readmission, or Outlier case payment then refer to #4, 5, or 6.</p> <p>4. If the case is a transfer case, then compute the Transfer Per Diem Case Rate amount, based on the Through Date of Service on the claim. Per diem payment is calculated based on the DRG case rate times the relative weight / Avg. L.O.S. from the DRG table of Relative weight times covered days. This becomes the Amount to Pay if lessor than or equal to the DRG case rate (amount in #2). This result needs to be stored for reporting purposes. It is possible for a transfer case to have an Outlier payment(See #6 below).</p> <p>5. If the case is determined to be a Re-admission payment request (5 days with same or similar diagnosis code), the 1st inpatient hospital claim is to</p>	<p>Provider Class Types: 001 (Hospital) 091 (Non-Enroll Hospital) date specific with full DRG implementation</p> <p>Bill Types: 111 112 113 114</p> <p>From DOS greater than or equal to implementation date.</p> <p>DRG Transfer Exclusions: 456 639 640</p>

be voided and re-processed to show zero payment. The reason message on the Remittance Advice should be 'Patient re-admitted, claim to be re-priced'. The second inpatient hospital claim is voided and re-processed to create one claim/case (combining the 1st and 2nd claims) to have one claim processed through the DRG grouper (Steps #1 and # 2). This result needs to be stored for reporting purposes.

6. Compute the Outlier rate amount. This rate applies to claims with a higher than usual charges. The Outlier formula is stored with First Health's current payment logic. DMAS will update the Outlier threshold and other factors as needed. Refer to the current ISR and implementation for Outlier payment calculations.

7. Add DRG Case rate # 2 or #5 + Outlier rate # 6 and this becomes Amount to Pay. If the DRG Case is a Transfer Case, add the Transfer Case Rate #4 + Outlier rate #6 and this becomes Amount to Pay. This result needs to be stored for reporting purposes.

8. Capital Percentage and Multiply by Per Diem. Add to result obtained in number 7.

9. Add Primary Carrier Amount Paid, Deductible, and Co-pay.

10. Subtract the Primary Carrier Amount Paid, Deductible, and Co-pay from the result of #7.

11. Move the results of #9 to the Amount to Pay.

T18 - Title XVIII

Title 18 claims are received from Medicare carriers as crossover claims electronically from Medicare and from providers on paper claim forms. As of December 1, 2003 Part A and Part B Outpatient are received on the standard UB rather than the DMAS Title 18 claim forms. All other Part B is still submitted on the DMAS Title 18 claim forms. Title 18 claims are now priced using Medicaid rules and the payment is reduced so that the total payment (Medicare plus Medicaid) does not exceed the total amount that Medicaid would normally allow for the same service. For all claims, other than the exceptions listed in this document, please refer to the appropriate section in the Medicaid pricing manual to determine the pricing algorithm; for example, inpatient, practitioner, transportation, nursing home, etc. Claims that are considered "non covered" services by Medicaid, but are covered by Medicare will pay the coinsurance and deductible without reduction. This includes claims that would set edits 210, 214, 146, 147, and 749 (see Value Set T18 EDITS TO SKIP PRICING). Only Provider Class Types 001-015, 027, 028, 046, 085, 091, 092, and 100 can bill for Medicare Part A services. If a claim is received from any other provider class type for Medicare Part A, the system changes the coverage code to Medicare Part B.

Pricing Method Criteria:	N/A
Billing Form:	DMAS-30, UB and Medicare cross over
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Determined by DSS edits.	Refer to Copay Section.

Rate Description	Rate Criteria
Part A and B Coinsurance and Deductible (All Institutional Claims submitted UB92 Claim Form) As of December 1st, 2003 VAMMIS will calculate the Medicaid allowable amount by pricing a crossover claim as if it were a regular Medicaid claim. To price the claim, we categorize it as a Medicaid Claim Type as follows: Part A Coverage: Hospital Inpatient Nursing Home (SNF) Intermediate Care (ICF) Part B Coverage: Hospital Outpatient Home Health	Bill Types: Hospital Inpatient Value Set XOVA INPATIENT BILL TYPE 111 thru 114 117 thru 118 151 thru 154 157 thru 158 161 thru 164 167 thru 168 171 thru 174 177 thru 178 181 thru 184 187 thru 188

	<p>411 thru 414 417 thru 418 451 thru 454 457 thru 458 461 thru 464 467 thru 468 471 thru 474 477 thru 478 481 thru 484 487 thru 488</p> <p>Nursing Home: Value Set XOVA NURSING HOME BILL TYPES</p> <p>211 thru 214 217 thru 218 511 thru 514 517 thru 518</p> <p>Intermediate Care: Value Set XOVA ICF BILL TYPES</p> <p>611 thru 614 617 thru 618 651 thru 654 657 thru 658 661 thru 664 667 thru 668</p> <p>Home Health: Value Set XOVA HOME HEALTH BILL TYPES</p> <p>331 334 337 338</p> <p>Hospital Outpatient: All other bill types</p> <p>Bypass Pricing for Provider Types 052, 053, 077 (Value Set XOVA PAY BILLED PROVIDER TYPES). For these provider types, pay the coinsurance and deductible as billed.</p>
<p>Part B Coinsurance and Deductible (All Non-Institutional Claims submitted on DMAS-30)</p> <p>As of December 1st, 2003 VAMMIS will calculate</p>	<p>Provider Types:</p> <p>Personal Care: 055</p>

<p>the Medicaid allowable amount by pricing a crossover claim as if it were a regular Medicaid claim. To price the claim, we categorize it as a Medicaid Claim Type as follows:</p> <p>Part B Coverage: Personal Care Practitioner Lab Transportation</p>	<p>Lab: 070, 098, 001, 091</p> <p>Transportation: 080, 082, 083, 084</p> <p>Practitioner: All other provider types</p>
<p>Part A CMS Annual Coinsurance PIRS Per Diem Rate:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <p>This is a provider specific PIRS coinsurance rate after 7/31/93 for Medicare Part A claims.</p>	<p>Provider Class Types: 010 (SNF Non-MH)</p> <p>Dates of Service: Before 07/01/96 After 07/31/93</p>
<p>Part A CMS Annual Coinsurance Per Diem Rate:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <p>This is a set coinsurance rate for Medicare part A claims based on the Dates of Service year. The yearly rates will be on the System Parameter Table.</p> <p>Medicare Part A and Part B claims (electronic and paper) reduces the payment of Medicare Coinsurance to no more than the Medicaid allowed amount.</p>	<p>Provider Class Types: 006 (SNF - MH) 010 (SNF - Non-MH) 011 (SNF - MR) 027 (CS - SNF) 028 (SNF - State) 092 (Non-Enroll SNF)</p> <p>Dates of Service: Before 08/01/93 After 06/30/96</p>
<p>Part A Original Coinsurance and Deductible Rate:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior</p>	<p>Provider Class Types: 015 (ICF) Claims Denied</p>

