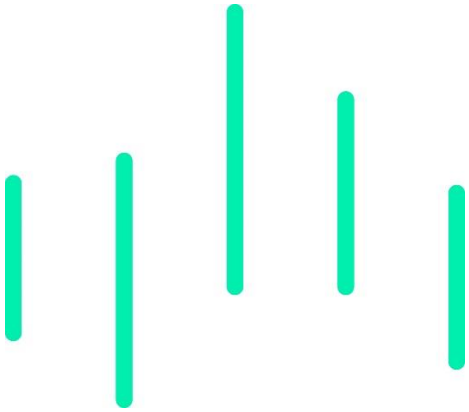

Managed Care Organization Pricing Administration Guide

Version 7.5
Date Last Updated: May 16, 2024

Wisconsin ForwardHealth

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1 Introduction

1.1 Introduction

This guide was developed to help interpret the MCO rate extracts and to be used for supplemental ForwardHealth pricing documentation. Due to new code and policy releases, the information in this guide has the potential to change. If so, an updated guide will be distributed.

2 Max Fee Extract Field Layout

In July 2022, ForwardHealth began providing an enhanced version of the monthly max fee extract file along with the legacy version of the file. ForwardHealth will provide both versions into the foreseeable future.

The legacy and enhanced versions of the file provide the same information; they are not intended to be used in conjunction with each other. The enhanced version provides this information in a more user-friendly format. See section 2.1 for the field layout descriptions for the legacy version and section 2.2 for the enhanced version.

2.1 Legacy Max Fee Extract (HMO_MAX_FEE.txt) Field Layout

The legacy max fee extract is a single file packaged in a .zip file and sent to the SFTP server monthly. (See HMO_max_fee_20220702.zip.) ForwardHealth provided this version of the file before July 2022 and will continue to provide it each month.

The file's records are sorted in the following order: by Contract Code, Procedure Code, Rate Type, Effective Date, and End Date. Below is the field layout for the legacy max fee extract.

Field	Data Type	Max Length	Max Recursions	Description
Contract Code	Character	5	1	Code used to uniquely identify a Provider Contract.
Contract Name	Character	20	1	Provider Contract Name.
Procedure Code	Character	5	1	HCPCS or CPT Procedure Code.
BC+ BM/Core Billing Indicator (obsolete as of 04/01/2014)	Character	1	1	Indicates whether the service is billable for the Benchmark and/or Core Plans. N = Not a billable Benchmark or Core service. Y = Billable Benchmark and Core service. B = Billable Benchmark service only. C = Billable Core service only.
BP List	Character	8	Unlimited	List of Benefit Plans (BP) that are included or excluded from the reimbursement record, if applicable. For example: I~BCBP = Includes BC+ Benchmark E~BCBP = Excludes BC+ Benchmark

Field	Data Type	Max Length	Max Recursions	Description
PT/PS List	Character	8	Unlimited	Inclusive list of Provider Types (PT) and Provider Specialties (PS) that are related to the reimbursement record, if applicable. For example: I~77/000 = Includes Providers with PT 77, regardless of specialty .
Age Min-Max	Character	9	1	Reimbursement age restrictions (minimum and maximum). Format is 999999 – 999999. Note: There is 1 space in front and behind the dash.
Pricing Indicator	Character	6	1	Code that identifies the reimbursement/pricing methodology: ANESTH, MAXFEE, BILLED or SYSMAN.
Rate Type	Character	3	1	Code that identifies the type of rate.
Max Fee Modifiers	Character	2	Unlimited	Max Fee and Reimbursement rule modifiers, if applicable.
Rate	Number	10	1	Max fee rate for the procedure/service. Format is 9999999.99.
RVS Units	Number	5	1	Applicable relative value unit (RVU). Format is 999.9.
BAF Codes	Character	11	Unlimited	Benefit Adjustment Factor (BAF) codes, if applicable.
Effective Date	Date	8	1	First date of service the rate is effective. Format is CCYYMMDD.
End Date	Date	8	1	Last date of service the rate is effective. Format is CCYYMMDD.
POS List	Character	2	Unlimited	List of Places of Service (POS) that are included from the reimbursement record, if applicable. For example: I~08 = Includes Place of Service with 08
Routine Home Days	Number	25	1	Number of hospice days within an election period. (Note that election periods separated by less than 60 days will be counted as the same election period, but the days in between will not be counted towards the number of total hospice days). See ForwardHealth *Update* 2015-64 for further information.

Additional Extract Information:
File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Sub-field Delimiter for recursive fields: Semi-colon ->;
Max Data Length per field recursion including special characters such as decimals.
End of Record: Each record is terminated by a Line Feed (LF) character.
Frequency: First of every month.
Records included: Include max fee for active rows where the end date is greater than the system date or less than 90 days before the system date.
Record field order:
Contract Code|Contract Name|Procedure Code| BC+ BM/Core Billing Indicator|BP List|PT/PS|Age|Pricing Method|Rate Type|Modifiers|Rate|RVS Units|BAF Code|Effective|End|POS|Routine Home Days

Record examples:

Example 1
MHAOD|Mntl Hlth-
MH/AODA|H0022|B||I~10/000;11/080;11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;11/900;31/000;33/000;58/000||MAXFEE|C32|HN|32.28|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|B||I~10/000;11/080;11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;11/900;31/000;33/000;58/000||MAXFEE|C32|HO|55.55|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|B||I~10/000;11/080;11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;11/900;31/000;33/000;58/000||MAXFEE|C32|HP|65.65|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|B||I~10/000;11/080;11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;11/900;31/000;33/000;58/000||MAXFEE|C32|UA|80.93|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|B||I~10/000;11/080;11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;11/900;31/000;33/000;58/000||MAXFEE|C32|UB|80.93|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|C||I~11/125;11/801;11/802;11/803;31/339;33/339;58/000||MAXFEE|C32|HN|32.28|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|C||I~11/125;11/801;11/802;11/803;31/339;33/339;58/000||MAXFEE|C32|HO|55.55|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|C||I~11/125;11/801;11/802;11/803;31/339;33/339;58/000||MAXFEE|C32|HP|65.65|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-
MH/AODA|H0022|C||I~11/125;11/801;11/802;11/803;31/339;33/339;58/000||MAXFEE|C32|UA

|80.93|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

MHAOD|Mntl Hlth-MH/AODA|H0022|C||I~11/125;11/801;11/802;11/803;31/339;33/339;58/000||MAXFEE|C32|UB|80.93|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99|

Example 2
MHHC|Mntl Hlth-Home/Comm|H0022|N||I~11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;31/000||MAXFEE|C36|HN|60.00|0.0|FFPMH6016|20040101|22991231|I~03;04;12;13;14;15;34;56;99|

MHHC|Mntl Hlth-Home/Comm|H0022|N||I~11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;31/000||MAXFEE|C36|HO|90.04|0.0|FFPMH6016|20040101|22991231|I~03;04;12;13;14;15;34;56;99|

MHHC|Mntl Hlth-Home/Comm|H0022|N||I~11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;31/000||MAXFEE|C36|HP|112.53|0.0|FFPMH6016|20040101|22991231|I~03;04;12;13;14;15;34;56;99|

MHHC|Mntl Hlth-Home/Comm|H0022|N||I~11/112;11/122;11/123;11/124;11/125;11/801;11/802;11/803;31/000||MAXFEE|C36|UA|150.04|0.0|FFPMH6016|20040101|22991231|I~03;04;12;13;14;15;34;56;99|

Example 3
ANSTH|Medical-Anesthesia|00100|Y||I~01/000;31/000;32/000;33/000||ANESTH|C03||17.75|5.0||20080701|22991231|I~01;05;06;07;08;09;11;20;21;22;23;24;25;26;49;50;51;57;60;61;71;72|

ANSTH|Medical-Anesthesia|00100|Y||I~01/000;31/000;32/000;33/000||ANESTH|C03|QK|7.75|5.0||20080701|22991231|I~01;05;06;07;08;09;11;20;21;22;23;24;25;26;49;50;51;57;60;61;71;72|

ANSTH|Medical-Anesthesia|00100|Y||I~01/000;31/000;32/000;33/000||ANESTH|C03|QX|10.84|5.0||20080701|22991231|I~01;05;06;07;08;09;11;20;21;22;23;24;25;26;49;50;51;57;60;61;71;72|

ANSTH|Medical-Anesthesia|00100|Y||I~01/000;31/000;32/000;33/000||ANESTH|C03|QY|9.68|5.0||20080701|22991231|I~01;05;06;07;08;09;11;20;21;22;23;24;25;26;49;50;51;57;60;61;71;72|