<p>to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <p>The rate is the sum of the original coinsurance and deductible amount on the claim. The rate is for providers that are not certified by Medicare for nursing facility care.</p> <p>Medicare Part A and Part B claims(electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount.</p>	
<p>Part B Original Coinsurance and Deductible Rate:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <p>The rate is the sum of the original coinsurance and deductible amount on the claim. This rate is for claims that have been billed as part A by provider class types that are not allowed to bill part A. This rate is also applicable to part B claims with service dates after 6/30/96.</p> <p>Note: Medicaid payment is limited to the difference between the Medicaid maximum fee for a procedure and 80% of the Medicare allowance. Medicare Part A and Part B claims(electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount. The Medicaid reduction for Part B is based on coinsurance only.</p>	<p>Dates of Service:</p> <p>Before 08/01/93 After 06/30/96</p>
<p>Part B Claims with valid procedure code:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December</p>	<p>Dates of Service:</p> <p>Before 08/01/93 After 06/30/96</p>

<p>1st, 2003 please refer to the appropriate section above.</p> <p>For paper claims and crossover claims, the system accesses the Procedure Rate Table using the procedure code on the claim to obtain the Medicaid rate. This rate is the Region 1 Rate or Region 2 Rate on the Procedure Rate Table in effect for the From Date of Service on the claim. The Region 2 Rate is for adults and the Region 1 Rate, if present, is for a participant less than 21 years old. Refer to the Practitioners Section of this document for more information on these rates.</p> <p>Note: Medicaid payment is limited to the difference between the Medicaid maximum fee for a procedure and 80% of the Medicare allowance. Medicare Part A and Part B claims (electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount. The Medicaid reduction for Part B is based on coinsurance only.</p>	<p>Other Exceptions:</p> <ol style="list-style-type: none"> 1. If the claim is an anesthesia Type of Service 7) claim, the claim is priced as if the claim was a CMS 1500 for anesthesia services. Note: Anesthesia on the Title 18 claims is determined by DMAS Type Service Code "7" and a procedure code in the following ranges: 00001-08999 10000-89999 90870 92018 2. If the claim has a technical or professional component modifier, the claim is priced as if the claim was a CMS 1500 with these modifiers using the Procedure Table Rate in effect for the From Date of Service on the claim. Note: Technical component on Title 18 claims is determined by the modifier and a procedure code in the range 70000-89999. Professional component on Title 18 claims is determined by the modifier and a procedure code in the following ranges: 70000-89999 91000-91299 92541-92599 92950-92984 93000-93329 93501-93799 93859-93999 93859-93999 94010-94799 95819-95999 3. If the claim is billed with a modifier for assistant surgeon and the Provider Class Type is 020, 023, 024, 030, 031, 035, 052, 053, or 095, the system multiplies the rate by 20% 4. If the Provider Class Type is 052 or 053 and one of the Procedure Table Flags is equal to "CV" (clinic visit), the system calculates the amount to pay as if there is no valid procedure code 5. If the procedure code is not a Medicaid covered service as defined on the Procedure Table, or if
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	the Procedure Table Rate is "IC" or \$0.00, the system calculates amount to pay as if there is no valid procedure code
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Calculation Description	Calculation Criteria
<p>Part A Coinsurance and Deductible - Hospital Inpatient</p> <p>1. Determine if claim is priceable by reviewing the following criteria. If either A or B is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible.</p> <p>A. Is the provider type one that Medicaid would allow to bill this claim? See edit 0022.</p> <p>B. Is the bill type 112, 113, or 114 (interim bill) for provider type 001, 014, 085, or 091? They are DRG providers, and interim bills are not priced during daily adjudication. They are priced during the monthly DRG case building and adjusted accordingly. Please refer to Hospital Inpatient pricing manual for details on DRG pricing.</p> <p>2. Set the billed charges equal to the Medicare billed charges for pricing purposes.</p> <p>3. Apply Medicaid pricing algorithm. Please refer to the Hospital Inpatient pricing manual for details.</p> <p>4. Subtract the Medicare Paid from the calculated Medicaid Allowed amount from step 3. If the billed amount (Coinsurance plus Deductible) is less than the Medicaid allowed amount then reduce the Medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.</p> <p>5. If the result of step 4 is \$0.00, deny the claim for reason 364.</p>	<p>Provider Types:</p> <p>001, 002, 003, 004, 005, 007, 008, 009, 012, 013, 014, 046, 085, 091, 100</p> <p>For all other provider types, pay the coinsurance and deductible as billed.</p>

<p>6. If the allowed amount is greater than the medicare billed or medicare allowed, reduce the allowed amount to the lesser of the medicare billed and medicare allowed and set new EOB 1252.</p> <p>7. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.</p>	
<p>Part A Coinsurance and Deductible - Nursing Home</p> <p>1. Determine if claim is priceable by reviewing the following criteria. If A is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible..</p> <p>A. Is the provider type one that Medicaid would allow to bill this claim? See edit 0022.</p> <p>2. Set computed Medicare Billed amount equal Medicare Coinsurance amount plus Medicare Deductible amount</p> <p>3. Compute Medicare Allowed amount as Medicare Coinsurance amount plus the Medicare Paid amount</p> <p>4. If the submitted Covered Days is greater than zero compute the assumed Medicare Allowed Rate as the Medicare Allowed amount divided by submitted Covered Days</p> <p>5. Compute the assumed Medicare Allowed amount as the assumed Medicare Allowed Rate times the Payment Days</p>	<p>Provider Types: 006, 010, 011, 015, 028, 092</p> <p>For all other provider types, pay the coinsurance and deductible as billed.</p>

6. Compute the assumed Medicare Paid amount as the Assumed Medicare Allowed amount less the Medicare Coinsurance amount

7. Apply Medicaid pricing algorithm. Please refer to the Nursing Home pricing manual for details.

8. Subtract the assumed Medicare Paid Amount calculated in step 6 from the calculated Medicaid Allowed amount from step 7 giving the adjusted Medicaid Allowed amount. If the result is less than zero, then assume zero.

9. Subtract the Medicare Paid from the calculated Medicaid Allowed amount from step 2. If the billed amount (Coinsurance plus Deductible) is less than the medicaid allowed amount then reduce the medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.

10. If the result of step 5 is \$0.00, deny the claim for reason 364.

11. If the allowed amount is greater than the medicare billed or medicare allowed, reduce the allowed amount to the lesser of the medicare billed and medicare allowed and set new EOB 1252.

12. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

Part A Coinsurance and Deductible - Intermediate Care

Provider Types:
 016, 017, 018, 029, 086
 For all other provider types, pay the coinsurance

1. Determine if claim is priceable by reviewing the following criteria. If A is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible..

A. Is the provider type one that Medicaid would allow to bill this claim? See edit 0022.

2. Set the billed charges equal to the Medicare billed charges for pricing purposes.

3. Apply Medicaid pricing algorithm. Please refer to the ICF pricing manual for details.

4. Exclude the first 20 days after admission:

(a) Calculate a per diem paid amount by dividing the Medicare Paid by the total days.

(b) Subtract the number of days that are within the first 20 days after admission if any.

(c) Calculate a prorated Medicare Paid Amount by multiplying the per diem (a) by the total days (b).

5. Subtract the Medicare Paid calculated in step 4 from the calculated Medicaid Allowed amount from step 3. If the billed amount (Coinsurance plus Deductible) is less than the Medicaid allowed amount then reduce the Medicaid allowed amount to the billed amount. If the result is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.

6. If the result of step 5 is \$0.00, deny the claim for reason 364.

7. If the allowed amount is greater than the Medicare billed or Medicare allowed, reduce the allowed amount to the lesser of the Medicare billed and Medicare allowed and set new EOB 1252.

and deductible as billed.

8. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

Part B Coinsurance and Deductible - Hospital Outpatient

1. Determine if claim is priceable by reviewing the following criteria. If A is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible.

A. Is the provider type one that Medicaid would allow to bill this claim? See edit 0022.

2. Set the billed charges equal to the Medicare billed charges for pricing purposes.

3. Apply Medicaid pricing algorithm. Please refer to the Hospital Outpatient pricing manual for details.

4. Subtract the Medicare Paid calculated in step 3 from the calculated Medicaid Allowed amount from step 2. If the billed amount (Coinsurance plus Deductible) is less than the Medicaid allowed amount then reduce the Medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.

5. If the result of step 4 is \$0.00, deny the claim for reason 364.

6. If the allowed amount is greater than the Medicare billed or Medicare allowed, reduce the allowed amount to the lesser of the Medicare

Provider Types:

001, 002, 003, 004, 005, 007, 008, 009, 012, 013, 014, 019, 057, 085, 091, 046, 100

For all other provider types, pay the coinsurance and deductible as billed.

<p>billed and medicare allowed and set new EOB 1252.</p> <p>7. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.</p>	
<p>Part B Coinsurance and Deductible - Home Health</p> <p>1. Determine if claim is priceable by reviewing the following criteria. If A is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible.</p> <p>A. Is the provider type one that Medicaid would allow to bill this claim? See edit 0022.</p> <p>2. Set the billed charges equal to the Medicare billed charges for pricing purposes.</p> <p>3. Apply Medicaid pricing algorithm. Please refer to the Home Health pricing manual for details.</p> <p>4. Subtract the Medicare Paid from the calculated Medicaid Allowed amount from step 3. If the billed amount (Coinsurance plus Deductible) is less than the medicaid allowed amount then reduce the medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.</p> <p>5. If the result of step 4 is \$0.00, deny the claim for reason 364.</p> <p>6. If the allowed amount is greater than the medicare billed or medicare allowed, reduce the</p>	<p>Provider Types: 058, 059, 094</p> <p>For all other provider types, pay the coinsurance and deductible as billed.</p>

<p>allowed amount to the lesser of the medicare billed and medicare allowed and set new EOB 1252.</p> <p>7. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.</p>	
<p>Part B Coinsurance and Deductible - Personal Care</p> <p>1. Set the billed charges equal to the Medicare billed charges for pricing purposes.</p> <p>2. Apply Medicaid pricing algorithm. Please refer to the Hospital Inpatient pricing manual for details.</p> <p>3. Subtract the Medicare Paid from the calculated Medicaid Allowed amount from step 2. If the billed amount (Coinsurance plus Deductible) is less than the medicaid allowed amount then reduce the medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.</p> <p>4. If the result of step 3 is \$0.00, deny the claim for reason 364.</p> <p>5. If the allowed amount is greater than the medicare billed or medicare allowed, reduce the allowed amount to the lesser of the medicare billed and medicare allowed and set new EOB 1252.</p> <p>6. Apply the allowed amount (as described above) to the billed deductible first, and then any</p>	<p>Provider Types: 055</p>

remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

Part B Coinsurance and Deductible - Practitioner

1. Determine if claim is priceable by reviewing the following criteria. If A is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible.

A. Is the provider type one that Medicaid would allow to bill this claim? See edit 0022.

2. Set the billed charges equal to the Medicare billed charges for pricing purposes.

3. Apply Medicaid pricing algorithm. Please refer to the appropriate Practitioner pricing manual for details.

4. Subtract the Medicare Paid from the calculated Medicaid Allowed amount from step 3. If the billed amount (Coinsurance plus Deductible) is less than the medicaid allowed amount then reduce the medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.

5. If the result of step 4 is \$0.00, deny the claim for reason 364.

6. If the allowed amount is greater than the medicare billed or medicare allowed, reduce the allowed amount to the lesser of the medicare billed and medicare allowed and set new EOB 1252.

7. Apply the allowed amount (as described

Provider Types:

001, 014, 019, 020, 021, 022, 023, 024, 025, 026, 030, 031, 032, 034, 035, 036, 037, 038, 039, 044, 046, 047, 048, 049, 053, 055, 056, 057, 060, 061, 062, 063, 064, 067, 069, 071, 072, 073, 076, 077, 078, 079, 093, 095, 0100

For all other provider types, pay the coinsurance and deductible as billed.

above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

Part B Coinsurance and Deductible - Lab

1. Set the billed charges equal to the Medicare billed charges for pricing purposes.
2. Apply Medicaid pricing algorithm. Please refer to the Lab pricing manual for details.
3. Subtract the Medicare Paid from the calculated Medicaid Allowed amount from step 2. If the billed amount (Coinsurance plus Deductible) is less than the medicaid allowed amount then reduce the medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.
4. If the result of step 3 is \$0.00, deny the claim for reason 364.
5. If the allowed amount is greater than the medicare billed or medicare allowed, reduce the allowed amount to the lesser of the medicare billed and medicare allowed and set new EOB 1252.
6. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

N/A

Part B Coinsurance and Deductible - Transportation
 DOS prior 11/1/2009:

1. Determine if claim is priceable by reviewing the following criteria. If A is met, proceed to step 2. Otherwise, bypass pricing and pay the billed coinsurance and deductible.
 - A. Is the procedure code one of the procedure codes that are currently priced for Medicaid?
2. Set the billed charges equal to the Medicare billed charges for pricing purposes.
3. Apply Medicaid pricing algorithm. PLEASE REFER TO THE TRANSPORTATION PRICING MANUAL FOR DETAILS.
4. Subtract the Medicare paid from the calculated Medicaid allowed amount from step 3. If the billed amount (Coinsurance plus Deductible) is less than the Medicaid allowed amount then reduce the Medicaid allowed amount to the billed amount. If the results is less than zero, then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.
5. If the result of step 4 is \$0.00, deny the claim for reason 364, prior to April 2008. From April 2008 forward with dates of service prior to 11/1/2009, set EOB 364.
6. If the allowed amount is greater than the Medicare billed or Medicare allowed, reduce the allowed amount to the lesser of the Medicare billed and Medicare allowed and set new EOB 1252.
7. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the

Claims processed prior to April 2008:
 Procedure Codes:
 Y0109, Y0110, Y0111, Y0112, Y0113, Y0114, Y0115, Y0118, Y0119, Y0121, A0225, A0427, A0429, A0430, A0431, A0999

For all other procedure codes, pay the coinsurance and deductible as billed.