ANSTH|Medical-Anesthesia|00100|Y||I~01/000;31/000;32/000;33/000||ANESTH|C03|QZ|16.00|5.0||20080701|22991231|I~01;05;06;07;08;09;11;20;21;22;23;24;25;26;49;50;51;57;60;61;71;72|

Example 4

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~27/270;27/271;27/272;27/273;27/274;27/275;27/276;27/277;27/900;31/000;33/000;72/000|0 – 7|MAXFEE|PT2||32.51|0.0||20080701|22991231|I~21;22;24|

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~27/270;27/271;27/272;27/273;27/274;27/275;27/276;27/277;27/900;31/310;31/311;31/312;31/314;31/315;31/317;31/319;31/320;31/324;31/325;31/326;31/327;31/329;31/330;31/331;31/332;31/333;31/336;31/337;31/338;31/339;31/340;31/341;31/342;31/343;31/354;33/000;72/000|0 – 7|MAXFEE|C10||13.14|0.0|DNTL278|20080701|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;23;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~27/270;27/271;27/272;27/273;27/274;27/275;27/276;27/277;27/900;31/310;31/311;31/312;31/314;31/315;31/317;31/319;31/320;31/324;31/325;31/326;31/327;31/329;31/330;31/331;31/332;31/333;31/336;31/337;31/338;31/339;31/340;31/341;31/342;31/343;31/354;33/000;72/000|21 – 999|MAXFEE|C10||13.14|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;21;22;23;24;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~27/270;27/271;27/272;27/273;27/274;27/275;27/276;27/277;27/900;31/310;31/311;31/312;31/314;31/315;31/317;31/319;31/320;31/324;31/325;31/326;31/327;31/329;31/330;31/331;31/332;31/333;31/336;31/337;31/338;31/339;31/340;31/341;31/342;31/343;31/354;33/000;72/000|8 – 20|MAXFEE|C10||13.14|0.0|DNTL278|20080701|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;21;22;23;24;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~31/316;31/318;31/322;31/328;31/345|0 – 7|MAXFEE|PT1||12.41|0.0|DNTL278|20080701|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;23;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~31/316;31/318;31/322;31/328;31/345|21 – 999|MAXFEE|PT1||12.41|0.0||20080701|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;21;22;23;24;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

DENTL|Dental|D0120|B|E~BCBEE;BCBPD|I~31/316;31/318;31/322;31/328;31/345|8 – 20|MAXFEE|PT1||12.41|0.0|DNTL278|20080701|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;21;22;23;24;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

DENTL|Dental|D0120|B|I~BCBEE;BCBPD|I~27/270;27/271;27/272;27/273;27/274;27/275;27/276;27/277;27/900;31/000;33/000;72/000||SYSMAN|DEF|||||||I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;21;22;23;24;25;26;31;32;33;34;49;50;51;54;56;57;60;61;71;72;99|

Example 5

AMBSR|Medical-Amb Surg Ctr|21141|C||I~02/000||SYSMAN|DEF|||||||I~24|

Example 6

HOSPC|Hospice|T2042|Y||I~06/000||MAXFEE|005||155.71|0.0||20151001|20151130||1 – 60

2.2 Enhanced Max Fee Extract Field Layout

The following sections provide details of the record layouts for each of the five files.

The Enhanced Max Fee Extract is a set of files that are packaged in a .zip file and sent to the SFTP server monthly. There are three versions of the packaged .zip file:

- ***MMIS_Business_Rules_Comprehensive_CCYYMMDD.zip***: contains all "max fee" rules for ForwardHealth programs.
- ***MMIS_Business_Rules_HMO_CCYYMMDD.zip***: contains "max fee" rules for ForwardHealth's BC+ and SSI managed care programs.
    - Subset of comprehensive rules to be used by HMOs.
- ***MMIS_Business_Rules_MLTC_CCYYMMDD.zip***: contains "max fee" rules for ForwardHealth's managed long-term care programs and IRIS.
    - Subset of comprehensive rules to be used by MCOs and FEAs

Each of the three packages contains five files. Three files provide the business rules ForwardHealth uses to process claims and encounters in the Medicaid Management Information System (MMIS):

- ***ForwardHealth Coverage MMIS Business Rules File***: Provides rules for determining when a service is covered under a specific benefit area (i.e., provider contract).
- ***MCO Carve-in Carve-out MMIS Business Rules File***: Provides rules for whether coverage for that service should be provided through a managed care organization or on a fee-for-service basis (i.e., carve-out service).
- ***ForwardHealth Pricing MMIS Business Rules File***: Provides rules for determining the Medicaid allowed amount for the service.

The remaining two files provide the descriptions of codes used for the business rules' variables:

- ***Group to Code MMIS Business Rules Comprehensive File***: Links diagnosis codes to associated Diagnosis Groups referenced in the 'FFS Coverage' file.
- ***Code Description MMIS Business Rules Comprehensive File***: Provides descriptions of codes included in the 'FFS Coverage,' 'Managed Care Coverage,' and 'FFS Pricing' files. Also provides descriptions of the diagnosis codes in the 'Group to Code' file. (Note: For procedure codes and modifiers, please refer to proprietary documentation for CPT and HCPCS procedure codes, modifiers, and descriptions.)

2.2.1 ForwardHealth Coverage Rules File Layout *(ForwardHealth_Coverage_MMIS_Business_Rules_ Comprehensive.txt)*

The following table lists the variables in this file by field, formatting features of a field, and the description of the variables. The first two fields are "metadata" where Change Indicator informs the MCO if a business rule is newly inserted or updated since the previous month's extract, going to be deleted from the next month's extract, or unaltered. The second field is the identifier for the business rule. The remaining fields define the conditions that need to be met for the specified service (i.e., procedure code) to be covered under the specified benefit area (i.e., provider contract). The file's records are sorted first by Provider Contract, then by Procedure Code, and finally by Rule Number.

Field	Data Type	Max Length	Recursions Y/N	Example	Description
Change Indicator	Alpha Character or Space	1	N	D	Indicates if the rule is: unaltered (space), (I)nserted, (U)pdated, or about to be (D)eleted. · Refer to the value in the DOS From field for effective date of rule · Refer to value in DOS Thru field for "sunset" date of rule. · Note: DOS From and DOS Thru values may indicate a date in the past as well as the future.
Rule Number (FFS Coverage File)	Numeric Character	9	N	6050002	Unique ID for rule.
Provider Contract[1]	Alpha-Numeric Character	5	N	AMBSR	Plain language short descriptions of the benefit area. (e.g., Dental, Behavioral Health, etc.).
Procedure Code	Alpha-Numeric Character	5	N	10005	National code which identifies the HCPCS / CPT / CDT code.
Modifier	Alpha-Numeric Character	2000	Y	E~80;81;82;AS~0-4	Listing of national codes which further define a procedure code.
DOS From	Date CCYYMMDD	8	N	20190101	Date of Service – first date the service can be performed to match the rule.

[1] For descriptions of Provider Contract values, see rows in 'Code Description' file with Code Set Name of PR_CONTRACT.

DOS Thru	Date CCYYMMDD	8	N	22991231	Date of Service – last date the service can be performed to match the rule.
Age	Alpha-Numeric Character	20	N	18-999	Age range of recipient (at time of service) required to match rule.
Claim Region[2]	Alpha-Numeric Character	100	Y	I~70;72;73;74	Identifies the claim media and type of submission.
Claim Type[3]	Alpha-Numeric Character	20	Y	I~M	Listing of Wisconsin based codes which further define the National Claim Forms. See encounter user guide for more info.
Current Benefit Plan[4]	Alpha-Numeric Character	100	Y	I~FPW~1-1	Current Benefit Plan of member.
Diagnosis Detail (Any Group)[5]	Alpha-Numeric Character	2000	Y	E~5139~0-99	Diagnosis group restrictions associated with service line information utilizing the diagnosis pointer.
Diagnosis Header (Any Group)[6]	Alpha-Numeric Character	2000	Y	I~5174~1-1	Diagnosis group restriction associated with the claim/ encounter.
Medical Review	Y/Space	1	N	Y	Indicates when the service requires additional review by ForwardHealth staff.
Prior Authorization (PA) Required	Y/Space	1	N	Y	Indicates when the service requires prior authorization for FFS claims.
Prescribing / Referring / Ordering (PRO) Provider Required	Y/Space	1	N	Y	Indicates whether a prescribing / referring / ordering provider must be identified on the detail.

[2] For descriptions of Claim Region values, see rows in 'Code Description' file with Code Set Name of REGION.
[3] For descriptions of Claim Type values, see rows in 'Code Description' file with Code Set Name of CLM_TYPE.
[4] For descriptions of Current Benefit Plan values, see rows in 'Code Description' file with Code Set Name of BNFT_PLAN.
[5] For descriptions of Diagnosis Detail values at the service line level, see rows in 'Code Description' file with Code Set Name of DIAG_GRP.
[6] For descriptions of Diagnosis Header values, see rows in 'Code Description' file with Code Set Name of DIAG_GRP.

PRO Type/Specialty[7]	Alpha-Numeric Character	2000	Y	I~09/000;10/000;16/160;16/212;31/000	Indicates the required provider type/specialty of prescribing / referring / ordering provider. A preceding value of E~ indicates the provider type/specialty is not allowed. A value of "000" after the slash indicates any Provider Specialty.
Place of Service[8]	Alpha-Numeric Character	2000	Y	I~01;05;06;07;08;09;11;12;13;14;19;20;26;34;49;50;57;60;71;72	Listing of national codes that identify where the services are rendered maintained by The Centers for Medicare & Medicaid Services.
Performing Provider Type / Specialty[9]	Alpha-Numeric Character	2000	Y	I~09/000;10/000;16/160;16/212;31/000	Listing of Wisconsin based codes which identify performing provider types and specialties. These are the types and specialties required to perform the service.
Unit Per Day	Alpha-Numeric Character	20	N	0-1	Minimum to maximum units the service is allowed to bill for on a claim / encounter detail. This is WI based policy and does not include NCCI or other unit limitations.
Program Indicator – HMO (Medical)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – HMO (Medical / Dental)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – HMO (Medical / Chiro)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.

[7] For descriptions of Prescribing/Referring/Ordering Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.
[8] For descriptions of Place of Service values, see rows in 'Code Description' file with Code Set Name of PLACE_SVC.
[9] For descriptions of Billing Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.

Program Indicator – HMO (Medical / Chiro / Dental)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – SSI (Medical)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – SSI (Medical / Dental)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – SSI (Medical / Chiro)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – SSI (Medical / Chiro / Dental)	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – FamilyCare	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – FamilyCare Partnership	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – PACE	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – Care4Kids	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – Children Come First	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Program Indicator – Wrap Around Milwaukee	Y/Space	1	N	Y	Indicates when the service is potentially covered by the managed care organization.
Benefit Group	Numeric Character	200	Y	I~2259	Indicates to match the rule variable if the recipient has at least one of the configured Recipient Plans in the specified Benefit Plan Group for any date on the detail date span.

Billing Provider Type/Specialty[10]	Alpha-Numeric Character	150	Y	E~11/112; 16/212	Indicates to match the rule variable if the billing provider type/specialty matches one of the configured PT/PS combinations. PT '00' indicates any PT. PS '000' indicates any PS.
Diagnosis Detail Any	Alpha-Numeric Character	200	Y	V1201 - V1201	Indicates to match the rule variable if the claim form is physician and any of the diagnosis pointed to by the detail is one of the configured values.
Diagnosis Header Any	Alpha-Numeric Character	200	Y	V618 - V618	Indicates to match the rule variable if the claim form is not dental and any of the header diagnosis is one of the configured values. This is not a tuple set configuration.
Diagnosis Header Primary Group[11]	Alpha-Numeric Character	200	Y	I~5111~1-1	Indicates to match the rule variable if the claim type is M, B, H, O, C, L, D when the primary header diagnoses is effective in the configured diagnosis group for the claim header FDOS and TDOS.
EAPG Exempt	Y/N/Space	1	N	N	Indicates whether or not the claim is EAPG Exempt (exempt from EAPG pricing).
Emergency Indicator	Alpha-Numeric Character	1	N	N	Indicates whether to match the rule variable if the claim form is physician or institutional and a claim diagnosis is indicated as an emergency diagnosis in the diagnosis type and the diagnosis is in the configured values.
Gender	Alpha-Numeric Character	1	N	F	Indicates to match the rule variable if the claim recipient gender is one of the configured values.

[10] For descriptions of Billing Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.
[11] For descriptions of Diagnosis Header Primary Group values, see rows in 'Code Description' file with Code Set Name of DIAG_GRP.

IRIS	Alpha-Numeric Character	20	Y	I~A S	Indicates to match the rule variable if the IRIS Enrollment Status is one of the configured values.
Lock-in Plan	Alpha-Numeric Character	50	Y	I~45~1-1	Indicates to match the rule variable if the recipient has one of the configured lock in plans for the detail DOS span.
Medicare Disclaimer[12]	Alpha-Numeric Character	50	Y	I~7;8~1-1	Indicates to match the rule variable if the claim Medicare Disclaimer code matches one of the configuration values.
OI Allowed	Alpha-Numeric Character	1	N	Y	Indicates to match the rule variable if: 1) Other insurance payment of at least $0.01 - identified by an other insurance disclaimer of P for the detail which the restriction is applicable, AND/OR 2) Submission of one or more of the following Adjustment Reason (American National Standards Institute - ANSI) codes for the detail which the restriction is applicable: - 1: Deductible Amount - 2: Coinsurance Amount - 3: Copayment Amount"
Primary Diagnosis Header	Alpha-Numeric Character	200	Y	E~5139	Indicates to match the rule variable if the claim form is physician or UB92 and the primary header diagnosis is one of the configured values. This is not a tuple set configuration.
Procedure Any Detail	Alpha-Numeric Character	500	Y	I~00100-99499;A0021-T1012;T1014-T5999	Indicates to match the rule variable if the claim has one of the procedure configured on any of the claim details including the current detail.

[12] For descriptions of Medicare Disclaimer, see rows in 'Code Description' file with Code Set Name of MCARE_DISC.

Program Code[13]	Alpha-Numeric Character	50	Y	E~ENCFC;ENCFCP;ENCIRIS;ENCPACE	Indicates to match the rule variable if the claim form is any CT and the special program codes is assigned to the claim header. This will include and exclude configurable options.
Support Indicator[14]	Alpha-Numeric Character	20	Y	I~C	Indicates to match the rule variable if the submitted detail support indicator is one of the configured values.

Additional Extract Information:

File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Sub-field Delimiter for recursive fields: Semi-colon ->;
Max Data Length per field recursion including special characters such as decimals.
End of Record: Each record is terminated by a Line Feed (LF) character.

Frequency: Monthly on the Saturday before the first Monday of the month.

Records included: Active and effective 'FFS Coverage'[15] rules with the caveat of the change indicator. The change indicator logic will identify (I)nserted, (U)pdated, and (D)eleted records (deleted records will remain on the extract for three months before being removed.**)**

Record examples:
U|2192663|AMBSR|10005|E~80;81;82;AS~0-4|20190101|22991231| | |I~M| | | | | |Y| |I~24| |0-1|Y|Y|Y|Y|Y|Y|Y|Y| |Y|Y|Y| | |-1| | | | | | | | | | | | | |

2.2.2 MCO Carve-in Carve-out Rules_File Layout *(MCO_Carve-in_Carve-out_MMIS_Business_Rules_Comprehensive.txt)*

The following table lists the variables in this file by field, formatting features of a field, and the description of the variables. The first two fields are "metadata" where Change Indicator informs the MCO if a business rule is newly inserted or updated since the previous month's extract, going to be deleted from the next month's extract, or unaltered. The second field is the identifier for the business rule. The remaining fields define the conditions that must be met for the specified service (i.e., procedure code) to be covered under the specified managed care program; otherwise, the covered service is provided on a fee-for-service basis. The file's records are sorted first by Managed Care Program, then by Procedure Code, and finally by Rule Number.

[13] For descriptions of Program Code values, see rows in 'Code Description' file with Code Set Name of PGM_CODE.
[14] For descriptions of Support Indicator values, see rows in 'Code Description' file with Code Set Name of SUPP_IND.
[15] Provider Contract Billing Rules

Field	Data Type	Max Length	Recursions Y/N	Example	Description
Change Indicator	Alpha Character or Space	1	N	D	Indicates if the rule is: unaltered (space), (I)nserted, (U)pdated, or about to be (D)eleted.
Rule Number (Managed Care Coverage File)	Numeric Character	9	N	6050002	Unique ID for rule.
Managed Care Program	Alpha-Numeric Character	50	Y	Care4Kids	Name of type of managed care organization. This helps organize the collection of benefits that the MCO is expected to provide to the members.
Procedure Code	Alpha-Numeric Character	5	N	11471	National code which identifies the HCPCS / CPT / CDT code.
Modifier	Alpha-Numeric Character	2000	Y	E~UA	Listing of national codes which further defines a procedure code.
DOS From	Date CCYYMMDD	8	N	20230801	Date of Service – first date the service can be performed to match the rule.
DOS Thru	Date CCYYMMDD	8	N	22991231	Date of Service – last date the service can be performed to match the rule.
Claim Region[16]	Alpha-Numeric Character	100	Y	E~70;72;73;74	Identifies the claim media and type of submission.