Claims processed after March 2008 with dates of service prior to 11/1/2009:
 Procedure codes in value sets 'PROC - TRANSPORT - EMERGENCY' and 'PROC - TRANSPORT - NON -EMERGENCY' and procedure codes A0435 and A0436.

allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

Part B Coinsurance and Deductible - Transportation
DOS on or after 11/1/2009 Service/mileage pricing

1. Set the billed charges equal to the Medicare billed charges for pricing purposes.
2. Apply Medicaid pricing algorithm. Please refer to the Transportation pricing manual for details. If there is no rate for the procedure, the claim will pend for manual pricing.
3. Subtract the Medicare paid from the calculated Medicaid allowed amount from step 3. If the billed amount (Coinsurance plus Deductible) is less than the Medicaid allowed amount then reduce the Medicaid allowed amount to the billed amount. If the allowed amount is greater than the Medicare billed or Medicare allowed, reduce the allowed amount to the lesser of the Medicare billed and Medicare allowed and set new EOB 1252.
4. a. If the result is less than zero and the claim line is not part of a service/mileage pair (See Transportation Pricing Manual), then assume zero. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.
b. If one claim line of a service/mileage pair is positive and one is negative, the amount that is negative is subtracted from the positive line and EOB

Claims processed with dates of service on or after 11/1/2009, see Transportation Pricing

1176 is set on that line. If either line results in zero, then assume zero for that line. This is the Medicaid allowed amount that can be applied to the reimbursement for coinsurance and deductible.

5. If the result of step 4 is \$0.00, pay \$0.00 with EOB 364.

6. Apply the allowed amount (as described above) to the billed deductible first, and then any remaining to the calculated coinsurance. If the allowed amount is less than the billed amount, then reduce the coinsurance and deductible accordingly. For example, assume a claim was submitted for \$840 deductible and \$50 coinsurance. After step 4, the allowed amount is \$860. The system would pay \$840 deductible and \$20 coinsurance for a total payment of \$860.

Part A CMS Annual Coinsurance (PIRS) Calculation of Amount to Pay:

The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.

1. Determine the HCFA Annual Coinsurance Per Diem Rate that is applicable for the claim based on the From Date of Service on the claim.
2. Determine the Calculated Coinsurance Amount by multiplying the number of days to pay (units) on the claim by the Annual Coinsurance Per Diem Rate, as defined in #1
3. Determine the nursing home's PIRS Provider Per Diem Rate based on the From Date of Service of the claim. This rate is currently on the Provider Rate File.
4. Calculate the PIRS Amount to Pay by multiplying the number of days to pay on the claim (units) by the nursing home's PIRS Per Diem

N/A

<p>Rate, as defined in #3.</p> <p>5. Subtract the Medicare Paid Amount on the claim from the result of #4. If this is equal to or less than \$0.00, deny the claim for DMAS reason 364 (Primary Carrier Payment equals/exceeds VMAP's).</p> <p>6. Determine the least amount of #2, #5, or the Original Coinsurance Amount on the claim form.</p> <p>7. Calculate Non-Covered Charges by subtracting the result of #6 from the Original Coinsurance Amount on the claim. If the Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.</p> <p>8. Subtract the Primary Carrier Paid Amount, if applicable, from #6.</p> <p>9. If the result of #8 is \$0.00 or less, deny the claim for reason 364.</p> <p>10. Subtract the Patient Pay Amount, if applicable, from #8</p> <p>11. If the result of #10 is \$0.00 or less, deny the claim for DMAS reason 300.</p> <p>12. If the result of #10 is less than \$0.00, move \$0.00 to the Amount to Pay. Otherwise, #10 is the Amount to Pay for an approved claim.</p>	
<p>Part A CMS Annual Coinsurance Calculation of Amount to Pay:</p> <p>1. Determine the CMS Annual Coinsurance Per Diem Rate based on the From Date of Service on the claim.</p> <p>2. Determine the number of days stay on the claim by the calculation:</p> <p>Through Date minus From Date plus 1</p> <p>3. Determine the Calculated Coinsurance Amount by multiplying the result of #2 by the Annual Coinsurance Per Diem Rate, as defined</p>	<p>Provider Class Types:</p> <p>10 (SNF Non-MH)</p> <p>Bill Types:</p> <p>211 thru 214 217 thru 218 511 thru 514 517 thru 518</p> <p>Dates of Service:</p> <p>Before 07/1/96 After 06/30/98</p> <p>Note: Medicare Part A and Part B claims(elec-</p>

<p>in #1.</p> <p>4. Determine the lesser of the Original Coinsurance Amount on the claim and the result of #3.</p> <p>5. Calculate Non-Covered Charges by subtracting the result of #4 from the Original Coinsurance Amount on the claim. If the Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.</p> <p>6. Subtract Primary Carrier Amount Paid, if applicable, from #4.</p> <p>7. Subtract Patient Pay Amount, if applicable, from #6.</p> <p>8. If the result of #7 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #7 is the Amount to Pay.</p>	<p>tronic and paper) reduces the payment of Medicare deductibles to no more than the Medicaid allowed amount.</p>
<p>Part A Original Coinsurance and Deductible Calculation of Amount to Pay:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <p>1. Amount to Pay is equal to the sum of Original Coinsurance and Deductible Amount on the claim.</p> <p>2. Subtract Primary Carrier Amount Paid, if applicable, from #1.</p> <p>3. Subtract Patient Pay Amount, if applicable, from #2.</p> <p>4. If the result of #3 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #3 is the Amount to Pay.</p> <p>5. Set Calculated Coinsurance equal to the Original Coinsurance on the claim.</p>	<p>Provider Class Types:</p> <p>06 (SNF - MH) 10 (SNF - Non-MH) 11 (SNF - MR) 27 (CS - SNF) 28 (SNF - State) 92 (Non-Enroll SNF)</p> <p>Dates of Service:</p> <p>Before 08/01/93 After 06/30/96</p> <p>Note: Medicare Part A and Part B claims(electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount.</p>