[16] For descriptions of Claim Region values, see rows in 'Code Description' file with Code Set Name of REGION.

Claim Type[17]	Alpha-Numeric Character	20	N	I~B;M	Listing of Wisconsin based codes which further define the National Claim Forms.
Family Planning Indicator	N/space	1	N	N	This field is not applicable to adjudication decisions for encounters.
Place of Service[18]	Alpha-Numeric Character	2000	Y	E~03;04;15;56;99	Listing of national codes that identify where the services are rendered maintained by The Centers for Medicare & Medicaid Services.
Billing Provider Type / Specialty[19]	Alpha-Numeric Character	2000	Y	E~21/000;71/000	Listing of Wisconsin based codes which identify billing provider types and specialties. These are the types and specialties required to bill for service.
Performing Provider Type / Specialty[20]	Alpha-Numeric Character	2000	Y	I~20/000;77/000;78/000;79/000	Listing of Wisconsin based codes which identify performing provider types and specialties. These are the types and specialties required to perform the service.
Provider Contract[21]	Alpha-Numeric Character	4000	Y	LTC;SMV	Plain language short descriptions of logically related services (e.g., Dental, Behavioral Health, etc.) that a given provider type may perform.
Age	Alpha-Numeric Character	15	N	999999-999999	If the recipient age is between the configured range.

[17] For descriptions of Claim Type values, see rows in 'Code Description' file with Code Set Name of CLM_TYPE.
[18] For descriptions of Place of Service values, see rows in 'Code Description' file with Code Set Name of PLACE_SVC.
[19] For descriptions of Billing Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.
[20] For descriptions of Performing Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.
[21] For descriptions of Provider Contract values, see rows in 'Code Description' file with Code Set Name of PR_CONTRACT.

Benefit Group	Numeric Character	9	N	2678	Indicates to match the rule variable if the benefit plan code is found in the benefit plan type. Used to identify benefit plans for use in certain processing methodologies.

Additional Extract Information:

File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Sub-field Delimiter for recursive fields: Semi-colon ->;
Max Data Length per field recursion including special characters such as decimals.
End of Record: Each record is terminated by a Line Feed (LF) character.

Frequency: Monthly on the Saturday before the first Monday of the month.

Records included: Active and effective Managed Care Coverage[22] rules with the caveat of the change indicator. The change indicator logic will identify (I)nserted, (U)pdated, and (D)eleted records (deleted records will remain on the extract for three months before being removed.)

Record examples:
U|6050002|Care4Kids|00100| |20140101|22991231|I~70;72;73;74| | | | |ANSTH||2678
|6013165|HMO - Medical|00100| |20100101|22991231|E~70;72;73;74|I~B;D;M|N|
|E~21/000;71/000|E~20/000;27/000;77/000;78/000;79/000|ANSTH||73242

2.2.3 ForwardHealth Pricing Rules File Layout *(ForwardHealth_Pricing_MMIS_Business_Rules_Comprehensive.txt)*

The following table lists the variables in this file by field, formatting features of a field, and the description of the variables. The first two fields are "metadata" where Change Indicator informs the MCO if a business rule is newly inserted or updated since the previous month's extract, going to be deleted from the next month's extract, or unaltered. The second field is the identifier for the business rule. The remaining fields list the conditions that must be met for the specified pricing indicator (i.e., pricing methodology) and rate to be used to price the specified service (i.e., procedure code). The file's records are sorted first by Provider Contract, then Procedure Code, and finally by Rule Number.

Field	Data Type	Max Length	Recursions Y/N	Example	Description
Change Indicator	Alpha Character or Space	1	N	D	Indicates if the rule is: unaltered (space), (I)nserted, (U)pdated, or about to be (D)eleted.

[22] Assignment Plan

Rule Number (FFS Pricing File)	Numeric Character	9	N	6050002	ID for rule (can be duplicated due to DOS / Max Fee DOS logic).
Provider Contract[23]	Alpha-Numeric Character	5	N	AMBSR	Plain language short descriptions of logically related services (e.g., Dental, Behavioral Health, etc.) that a given provider type may perform.
Procedure Code	Alpha-Numeric Character	5	N	10005	National code which identifies the HCPCS / CPT / CDT code.
Modifier	Alpha-Numeric Character	2000	Y	I~52~0-1~E~TL~0-3	Indicates to match the rule variable if the current claim modifiers match the configuration.
Modifiers	Alpha-Numeric Character	2000	Y	52;TL	Identifies to override the modifier type if a specific modifier has rates associated on the maxfee table the modifier type needs to be changed to "pricing" when a rule is matched.
Pricing Indicator	Alpha Character	6	N	MAXFEE	Identifies the Medicaid pricing methodology associated with the rule.
Rate[24]	Numeric Character with Decimal	9	N	106.18	Medicaid allowed amount associated with the service and criteria.
BAF %	Numeric Character with Decimal	8,6	N	0.9	Benefit Adjustment Factor Percentage.
BAF $	Numeric Character with Decimal	6,2	N	0	Benefit Adjustment Factor Dollar Amount.
DOS From	Date CCYYMMDD	8	N	20190101	Date of Service – first date the service can be

[23] For descriptions of Provider Contract values, see rows in 'Code Description' file with Code Set Name of PR_CONTRACT.
[24] For descriptions of Rate values, see rows in 'Code Description' file with Code Set Name of RATE_TYPE.

					performed to match the rule.
DOS Thru	Date CCYYMMDD	8	N	22991231	Date of Service – last date the service can be performed to match the rule.
Max Fee DOS From	Date CCYYMMDD	8	N	20190101	Max Fee Date of Service – first date the service can be performed to match the rate.
Max Fee DOS Thru	Date CCYYMMDD	8	N	22991231	Max Fee Date of Service – last date the service can be performed to match the rate.
Age	Alpha-Numeric Character	20	N	4-999	Age range of recipient (at time of service) required to match rule.
Claim Region[25]	Alpha-Numeric Character	2000	Y	I~70;72;73;74	Indicates the claim regions for which the row is applicable. Claim region is an internally derived field which indicates the method by which the claim or encounter was submitted.
Claim Type[26]	Alpha-Numeric Character	20	Y	I~B	Listing of Wisconsin based cods which further define the National Claim Forms.
Conversion Factor	Numeric Character	4	N	15	Identifies the value to use to convert the claim detail units when a rule is matched. Example: If the variable is configured as 15.0 and claim units are 90 then the units used for rule will be 6 (90/15 =6).
Current Benefit Plan[27]	Alpha-Numeric Character	100	Y	E~BCBPD; BCBEE	Current Benefit Plan of member.

[25] For descriptions of Claim Region values, see rows in 'Code Description' file with Code Set Name of REGION.
[26] For descriptions of Claim Type values, see rows in 'Code Description' file with Code Set Name of CLM_TYPE.
[27] For descriptions of Current Benefit Plan values, see rows in 'Code Description' file with Code Set Name of BNFT_PLAN.

Explanation of Benefits (EOB)[28]	Alpha-Numeric Character	20	N	1236	Explanation of Benefit Code that will be assigned to the claim/encounter to describe additional pricing considerations that are applied.
Episode Care	Alpha-Numeric Character	20	N	61 - 999999	Indicates to match the rule variable if the episode of care day falls within the configured range. The episode of care day is determined by comparing the detail from date of service against a member's hospice election period(s).
Geographic Location Group – Performing Provider[29]	Alpha-Numeric Character	20	Y	E~101	Geographic Location Group for performing provider – used for HPSA incentive program.
Geographic Location Group – Recipient[30]	Alpha-Numeric Character	200	Y	E~101	Geographic Location Group for member – used for HPSA incentive program.
Greater Than Billed Allowed	Y/Space	1	N	Y	Greater than billed flag allows for allowed amount greater than the billed amount.
Medical Status Code Group	Alpha-Numeric Character	20	Y	E~1017	Indicates the medical status code group applicable to the rule.
Place of Service[31]	Alpha-Numeric Character	2000	Y	E~11;19	Listing of national codes that identify where the services are rendered maintained by The Centers for Medicare & Medicaid Services.

[28] For descriptions of Explanation of Benefits values, see rows in 'Code Description' file with Code Set Name of EOB.
[29] For descriptions of Geographic Location Group – Performing Provider values, see rows in 'Code Description' file with Code Set Name of GEO_LOC.
[30] For descriptions of Geographic Location Group – Recipient values, see rows in 'Code Description' file with Code Set Name of GEO_LOC.
[31] For descriptions of Place of Service values, see rows in 'Code Description' file with Code Set Name of PLACE_SVC.

Performing Provider Type / Specialty[32]	Alpha-Numeric Character	2000	Y	I~10/100	Listing of Wisconsin based codes which identify performing provider types and specialties. These are the types and specialties required to perform the service.
Relative Value Unit	Numeric Character with Decimal	4	N	0.5	Relative Value Unit (RVU) is applied to the rate when applicable.
Tribal Indicator	Y/N/Space	1	N	Y	Indicates if the rule applies to a members identified as part of a federally recognized tribe.
Benefit Group	Numeric Character	200	Y	I~2259	Indicates to match the rule variable if the recipient has at least one of the configured Recipient Plans in the specified Benefit Plan Group for any date on the detail date span.
Benefit Plan Type	Numeric Character	9	N	2678	Indicates to match the rule variable if the benefit plan code is found in the benefit plan type. Used to identify benefit plans for use in certain processing methodologies.
Billing Provider Type/Specialty[33]	Alpha-Numeric character	150	Y	E~75/081	Indicates to match the rule variable if the billing provider type/specialty matches one of the configured PT/PS combinations. PT '00' indicates any PT. PS '000' indicates any PS.

[32] For descriptions of Performing Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.
[33] For descriptions of Billing Provider Type and Specialty values, see rows in 'Code Description' file with Code Set Names PR_TYPE and PR_SPEC.

Birth to 3	Alpha Character or Space	1	N	Y	Configured on the procedure code reimbursement rule (RP) and used to restrict the birth to three natural environment incentive payment to once per date of service, per therapy discipline, per member.
EAPG Exempt	Alpha Character or Space	1	N	Y	Indicates whether or not the claim is EAPG Exempt (exempt from EAPG pricing).
Hospital Class[34]	Alpha Character or Space	20	Y	AH	Indicates whether to match the rule variable if the hospital classification status of the billing provider matches the configured value.
Rate Type	Alpha Character or Space	3	N	C01	Identifies the rate type to be used in claims processing when a rule is matched.

Additional Extract Information:

File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Sub-field Delimiter for recursive fields: Semi-colon ->;
Max Data Length per field recursion including special characters such as decimals.
End of Record: Each record is terminated by a Line Feed (LF) character.
Frequency: Monthly on the Saturday before the first Monday of the month.
Records included: Active and effective FFS Pricing[35] rules with the caveat of the change indicator. The change indicator logic will identify (I)nserted, (U)pdated, and (D)eleted records (deleted records will remain on the extract for three months before being removed.**)**
Record examples:

U|3334899|AMBSR|10005| | |MAXFEE|106.18| | |20190101|22991231|20190101|22991231|
| | | | | | | | | | | | | |0| | | | | | |C01

[34] For descriptions of Hospital Class values, see rows in 'Code Description' file with Code Set Names HOSP_CLASS.
[35] Provider Contract Reimbursement Rules

2.2.4 Group to Code File Layout *(GroupToCode_MMIS_Business_Rules_Comprehensive.txt)*

The following table lists the variables in this file by field, formatting features of a field, and the description of the field. Each row of the text file has a combination of the diagnosis group code and a diagnosis code that is a part of that diagnosis group. There are around fifty unique diagnosis groups in the 'Group to Code' file for any given month. Several groups have just one diagnosis code, but most groups have multiple diagnosis codes. (Note: Two Diagnosis Group codes have over 1,000 diagnosis codes associated with them—the '5150' Diagnosis Group code having over 54,000 diagnosis codes associated with it.) Most diagnosis codes are associated with one Diagnosis Group, but about 1,800 of them are associated with multiple Diagnosis Groups. The file's records are sorted first by Diagnosis Group and then by Diagnosis Code.

Field	Data Type	Max Length	Recursions Y/N	Description
Diagnosis Group[36]	Varchar2	9	N	Group number which appears on the 'FFS Coverage' file.
Diagnosis Code[37]	Varchar2	7	N	Code which is a part of Diagnosis Group.

Additional Extract Information:

File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Sub-field Delimiter for recursive fields: N/A
End of Record: Each record is terminated by a Line Feed (LF) character.

Frequency: Monthly on the Saturday before the first Monday of the month.

Records included: All group codes utilized within the Max Fee Extract

Record examples:
5038|Z30011

[36] For descriptions of Diagnosis Group values, see rows in 'Code Description' file with Code Set Name of DIAG_GRP.
[37] For descriptions of Diagnosis Code values, see rows in 'Code Description' file with Code Set Name of DIAGNOSIS.

2.2.5 Code Description File Layout (CodeDescription_MMIS_Business_Rules_Comprehensive.txt)

The 'Code Description' file contains information about the codes included in the 'FFS Coverage', 'MCO Coverage', 'FFS Pricing', and 'Group to Code' extracts. (Note: This extract does not provide explanations for procedure codes and modifiers. Please refer to the appropriate proprietary guides for explanations of procedure codes.) It explains the meanings of the codes for the following code set names:

- Benefit Plan
- Claim Type
- Diagnosis Code
- Diagnosis Group Code
- Explanation of Benefits
- Geographic Location
- Medical Status Group
- Place of Service
- Pricing Indicator
- Prescribing / Referring / Ordering Provide Type & Specialty
- Provider Type & Specialty
- Claim Region
- Hospital Class
- Medicare Disclaimer
- Program Code
- Provider Contract
- Rate Type
- Support Indicator

The following table lists the code set name, a listing of all codes within a given code set name, and a description of each code, along with formatting features of each field. The file's records are sorted first by Code Set Name and then by Code value.

Field	Data Type	Max Length	Recursions Y/N	Description
Code Set Name	Varchar2	9	N	Identifies which code set the code belongs to (e.g., Dx, POS). See the footnotes in this document for matching back to fields and files.
Code	Varchar2	7	N	Code appearing in extract files (FFS Coverage, FFS Pricing, MCO Coverage, Group to Code).
Description	Varchar2	4000	N	National or state-based descriptions associated with the code / code set.

Additional Extract Information:

File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Sub-field Delimiter for recursive fields: N/A
End of Record: Each record is terminated by a Line Feed (LF) character.

Frequency: Monthly on the Saturday before the first Monday of the month.

Records included: All codes within the Max Fee Extract except procedure codes.

Record examples:
DIAGNOSIS|A1781|TUBERCULOMA OF BRAIN AND SPINAL CORD

3 Max Fee Extract Code Values and Descriptions

3.1 Provider Contract Codes

The provider contract code value identifies the policy area for the displayed record. When a procedure code is present in multiple contracts, the rate data will be different depending on the provider contract code. Where applicable, there may be provider contract-specific criteria that will help determine the contract rate to use.

The following table contains the provider contract code values, descriptions of the code values, criteria for determining provider contract, and the rate types used in the provider contract.

Provider Contract Code	Description	Contract Criteria PT/PS or Modifier(s)	Specific Rate Types used in contract*
AMBSR	Medical - Ambulatory Surgical Center	PT/PS 02/000	C01
AMBUL	Transportation - Ambulance	PT/PS 26/000	C02
ANSTH	Medical – Anesthesia	Modifiers QK, QS, QX, QY, QZ	C03
ASTSG	Medical - Assistant Surgery	Modifier 80, 81, 82, AS	C04 FAP – PT 71
AUDHA	Hearing Services - Hearing Aid and Audio logy	N/A	C05 RNT – Modifier RR
C4K	Care4Kids (*Used only for Care4Kids MCOs*)	N/A	C71
CCO	Community Care Organizations	PT/PS 69/000	PT1 – Barron Co. PT2 – La Crosse Co. PT3 – Milwaukee Co.
CHIRO	Medical – Chiropractor	PT/PS 15/000	C07
CRMGT	MCO Care Management *(Currently used only for SSI HMOs)*	PT/PS 65/000	C69
CSMGT	Case Management	PT/PS 21/000 NOTE: Targeted Case Management provided by tribes to their members are eligible for full federal/state reimbursement instead of federal share reimbursement only.	C09 – Non-tribal Case Management T09 - Tribal Case Management
DENTL	Dental Services	PT/PS 27/000 (CPT codes)	C10
DME	Durable Medical Equipment	N/A	C11 RTL – Modifier RR
DMS	Supplies - Disposable Medical Supplies	All provider types	C12