<p>6. Set Non-Covered Charges equal to \$0.00 for these claims.</p>	
<p>Part A Hospital Claims Original Coinsurance and Deductible Calculation of Amount to Pay:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <ol style="list-style-type: none"> 1. Add Deductible and Coinsurance on claim. 2. Subtract Primary Carrier Amount Paid, if applicable, from the result of #1. 3. Subtract Copay, if applicable, from the result of #2. 4. If the result of #3 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #3 is the Amount to Pay. 5. Set Non-Covered Charges to \$0.00 for these claims. 	<p>Provider Class Types:</p> <p>15 (ICF)</p> <p>Note: Medicare Part A and Part B claims(electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount.</p>
<p>Part B Billed as Part A Original Coinsurance and Deductible Calculation of Amount to Pay:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <ol style="list-style-type: none"> 1. Determine Calculated Coinsurance as (Medicare Allowed Amount minus Deductible on claim) times 20%. 2. If Calculated Coinsurance is less than \$0.00, move \$0.00 to the Calculated Coinsurance. 3. Determine the lesser of the Calculated Coinsurance and the Original Coinsurance on the 	<p>Note: Medicare Part A and Part B claims(electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount.</p>

<p>claim.</p> <p>4. Add the result of #3 and the Deductible on the claim.</p> <p>5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #2.</p> <p>6. Subtract Patient Pay Amount, if applicable, from the result of #3.</p> <p>7. Subtract Copay, if applicable, from the result of #4.</p> <p>8. If the result of #5 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #5 is the Amount to Pay.</p> <p>9. The system then calculates the following (which could change the amount the provider billed):</p> <p>Billed Amount on the claim is equal to the sum of (result of #4 plus Deductible on the claim).</p> <p>10. The system sets Non-Covered Charges to \$0.00 for Part B claims.</p> <p>11. For these claims, the Calculated Coinsurance equals the Original Coinsurance on the claim.</p>	
<p>Part B Original Coinsurance and Deductible Calculation of Amount to Pay:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <p>1. Add the Original Coinsurance and Deductible on the claim.</p> <p>2. Subtract Primary Carrier Amount Paid, if applicable, from the result of #1.</p>	<p>Note: Medicare Part A and Part B claims (electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount.</p>

3. Subtract Patient Pay Amount, if applicable, from the result of #2.

4. Subtract Copay, if applicable, from the result of #3.

5. If the result of #4 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #4 is the Amount to Pay.

6. The system then calculates the following (which could change the amount the provider billed):

Billed Amount on the claim is equal to the sum of (result of #3 plus Deductible on the claim)

7. The system sets Non-Covered Charges to \$0.00 for Part B claims.

8. For these claims, the Calculated Coinsurance equals the Original Coinsurance on the claim.

Part B (Non-Psych Diagnosis) Coinsurance and Deductible with Valid Procedure Code Calculation of Amount to Pay:

The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.

1. Multiply the procedure rate, as defined above, by the units on the claim. Exception: If the claim is billed with a procedure code in the range 00001-06999 and the Provider Class Type is 20, 23, 24, 30, 31, 35, 52, 53, or 95, the rate from the Procedure Rate Table is used but is not multiplied by the units on the claim.
2. If the result of #1 is less than the Medicare Allowed Amount on the claim, and the Coinsurance on the claim is greater than \$0.00, the system computes the following:

Dates of Service:

After 06/30/96

Note: Medicare Part A and Part B claims (electronic and paper) reduces the payment of Medicare coinsurance to no more than the Medicaid allowed amount.

<p>a) Subtract the result of #1 from the Medicare Allowed Amount on the claim.</p> <p>b) Determine the Calculated Coinsurance by subtracting the result of a) from Original Coinsurance on the claim.</p> <p>c) If Calculated Coinsurance is less than \$0.00, move \$0.00 to the Calculated Coinsurance.</p> <p>d). Add Calculated Coinsurance and Deductible on the claim.</p> <p>e). Subtract Primary Carrier Amount Paid, if applicable, from the result of d).</p> <p>f). Subtract Patient Pay Amount, if applicable, from the result of e).</p> <p>g). Subtract Copay, if applicable, from the result of f).</p> <p>h). If the result of g) is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of g) is the Amount to Pay.</p> <p>i). The system then calculates the following (which could change the amount the provider billed):</p> <p>Billed Amount on the claim is equal to the sum of (Calculated Coinsurance plus Deductible on the claim).</p> <p>j) The system sets Non-Covered Charges to \$0.00 for Part B claims.</p>	
<p>Part B (Psych Diagnosis) Coinsurance and Deductible with Valid Procedure Code Calculation of Amount to Pay:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of</p>	<p>Dates of Service:</p> <p>Before 07/01/96 and After 06/30/98</p> <p>Diagnosis Codes:</p> <p>Not psychiatric (in the range of 290 - 31999 (ICD-9 value set 314 – DIAG CODE PSYCH CLAIM) or F0150 – F99 (ICD-10 value set 20314 – ICD-10 DIAG CODE PSYCH CLAIM))</p>

service. For claims processed after December 1st, 2003 please refer to the appropriate section above.

1. Multiply the procedure rate, as defined above, by the units on the claim. Exception: If the claim is billed with a procedure code in the range 00001-06999 and the Provider Class Type is 20, 23, 24, 30, 31, 35, 52, 53, or 95, the rate from the Procedure Rate Table, is used but is not multiplied by the units on the claim.

2. Multiply the Original Coinsurance on the claim by 2. This does not replace the Original Coinsurance on the claim.

3. If #2 is greater than #1, the system computes the following:

a) Subtract the result of #1 from result of #2.

b) Determine the Calculated Coinsurance by subtracting the result of a) from the Original Coinsurance on the claim.

c) If Calculated Coinsurance is less than \$0.00, move \$0.00 to the Calculated Coinsurance.

4. Add Calculated Coinsurance and Deductible on the claim.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #4.

6. Subtract Patient Pay Amount, if applicable, from the result of #5.

7. Subtract Copay, if applicable, from the result of #6.

8. If the result of #7 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #7 is the Amount to Pay.

9. The system then calculates the following (which could change the amount the provider billed):

New Billed Amount on the claim is equal to Calculated Coinsurance Amount plus Deductible on the claim.

10. The system sets Non-Covered Charges to \$0.00 for Part B claims.

Part B Exception to (Non-Psych Diagnosis) Coinsurance and Deductible with Valid Procedure Code Calculation of Amount to Pay:

The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.

1. Determine Calculated Coinsurance as:

(Medicare Allowed Amount on the claim minus Deductible on the claim) times 20%.

2. If Calculated Coinsurance is less than \$0.00, move \$0.00 to the Calculated Coinsurance.

3. Determine the lesser of the Calculated Coinsurance and the Original Coinsurance on the claim.

4. Add the result of #3 and Deductible on the claim.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #4.

6. Subtract Patient Pay Amount, if applicable, from the result of #5.

7. Subtract Copay, if applicable, from the result of #6.

8. If the result of #7 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise the result of #7 is the Amount to Pay.

Dates of Service:

Before 07/01/96 and After 06/30/98

Diagnosis Codes:

in the range of 290 - 31999 (ICD-9 value set 314 – DIAG CODE PSYCH CLAIM) or F0150 – F99 (ICD-10 value set 20314 – ICD-10 DIAG CODE PSYCH CLAIM)

<p>9. The system then calculates the following (which could change the amount the provider billed):</p> <p>Billed Amount on the claim is equal to the sum of (result of #3 plus Deductible on the claim).</p> <p>10. The system sets Non-Covered Charges to \$0.00 for Part B claims.</p>	
<p>Part B Exception to (Psych Diagnosis) Coinsurance and Deductible with Valid Procedure Code Calculation of Amount to Pay:</p> <p>The following has been left in for historical purposes. This only applies to claims processed prior to December 1st, 2003 regardless of the dates of service. For claims processed after December 1st, 2003 please refer to the appropriate section above.</p> <ol style="list-style-type: none"> 1. Determine Calculated Coinsurance as: (Medicare Allowed Amount minus Deductible Amount on the claim) times 50%. 2. If Calculated Coinsurance is less than \$0.00, move \$0.00 to this field. 3. Determine the lesser of the Calculated Coinsurance and the Original Coinsurance on the claim. 4. Add the result of #3 and Deductible on the claim. 5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #4. 6. Subtract Patient Pay Amount, if applicable, from the result of #5. 7. Subtract Copay, if applicable, from the result of #6. 8. If the result of #7 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #7 is the Amount to Pay. 	<p>Dates of Service:</p> <p>Before 07/01/96 and After 06/30/98</p> <p>Diagnosis Codes:</p> <p>Not 290 - 31999 (psychiatric)</p> <p>Other Exceptions:</p> <ol style="list-style-type: none"> 1. Claim does not have a valid procedure code on the Procedure Table 2. Claim does have a valid procedure code, but the Procedure Rate Table rate is "IC" or \$0.00 3. Claim did not meet calculation step #2 defined in 'Part B (Non-Psych Diagnosis) Coinsurance and Deductible with Valid Procedure Code Calculation'

9. The system then calculates the following (which could change the amount the provider billed):

Billed Amount on the claim is equal to the sum of (result of #3 plus Deductible on the claim).

10. The system sets Non-Covered Charges to \$0.00 for Part B claims.

TDO - Involuntary Detention Services

Temporary Detention Orders (TDOs) involve temporary internment to a hospital due to mental instability. The billing provider could be any hospital or facility, physician/psychologist. This is a Supreme Court of Virginia program being administrated by DMAS. This is not a Medicaid Program. A TDO is indicated on the participant file as a separate program and benefit plan indicator. Provider and Enrollee(recipient) must BOTH be enrolled in Medicaid order for Medicaid to pay the claim. If the payment request is for a Medicaid recipient with a Medicaid provider, TDO should pay the balance after Medicaid of copays and/or deductibles. The per diem is based on the individual psychiatric rate on the Provider File. Primary Carrier amount is subtracted if applicable.

Pricing Method Criteria:	N/A
Billing Form:	UB and CMS-1500 Claim Forms
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
<p>Medicaid Physicians For Medicaid Recipient under and over 21</p> <p>Subtract other insurance (third party always pays first) If there is are remaining balance Medicaid program pays. If there is a remaining balance TDO program pays.</p> <p>For Non-Medicaid Recipient Subtract other insurance If there is a remaining balance TDO program pays</p>	Medicaid Enrolled Physicians
<p>Non-Medicaid Physicians: Non-Medicaid Recipients and Medicaid Recipients for under and over 21 If other insurance subtract other insurance first If there is a remaining balance TDO program pays.</p>	Non-Medicaid Physicians
<p>Free Standing Psychiatric: For Medicaid Provider:</p>	Free Standing Psychiatric

<p>For over 21 Medicaid Claim should be processed through TDO Program and pay average per diem rate.</p> <p>For under 21 Medicaid Program pays first then TDO.</p> <p>For Medicaid Psychiatric with non-Medicaid Enrollee TDO Program pays average per diem rate.</p> <p>For Non-Medicaid Provider:</p> <p>For Over and under 21 Medicaid and Non-Medicaid Enrollee TDO program pays average per diem rate.</p>	
<p>State and Local Hospitals (SLH):</p> <ol style="list-style-type: none"> 1. TDO Pays 2. If remaining balance SLH is last resort payer. <p>For SLH with insurance</p> <ol style="list-style-type: none"> 1. Other Insurance 2. TDO 3. SLH if there is a remaining balance after 1 & 2 pay. 	<p>SLH (State and Local Hospitals)</p>
<p>Regular Per Diem and DSA Rate:</p> <p>This is a individual provider specific psychiatric per diem rate. This secondary DSA rate is not included for the TDO program</p>	<p>Medicaid Enrolled Providers</p>
<p>Average State-Wide Per Diem Rate:</p> <p>This is a state-wide average inpatient psychiatric per diem rate for providers not enrolled in Medicaid. There is no DSA rate associated with this rate.</p>	<p>Non-Enrolled Providers</p>
<p>Procedure Rate:</p> <p>The TDO procedures and rates are the same as the procedure codes and rates established by Medicaid that will be used by the physician providers for TDO. These codes and rates are stored within the Medicaid Program.</p>	<p>N/A</p>

Calculation Description	Calculation Criteria
<p>Calculation of Amount to Pay:</p> <ol style="list-style-type: none"> 1. Primary Rate is the provider's Per Diem Rate in effect based on the From Date on the claim that is on the Provider Eligibility File. 2. Multiply Primary rate by Payment Days on the claim to calculate the Primary Rate Amount to Pay. This result needs to be stored for reporting purposes. 3. Add Primary Carrier Amount Paid. 4. Subtract the result of # 3 from the result of # 2 to calculate a new Primary Rate to Pay. If this new Primary Rate is less than zero move zero to the New Primary Rate Amount to Pay. This new Primary Rate to Pay needs to be stored on the system for reporting purposes. 5. Move the result of #4 to the Amount to Pay. 	<p>Provider Class Types:001 (Hospital)002 (State Mental Hospital)003 (Private EPSDT Mental Hospital)007 (State Mental Hospital < 21)008 (State MH Med-Surg)012 (Long Stay Inpatient Hospital)020 (Physician)091 (Non-Enrolled Hospital)</p>

TRANS - Transportation Services

..... Date of Service prior to 11/1/2009.....

Transportation providers bill on the CMS-1500 claims form that is automatically converted into a transportation claim record for processing. Reimbursement for transportation services are determined by mileage, and whether the service was one-way or round-trip. Mileage is used to derive the transportation rate. The mileage component is based on the one-way or round-trip miles accumulated for a transportation service. The rate increases in 1-5, 6-10, 11-40, and > 40 mile increments. The wait time (where applicable) component is an hourly rate based on the amount of wait time accumulated during round-trip transportation services. If wait time applies, rates are added together to derive the transportation rate. For Round-trip claims without wait time, Mileage is divided by two and the amount is calculated based on the rate criteria. The result is multiplied by Two to determine the amount to pay then used in the Transportation Calculation.