Provider Contract Code	Description	Contract Criteria PT/PS or Modifier(s)	Specific Rate Types used in contract*
DMSJB	Supplies-Disposable Medical Supplies (incontinence and ostomy) for single vendor J&B Medical Supply.	PT 25/251	C54
DTAOD	Day Treatment for Alcohol and Other Drug Addiction	Modifier HF	C13
DTCHD	Day Treatment for Children	Modifier HA	C14
DTMED	Day Treatment Medical	Modifier HE	C15
HCCM	HealthCheck - Case Management	Modifier EP	C17
HCPCC	HealthCheck Other - Pediatric Community Care	Modifier 59	C19
HCRS	Home Care - Respiratory Care Services	N/A	C21
HHPC	Home Care - Home Health and Personal Care	N/A	C22 HPC-PT 16
HIVHH	Health Home for Individuals with HIV/AIDS	N/A	C57
HOSPC	Hospice	PT/PS 06/000	005-096, 05A-96A, RWA, and RWI – rates by county
LAB	Medical - Laboratory	N/A	LA5 – Global LAT – Modifier TC LAP – Modifier 26 FAP – PT 71 GFG – Global PT 71 PFP – Modifier 26 and PT 71 TFP – Modifier TC and PT 71
LTC	Long Term Care (Nursing Home Procedure Codes for Transportation)	PT/PS 03/000;57/000	C55
MEDSV	Medical - Medical Services	Not modifier 80,81,82 or PT /PS 02/000	C30 – Global surgical codes TEC – Modifier TC PRO – Modifier 26 CG1 – Global PT 10 TE1 – Modifier TC and PT 10 PR1 – Modifier 26 and PT 10 FAP – PT 71 GFP – Global PT 71 MED – non surgical codes PFP – PT 71 and mod 26

Provider Contract Code	Description	Contract Criteria PT/PS or Modifier(s)	Specific Rate Types used in contract*
			HLK- PT 72
MHAOD	Mental Health - Mental Health and Mental Health for Alcohol and Other Drug Addictions		C32
MHCCS	Mental Health - Comprehensive Community Services	PT/PS 82/850, 82/851, 82/852, 82/853, 82/854, 82/855, (CCS Provider Type 80 specialties 652/654/655/656 are obsolete, effective July 1, 2014. Refer to ForwardHealth *Update* 2014-42 for more information)	C33
MHCI	Mental Health - Crisis Intervention	PT/PS 80/650, 80/653 (Specialties 654/656 removed as these are obsolete, effective July 1, 2014)	C34
MHCSP	Mental Health - Community Support Program	PT/PS 80/651, 80/653 (Specialties 655/656 removed as these are obsolete, effective July 1, 2014)	C35
MHHC	Mental Health - Mental Health and Substance Abuse Services in the Home or Community for Adults	Modifier UC	C36
MHIHP	Mental Health - In Home Psychotherapy	Modifier HA	C37
MHNTS	Mental Health - Narcotic Treatment Services	Modifier HG	C38
MHPW	MHPW, SBIRT & HC-ED - Formerly just mental health substance abuse screening and preventive counseling for pregnant women, this contract now also includes mental health/substance abuse screening, brief intervention and referral to treatment (SBIRT) for the general population plus limited health care education and self-management for CORE Plan members with	Modifier HE or HF	C53

Provider Contract Code	Description	Contract Criteria PT/PS or Modifier(s)	Specific Rate Types used in contract*
	chronic asthma, diabetes and/or hypertension.		
MIDWF	Certified Professional Midwives	PT/PS 35/350	C68
MISC	Miscellaneous Code/PT	N/A	C52 FAP – PT 71
OUTPA	Outpatient Hospital	N/A	LAC – Modifier TC (Used for laboratory services)
PNCCC	Prenatal Child Care Coordination	PT/PS 21/000, 61/000	C43
RDLGY	Medical - Radiology	N/A	C44 TEC – Modifier TC PRO – Modifier 26 CG1 – Global PT 10 TE1 – Modifier TC and PT 10 PR1 – Modifier 26 and PT 10 GFG – Global PT 71 PFP – Modifier 26 and PT 71 TFP – Modifier TC and PT 71
REHAB	Therapy - Rehabilitation Centers - Occupational, Physical and Speech Therapy	PT/PS 04/000	C45 Provider specific rates
SBS	School Based Services	PT/PS 12/000	C46
SMV	Transportation - Specialized Medical Vehicle	PT/PS 51/000	C47
SPEC	Vision - State Purchase Eyeglass Program	Modifier U3 or PT/PS 19/191	C48
THERP	Therapy - Occupational, Physical and Speech Therapy	N/A	C49
VISN	Vision Services	N/A	C51

*Note: Rate types PT1-PT9 can be used in any contract and the specific PT/PS listed in record would be the main criteria for using that rate within the contract for that code.

Additional provider contracts and descriptions that will not be found in the Professional Max fee Extract.

Provider Contract Code	Description
CCFWM	CCF and WM

Provider Contract Code	Description
COMA	Coma Certification - Hospital
ESRD	End Stage Renal Disease (refer to Medicaid *Update* 2011-45 for policy and pricing changes, effective as of September, 2011): https://www.forwardhealth.wi.gov/kw/pdf/2011-45.pdf
INPAT	Inpatient Hospital
INPPD	Inpatient Hospital Per Diem Only
LTC	Long Term Care (Nursing Home) – * Refers to provider-specific daily rates
MCERT	Medicaid Certification Only – Biller only
MEDCR	Medicare Crossover
MHCRS	Mental Health - Community Recovery Services
MLWCH	Milwaukee Children's Hospital
NDC	National Drug Code
NEURO	Neurobehavior Certification - Hospital
OUTPA	Outpatient Hospital (Note that most laboratory procedure codes are max fee priced as part of outpatient hospital reimbursement methodology)
RFSUD	Residential Facility Substance Use Disorder (SUD) Treatment
VENT	Ventilator Certification - Hospital
WCDC	Wisconsin Chronic Disease - Adult Cystic Fibrosis
WCDH	Wisconsin Chronic Disease - Hemophilia Home Care
WCDK	Wisconsin Chronic Disease - Renal Disease
WWWP	Wisconsin Well Woman

3.2 Benefit Plan Codes

The following Benefit Plans are allowable for members enrolled in HMO/SSI assignment plans.

Benefit Plan Code	Description
BC	Badgercare (end dated 2008)
BCBP	BC+ Benchmark Plan (end dated 2014)
BCBPD	BC+ Benchmark Plan and Dental (end dated 2014)
BCSP	BC+ Standard Plan
MAP	Medicaid Purchase Plan
MCD	Medicaid
SSIMA	Medicaid for SSI

3.3 Provider Type and Specialty Codes

The Provider Type (PT) / Specialty (PS) pricing determines a rate specific to the provider type and specialty of the performing provider. The guidelines are outlined below on who can be the performing provider on a claim.

Service Type	Billing or Rendering Provider
Institutional Services—NH, Outpatient, Inpatient	Billing provider only is required
Professional or Dental Services	Billing and Rendering providers are required. A billing indicator field was added to the provider report. The following rules must apply. 1. If the provider is indicated as "Y- Biller only" the provider can only be submitted in the billing provider field. A different provider that is certified to render will be required in the rendering provider field. 2. If the provider is indicated as "N- Performer only" the provider can only be submitted in the rendering field. A different provider that is certified to bill will be required in the billing provider field. 3. If the provider is "B-Biller and Performer" the provider can be submitted in both the billing and rendering fields.

Provider type and specialty values and the descriptions:

PT Code	Type Description	PS Code	Specialty Description
XX	A specific provider type	000	All Provider Specialties (under the specific provider type)
01	Hospital	010	Inpatient/Outpatient Hospital
02	Ambulatory Surgical Center (ASC)	020	Ambulatory Surgical Center (ASC)
03	Nursing Facility	035	Skilled Nursing Facility
04	Rehabilitation Agency	040	Restorative Care/Therapy
04	Rehabilitation Agency	080	FQHC Tribal
05	Home Health/Personal Care Agency	050	Home Health Agency