..... Date of Service on or after 11/1/2009.....

..... Transportation providers bill on the CMS-1500 claims form and the 837P that is automatically converted into a transportation claim record for processing. For all services payable by Medicaid except A0999 (Unlisted Ambulance Service), each service must be billed with two claim lines, one for the service procedure code and one for the mileage procedure code. Valid combinations are listed below. The units field for the service code defaults to 1; the units field for the mileage code or other codes (non-payable by Medicaid – may be payable for Title 18) represents the number of miles. An additional mileage field is carried on the service code claim line which contains the number of miles plugged from the corresponding mileage claim line. Both lines are priced. See Service/Mileage Codes under Rate Criteria.

Pricing Method Criteria:	Provider Class Types: 080 (Transportation) 081 (Registered Driver) 082 (Emergency Air Ambulance) 083 (Out-of-State Transportation) 084 (Out-of-State Emergency Air Ambulance)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	N/A

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Not Applicable.	Not Applicable.

Rate Description	Rate Criteria
Date of Service prior to 11/1/2009:	Processing prior to April 2008:

Procedure rates from the Procedure Transportation Rate Table.

Y-codes ended by 12/31/2003. See appendix A in Pricing User Manual.

For neonatal procedure A0225 if age < 3 years: Select rates from transportation rate table and compute allowed amount by summing trans base rate and product of claim units and trans mile/hour/pass rate. If age >= 3, set allowed amount to zero.

For emergency procedures A0427 and A0429: Select rates from transportation rate table and compute allowed amount by summing trans base rate and the product of the (difference of (claim units - cutback units) and system parameter CPA04013) and trans mile/hour/pass rate.

For emergency procedures A0430 and A0431: Set allowed amount equal to billed amount.

For procedure A0999: Set allowed amount equal to billed amount.

Processing between April 2008 and October 2009:

For neonatal procedure A0225 if age < 3 years: Select rates from transportation rate table and compute allowed amount by summing trans base rate and product of claim units and trans mile/hour/pass rate. If age >= 3, set allowed amount to zero.

For emergency procedures A0427 and A0429: Select rates from transportation rate table and compute allowed amount by summing trans base rate and the product of the (difference of (claim units - cutback units) and system parameter CPA04013) and trans mile/hour/pass rate.

For emergency procedures A0430 and A0431: If FFS claim, set allowed amount equal to billed amount.

If Crossover claim, select rates from transportation rate table and compute allowed amount

	<p>by summing trans base rate and the product of the (difference of (claim units - cutback units) and system parameter CPA04013) and trans mile/hour/pass rate.</p> <p>For procedure A0999: If FFS claim, set allowed amount equal to billed amount.</p> <p>If Crossover, pay zero.</p> <p>All other codes, pay zero.</p>
<p>Date of Service on or after 11/1/2009:</p> <p>Prior Authorized Rate:</p> <p>Authorized Amount from the Prior Authorization Table</p> <p>Other Rate:</p> <p>Base procedure rate from the Procedure Transportation Rate Table.</p>	<p>For a prior authorized claim whose procedure code does not have a procedure rate. Currently A0999 is the only procedure code that this applies to.</p> <p>For all other claims</p> <p>Service Mileage Mileage Code... Code... U1 Modifier</p> <p>A0426 A0425</p> <p>A0427 A0425</p> <p>A0428 A0425</p> <p>A0429 A0425</p> <p>A0433 A0425</p> <p>A0434 A0425</p> <p>A0225 A0425</p> <p>A0225 A0425 U1</p> <p>A0430 A0435</p> <p>A0431 A0436</p>
N/A	N/A

Calculation Description	Calculation Criteria
<p>Date of Service prior to 11/1/2009:</p> <p>Transportation Calculation of Amount to Pay:</p> <p>1. System determines the lesser of Billed Amount on the claim and the results of Amount to Pay as defined above for each service code</p>	N/A

<p>2. Subtract the result of #1 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges</p> <p>3. Subtract Primary Carrier Amount Paid, if applicable, from the result of #1</p> <p>4. If the result of #3 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, the result of #3 is the final Amount to Pay.</p>	
<p>Date of Service on or after 11/1/2009:</p> <p>Calculation of Amount to Pay – Prior Authorized</p> <p>1. Allowed Amount = PA authorized amount / PA authorized units</p> <p>2. Subtract Primary Carrier Amount Paid, if applicable, from the Allowed Amount to get the Payment Amount.</p> <p>3. If the result of #4 is less than \$0.00, move \$0.00 to Payment Amount.</p>	<p>N/A</p>
<p>Date of Service on or after 11/1/2009:</p> <p>Calculation of Amount to Pay - Other:</p> <p>1. Get the base rate from the Procedure Transportation Rate Table based on the claim date of service being within the rate effective dates and the number of miles being within the minimum and maximum mileage on the rate table.</p> <p>2. Multiply the rate from #1 by the claim units to get Allowed Amount.</p>	<p>N/A</p>

WAIV - Waivers

DMAS has the following CMS approved waivers for the Medicaid Program: Elderly and Disabled Technology Assisted AIDS Mental Retardation (MR) IFDDS (DD Waiver) Providers submit waiver services on the CMS-1500 claim form. Providers of waiver services are Provider Class Types 047, 048, 055, 056, 058, 059, 061, 062, 063, 073, 075. Provider Class Type 056 is a mental health clinic [also called Community Service Board (CSB)] which provides mental health services, State Plan Only (SPO) services, and waiver services. Refer to the Mental Health Clinics (CSB) Section of this document for the non-waiver services of these providers. Technical Waiver Respite prices according to the fee file.

Pricing Method Criteria:	Provider Class Types:047 (Respite Care)048 (Adult Day Care) 055 (Personal Care)056 (Mental Health Center) 063 (Private Duty Nursing) 058 (Home Health Agency-State) 059 (Home Health Agency-Private) 061 (Family Caregiver Training) 062 (Durable Medical Equipment/Supplies) 063 (Private Duty) 073 (Case Management Waiver) 075 (Mental Retardation Waiver Services)
Billing Form:	CMS-1500 Claim Form
Benefit Package:	Exception Indicators A, E, Q, Y, 9, R.

Primary Carrier Amount	Patient Pay Amount	Co-Pay Amount
Determined by TPL edits.	Determined by DSS edits.	Not Applicable.