PT Code	Type Description	PS Code	Specialty Description
05	Home Health/Personal Care Agency	052	Personal Care Agency
05	Home Health/Personal Care Agency	053	Home Health/Personal Care Agency
05	Home Health/Personal Care Agency	080	FQHC Tribal
06	Hospice	050	Home Health Agency
06	Hospice	061	Hospital
06	Hospice	063	Free Standing
06	Hospice	064	Nursing Home
06	Hospice	080	FQHC Tribal
07	SUD Health Home	070	Hub
08	Supportive Housing Agency	820	Supportive Housing Agency
09	Nurse Practitioner	090	Certified Pediatric Nurse Practitioner
09	Nurse Practitioner	092	Certified Family Nurse Practitioner
09	Nurse Practitioner	093	Other Nurse Practitioner
09	Nurse Practitioner	095	Nurse Practitioner/Nurse Midwife
09	Nurse Practitioner	900	Group
10	Physician Assistant	100	Physician Assistant
11	Mental Health and Substance Abuse Services	080	FQHC Tribal
11	Mental Health and Substance Abuse Services	112	Licensed Psychologist (PhD)
11	Mental Health and Substance Abuse Services	117	Psychiatric Nurse
11	Mental Health and Substance Abuse Services	120	Licensed Psychotherapist
11	Mental Health and Substance Abuse Services	121	Licensed Psychotherapist with SAC
11	Mental Health and Substance Abuse Services	122	Alcohol and Other Drug Abuse Counselor
11	Mental Health and Substance Abuse Services	123	Certified Psychotherapist with SAC
11	Mental Health and Substance Abuse Services	124	Certified Psychotherapist
11	Mental Health and Substance Abuse Services	125	Advanced Practice Nurse Prescriber
11	Mental Health and Substance Abuse Services	126	Qualified Treatment Trainee
11	Mental Health and Substance Abuse Services	801	Mental Health Agency
11	Mental Health and Substance Abuse Services	802	Substance Abuse Agency
11	Mental Health and Substance Abuse Services	803	MH/SA Agency
11	Mental Health and Substance Abuse Services	900	Group

PT Code	Type Description	PS Code	Specialty Description
12	School Based Services	770	CESA
12	School Based Services	771	School District
13	Community Recovery Services	130	Community Recovery Services
14	Podiatrist	140	Podiatrist
14	Podiatrist	900	Group
15	Chiropractor	150	Chiropractor
15	Chiropractor	900	Group
16	Nurse Service	160	Registered Nurse
16	Nurse Service	161	Licensed Practical Nurse
16	Nurse Service	208	LPN/RCS
16	Nurse Service	209	RN/RCS
16	Nurse Service	212	Nurse Midwife
16	Nurse Service	900	Group
17	Therapy Group	900	Group
18	Optometrist	180	Optometrist
18	Optometrist	192	Therapeutic Pharmaceutical Agents
18	Optometrist	900	Group
19	Optician	190	Optician
19	Optician	191	SPEC Contractor
20	Audiologist	200	Audiologist
20	Audiologist	900	Group
21	Case Management	080	FQHC Tribal
21	Case Management	751	Public Sector
21	Case Management	752	Private Sector
22	Hearing Instrument Specialist	220	Hearing Instrument Specialist
22	Hearing Instrument Specialist	900	Group
23	Pharmacist	241	Pharmacist
24	Pharmacy	080	FQHC Tribal
24	Pharmacy	081	FQHC Non-Tribal (CHC)
24	Pharmacy	240	Pharmacy
25	Medical Equipment Vendor	080	FQHC Tribal
25	Medical Equipment Vendor	250	Medical Equipment Vendor
25	Medical Equipment Vendor	251	Medical Supply Contractor
25	Medical Equipment Vendor	252	Complex Rehab Technology Supplier
26	Ambulance	080	FQHC Tribal
26	Ambulance	261	Air Ambulance
26	Ambulance	268	Water Ambulance
26	Ambulance	510	Basic Life Support Statewide
26	Ambulance	511	Advanced Life Support Statewide
26	Ambulance	512	Basic Life Support Metro
26	Ambulance	513	Advanced Life Support Metro
26	Ambulance	514	Basic Life Support Milwaukee County
26	Ambulance	515	Advanced Life Support Milwaukee County
27	Dentist	270	Endodontics
27	Dentist	271	General Practice
27	Dentist	272	Oral Surgery
27	Dentist	273	Orthodontics

PT Code	Type Description	PS Code	Specialty Description
27	Dentist	274	Pediatric Dentist
27	Dentist	275	Periodontics
27	Dentist	276	Oral Pathology
27	Dentist	277	Prosthodontics
27	Dentist	289	Dental Hygienist
27	Dentist	900	Group
28	Independent Lab	280	Independent Lab
28	Independent Lab	283	Blood Bank
29	Portable X-Ray	291	Portable X-Ray
29	Portable X-Ray	292	Independent Diagnostic Testing Facility
30	End Stage Renal Disease	080	FQHC Tribal
30	End Stage Renal Disease	300	Free Standing
30	End Stage Renal Disease	301	Hospital Affiliated
31	Physician	310	Allergy & Immunology
31	Physician	311	Anesthesiology
31	Physician	312	Cardiovascular Disease
31	Physician	314	Dermatology
31	Physician	315	Emergency Medicine
31	Physician	316	Family Practice
31	Physician	317	Gastroenterology
31	Physician	318	General Practice
31	Physician	319	General Surgery
31	Physician	320	Geriatrics
31	Physician	322	Internal Medicine
31	Physician	324	Nephrology
31	Physician	325	Neurological Surgery
31	Physician	326	Neurology
31	Physician	327	Nuclear Medicine
31	Physician	328	Obstetrics and Gynecology
31	Physician	329	Oncology and Hematology
31	Physician	330	Ophthalmology
31	Physician	331	Orthopedic Surgery
31	Physician	332	Otolaryngology
31	Physician	333	Pathology
31	Physician	336	Physical Medicine and Rehab
31	Physician	337	Plastic Surgery
31	Physician	338	Proctology
31	Physician	339	Psychiatry
31	Physician	340	Pulmonary Disease
31	Physician	341	Radiology
31	Physician	342	Thoracic and Cardiovascular Surgery
31	Physician	343	Urology
31	Physician	345	Pediatrician
31	Physician	354	Preventative Medicine
32	Anesthetist	094	CRNA
32	Anesthetist	101	Anesthesiologist Assistant
32	Anesthetist	900	Group

PT Code	Type Description	PS Code	Specialty Description
33	Physician Group	310	Allergy & Immunology
33	Physician Group	311	Anesthesiology
33	Physician Group	312	Cardiovascular Disease
33	Physician Group	314	Dermatology
33	Physician Group	315	Emergency Medicine
33	Physician Group	316	Family Practice
33	Physician Group	317	Gastroenterology
33	Physician Group	318	General Practice
33	Physician Group	319	General Surgery
33	Physician Group	320	Geriatrics
33	Physician Group	322	Internal Medicine
33	Physician Group	324	Nephrology
33	Physician Group	325	Neurological Surgery
33	Physician Group	326	Neurology
33	Physician Group	327	Nuclear Medicine
33	Physician Group	328	Obstetrics and Gynecology
33	Physician Group	329	Oncology and Hematology
33	Physician Group	330	Ophthalmology
33	Physician Group	331	Orthopedic Surgery
33	Physician Group	332	Otolaryngology
33	Physician Group	333	Pathology
33	Physician Group	336	Physical Medicine and Rehab
33	Physician Group	337	Plastic Surgery
33	Physician Group	338	Proctology
33	Physician Group	339	Psychiatry
33	Physician Group	340	Pulmonary Disease
33	Physician Group	341	Radiology
33	Physician Group	342	Thoracic and Cardiovascular Surgery
33	Physician Group	343	Urology
33	Physician Group	345	Pediatrician
33	Physician Group	354	Preventative Medicine
33	Physician Group	900	Group
34	Behavioral Treatment	400	Behavioral Treatment Licensed Supervisor
34	Behavioral Treatment	401	Behavioral Treatment Therapist
34	Behavioral Treatment	402	Behavioral Treatment Technician
34	Behavioral Treatment	403	Focused Treatment Licensed Supervisor
34	Behavioral Treatment	404	Focused Treatment Therapist
35	Licensed Midwife	350	Licensed Midwife (See ForwardHealth *Update* 2016-51 regarding this new provider/benefit)
44	Waiver Fiscal Employer Agent	969	Fiscal Employer Agent
51	Transportation	080	FQHC Tribal
51	Transportation	520	Specialized Medical Vehicle
52	Narcotic Treatment Service	160	Registered Nurse
52	Narcotic Treatment Service	161	Licensed Practical Nurse
52	Narcotic Treatment Service	532	Registered Alcohol and Drug Counselor (RADC)/NTS