Rate Description	Rate Criteria
<p>Waiver Rates:</p> <p>Waiver providers are paid the lesser of the billed amount or the calculated amount to pay. For waiver services, the Region Rate is the maximum rate allowed based on the From Date of Service of the claim. Region 1 Rate is the rate for providers in Northern Virginia and Region 2 Rate is the rate for providers in the rest of the state. All rates are based on the From Date of Service on the claim. There is no difference in rates for adults and children for waiver services. If there is no Region Rate, the PA rate should be used in the calculation of amount to pay.</p>	N/A

<p>Personal Care Rate:</p> <p>Personal Care rates are obtained from the Rate Database. Locality Code (City-County Code) is used to determine whether to use Region 1 or Region 2 rates.</p>	<p>From 08/01/1999</p> <p>Provider Class Types:</p> <p>055 (Personal Care)</p> <p>Locality Codes: (Enrollee)</p> <p>Region 1:</p> <p>510 013 043 047 059 600 610 061 630 685 153 177 179 187 099 107 683</p> <p>Region 2:</p> <p>[default] All others except as shown in region 1</p>
<p>Respite Services Rate:</p> <p>This rate is a hourly rate represented as Z codes on the claim. Any of the hourly respite rate codes should hit against the one line PA for 'RESPI'.</p>	<p>Procedure Codes:</p> <p>Z9408, Z9421, Z9423, Z9425, Z9403, Z9404, Z9407.</p>
<p>Technical Waiver Respite</p> <p>Technical Waiver rates are obtained from the Rate Database.</p>	<p>Provider Class Type:</p> <p>063 (Private Duty)</p>
<p>Elderly and Disabled:</p> <p>If the claim bills 14 or more hours for a single day then the claim pays a maximum of 14 hours, but subtracts the full number of hours billed from the PA file. Under 14 hours per day, pay at the hourly rate on the fee file.</p>	<p>Procedure Codes:</p> <p>Z4036, Z9412, Z9410, ,Z9421, Z9423, Y0071, Y0073. Effective 2/03: Y0072, Y0074, Y0075, Y0076.</p> <p>Provider Class Type:</p> <p>047, 048, and 055</p> <p>Level of Care: '9'</p>
<p>Aids Waiver:</p> <p>If the claim bills 14 or more hours for a single day then the claim pays a maximum of 14 hours, but subtracts the full number of hours billed from the PA file. Under 14 hours per day, pay at the hourly rate on the fee file.</p>	<p>Procedure Codes:</p> <p>Z4035, Z9401, Z9402, Z9403, Z9404, Z9421, Z9440, B4154, B4155.</p> <p>Exception Indicator; 'E'</p> <p>Provider Class Type:</p> <p>047, 048, 063, and 073.</p>

<p>CDPAS Waiver:</p> <p>Consumer Directed Personal Attendant Services (CDPAS) rate is obtained from The Rate Database. Locality Code (City-County Code) is used to determine whether to use Region 1 or Region 2 rates. If the flag indicator is 'RF' the Recipient's FIPS code will be used if not the Provider's FIPS Code is used.</p>	<p>Beginning 08/01/1997:</p> <p>Procedure Codes:</p> <p>Z9560, Z9562, Z9564, Z9566, Z9568, Z9570</p> <p>Provider Class Type: 073 (Case Management Waiver)</p> <p>Provider Specialty Code: 040 (CDPAS)</p> <p>Exception Indicator: Q</p> <p>Flag Indicator: RF</p> <p>Locality Codes:</p> <p>Region 1:</p> <p>510, 013, 043, 047, 059, 600, 610, 061, 630, 685, 153, 177, 179, 187, 099, 107, 683</p> <p>Region 2:</p> <p>[default] All others except as shown in region 1.</p>
<p>Mental Health:</p> <p>Mental Health rates are obtained from the Rate Database. The Region 1 Rate, if present for SPO services, is the rate for providers in Northern Virginia, and the Region 2 Rate is the rate for providers in the rest of the state.</p>	<p>Beginning 08/01/1999</p> <p>Procedure Codes:</p> <p>Z8503, Z8505, Z8507, Z8510, Z8512, Z8516, Z8998, Z9986, Z9987, Z8994, Z8997.</p> <p>Provider Class Type:</p> <p>056 (Mental Health Mental Retardation)</p> <p>Provider Specialty:</p> <p>042 (CSB Mental Health) 043 (CSB MR State Plan)</p>
<p>MR Waiver:</p> <p>MR Waiver rates are obtained from the Rate Database.</p>	<p>Procedure Codes:</p> <p>Y0058, Z8545, Z8999, Z8899, Z8551, Z8595,</p>

	<p>Z8597, Z8598, Z8556, Z8560, Z8557, Z8561, Z8565, Z8599, Z8600, Z8601, Z8602, Z8603, Z8604, Z8605, Z9401, Z9402, Z4036, Y0078, Z9570, Z9568, Y0061, Z9421, Y0064, Y0065, Y0066, Y0067, Y0068, Y0070, Y0071, Y0072, Y0073, Y0074, Y0075, Y0076.</p> <p>Provider Class Type: 047, 055, 056, 058, 059, 062, 063, 073, 075.</p> <p>Provider Specialty: 016, 040, 044, 045, 046.</p> <p>Level of Care = 'Y'</p>
<p>IFDDS (DD Waiver)</p> <p>DD Waiver rates are obtained from the Rate Database.</p>	<p>Procedure Codes:</p> <p>Y0056, Y0057, Z8595, Z8597, Z8598, Z8556, Z8560, Z8557, Z8561, Z8565, Y0058, Z8599, Z8600, Z8601, Z8602, Z8603, Z8604, Z8605, Y0059, Y0060, Z4036, Y0078, Y0062, Y0063, Z9562, Z9570, Z9564, Z9568, Z8811, Y0061, Z9421, Y0064, Y0065, Y0066, Y0067, Y0068, Y0069, Y0070, Y0071, Y0072, Y0073, Y0074, Y0075, Y0076, Y0077.</p> <p>Provider Class Type: 073, 056, 062, 063, 058, 059, 055, 047, 061.</p> <p>Provider Specialty: 016, 017, 040.</p> <p>Level of Care = 'R'.</p>

Calculation Description	Calculation Criteria
<p>Calculation of Amount to Pay:</p> <p>1. Rate is the Region 1 or Region 2 Rate in effect based on the From Date on the claim, or the PA rate. Refer to the rates section above for more information.</p> <p>2. Multiply #1 by units on the claim.</p> <p>3. Determine the lesser of Billed Amount on the claim and the result of #2.</p>	<p>N/A</p>

4. Subtract the result of #3 from the Billed Amount on the claim to determine Non-Covered Charges. If Non-Covered Charges is less than \$0.00, move \$0.00 to Non-Covered Charges.

5. Subtract Primary Carrier Amount Paid, if applicable, from the result of #3.

6. Subtract Patient Pay Amount, if applicable, from the result of #5.

7. If the result of #6 is less than \$0.00, move \$0.00 to Amount to Pay. Otherwise, #6 is the Amount to Pay.

For Elderly and Disabled and Aids Waiver:

If the claim bills 14 or more hours for a single day then the claim pays a maximum of 14 hours, but subtracts the full number of hours billed from the PA file. Under 14 hours per day, pay at the hourly rate on the fee file.