PT Code	Type Description	PS Code	Specialty Description
52	Narcotic Treatment Service	900	Group
53	Individual Medical Supply	080	FQHC Tribal
53	Individual Medical Supply	540	Individual Orthotist
53	Individual Medical Supply	541	Individual Prosthetist
53	Individual Medical Supply	542	Individual Orthotist/Prosthetist
53	Individual Medical Supply	543	Other Individual Medical Supply
57	Facility for the Developmentally Disabled (FDD)	700	SNF/ICF/FDD
57	Facility for the Developmentally Disabled (FDD)	702	Centers
58	Institution for Mental Disease	010	Inpatient/Outpatient Hospital
58	Institution for Mental Disease	712	AODA General Hospital
58	Institution for Mental Disease	713	Psychiatric Hospital
61	Prenatal Care Coordination	080	FQHC Tribal
61	Prenatal Care Coordination	751	Public Sector
61	Prenatal Care Coordination	752	Private Sector
63	High Cost Medically Complex Recipient - Case Management	765	High Cost Case Management
65	HMOs & Other Managed Care Programs	780	Managed Care Payee Provider
65	HMOs & Other Managed Care Programs	781	Managed Care Assigned Provider
65	HMOs & Other Managed Care Programs	782	Transportation Manager Payee
65	HMOs & Other Managed Care Programs	783	Transportation Manager Assigned
65	HMOs & Other Managed Care Programs	784	PIHP (Prepaid Inpatient Health Plans)
67	Day Treatment	010	Inpatient/Outpatient Hospital
67	Day Treatment	080	FQHC Tribal
67	Day Treatment	801	Mental Health Agency
67	Day Treatment	802	Substance Abuse Agency
67	Day Treatment	803	MH/SA Agency
69	Community Care Organization	831	Barron Co.
69	Community Care Organization	832	La Crosse Co.
69	Community Care Organization	833	Milwaukee Co.
70	Rural Health Clinic	184	Hospital Affiliated Clinic
70	Rural Health Clinic	185	Free Standing Clinic
71	Family Planning Clinic	080	FQHC Tribal
71	Family Planning Clinic	083	Family Planning
72	HealthCheck	080	FQHC Tribal
72	HealthCheck	733	Case Management Only
72	HealthCheck	734	Screener
72	HealthCheck	735	Screener Case Management
73	HealthCheck "Other Services"	740	Mental Health
73	HealthCheck "Other Services"	741	Residential Care Center for Children/Group Home

PT Code	Type Description	PS Code	Specialty Description
73	HealthCheck "Other Services"	742	WIC Agency
73	HealthCheck "Other Services"	743	Pediatric Community Care
73	HealthCheck "Other Services"	744	Other
74	Speech & Hearing Clinic	182	Speech and Hearing
75	Federally Qualified Health Clinic (FQHC)	080	FQHC Tribal
75	Federally Qualified Health Clinic (FQHC)	081	FQHC Non-Tribal (CHC)
77	Physical Therapy	170	Physical Therapist
77	Physical Therapy	175	Physical Therapy Assistant
77	Physical Therapy	900	Group
78	Occupational Therapist	171	Occupational Therapist
78	Occupational Therapist	174	Occupational Therapy Assistant
78	Occupational Therapist	900	Group
79	Speech-Language Pathology	173	SLP Master Level
79	Speech-Language Pathology	176	SLP Bachelor Level
79	Speech-Language Pathology	900	Group
80	Crisis Intervention/CSP	080	FQHC Tribal
80	Crisis Intervention/CSP	650	Crisis Intervention
80	Crisis Intervention/CSP	651	Community Support Program (CSP)
80	Crisis Intervention/CSP	652	Comprehensive Community Services (CCS) (No longer in use as of July 1, 2014 – See new Provider Type 82)
80	Crisis Intervention/CSP	653	Crisis Intervention & CSP
80	Crisis Intervention/CSP	654	Crisis Intervention & CCS (No longer in use as of July 1, 2014 – See new Provider Type 82)
80	Crisis Intervention/CSP	655	CSP & CCS (No longer in use as of July 1, 2014 – See new Provider Type 82)
80	Crisis Intervention/CSP	656	Crisis Intervention/CSP/CCS (No longer in use as of July 1, 2014 – See new Provider Type 82)
80	Crisis Intervention/CSP	657	Enhanced Crisis Intervention
81	WPI "Other" (Wisconsin Provider Index use only)	810	WPI "Other"
82	Comprehensive Community Services (CCS)	850	Regional Lead (refer to ForwardHealth *Update* 2014-42 for more information)
82	Comprehensive Community Services (CCS)	851	Regional Non-Lead (refer to ForwardHealth *Update* 2014-42 for more information)
82	Comprehensive Community Services (CCS)	852	Regional Pop/Shared/51.42 (refer to ForwardHealth *Update* 2014-42 for more information)

PT Code	Type Description	PS Code	Specialty Description
82	Comprehensive Community Services (CCS)	853	Non-Regional Matching Funds (refer to ForwardHealth *Update* 2014-42 for more information)
82	Comprehensive Community Services (CCS)	854	Non-Regional DQA (refer to ForwardHealth *Update* 2014-42 for more information)
82	Comprehensive Community Services (CCS)	855	Non-Regional Both (refer to ForwardHealth *Update* 2014-42 for more information)
83	WIMCR (Wisconsin Medicaid Cost Reporting) Regionalization	842	WIMCR Lead 2
83	WIMCR (Wisconsin Medicaid Cost Reporting) Regionalization	843	WIMCR Non-Lead 2
84	Residential Facility SUD Treatment	856	Clinically Managed High Intensity Res Servs
84	Residential Facility SUD Treatment	857	Clinically Managed Low Intensity Res Servs
84	Residential Facility SUD Treatment	956	IMD High Intensity
84	Residential Facility SUD Treatment	957	IMD Low Intensity
85	EVV	858	EVV Provider
85	EVV	859	EVV IRIS FEA
85	EVV	860	EVV Worker

3.4 Pricing Indicator Codes

The pricing indicator dictates the method utilized for pricing.

Pricing Indictor Code	Description
ANESTH	The system utilizes the Anesthesia pricing.
BILLED	The system utilizes the Billed amount of the claim detail.
DRG	The system utilizes DRG APR DRG pricing.
EAPG	The system utilizes EAPG pricing.
ESRD	The system utilizes End Stage Renal Disease pricing.
ESRDMX	The system utilizes ESRD Max Fee pricing.
HIPPS	The system utilizes Long Term Care HIPPS code pricing.
IPDIEM	The system utilizes inpatient per diem pricing.
LTCANC	The system utilizes Long Term Care Ancillary pricing.
LTCLOC	The system utilizes Level of Care pricing
MANUAL	The system suspends the claim for manual pricing.
MAXFEE	The system utilizes the procedure max fee rate on file.
MAXOUT	The system utilizes Outpatient procedure pricing.
OPPRVR	The system utilizes percent and per diem pricing.
PAY0	The system utilizes an allowed amount of zero.

Pricing Indictor Code	Description
SYSMAN	The system suspends the claim for manual pricing.
UCCALL	The system utilizes the providers UCC.

3.5 Rate Type Codes

A rate type is used in conjunction with the pricing indicator and contract to identify the rate to be utilized to calculate the allowable amount for the service. The rate type allows the same pricing methodologies, however a different rate for the same procedure code. There are specific rate types for every contract and additional rate types will be added as needed.

Rate types and the description.

Rate type	Description
C01	AMB SURG CTR
C02	AMBULANCE
C03	ANSTHESIA
C04	ASSIST SURGY
C05	AUDIO - PURCH AID
C07	CHIRO
C09	CASEMGT
C10	DENTAL
C11	PURCHASE DME
C12	DISP MED SUPPLY
C13	DAY TRTMT AODA
C14	DAY TRTMT CHILD
C15	DAY TRTMT MED
C17	HLTHCK CASE MGT
C19	HLTHCK PED CAR
C21	RESP CARE
C22	HM HLTH PERS CARE
C30	MED SERVICE
C32	MH AODA
C33	MH COMP COMM
C34	MH CRISIS INTVN
C35	MH COMM SUPRT
C36	MH HOME COMM
C37	MH HOME PSYCH
C38	MH NARC TRTMNT
C43	PN CHLD CARE
C44	RADIOLOGY
C45	REHABILITATION
C46	SCHL BASE SERV
C47	SPECL MED VECH
C48	VISION SPEC

Rate type	Description
C49	THERAPY
C51	VISION
C52	MISCELLANEOUS
C53	MHSA-PREGNANT WMN
C54	DISP MED SUPPLY J&B
C55	LTC TRANSPORT
C57	HIV AIDS HLTHHME
C68	CERT PROF MIDWIVES
C69	MCO CARE MNGMNT
C71	CARE4KIDS
CG1	PT GLOBAL (Not Modifier 26/TC)
DEF	DEFAULT
FAP	GEN PT-FAMILY PLANNING
GFP	GLOBAL-FAMILY PLANNING
HLK	HEALTHCHECK
HPC	PERSONAL CARE
LA5	LAB GLOBAL
LAC	OUTPATIENT LAB
LAP	LAB PROF (Modifier 26)
LAT	LAB TECH (Modifier TC)
MED	MEDICAL
OTH	OTHER
PA1	1 ADULT PTPS SPEC
PE1	MEDSV PEDIATRIC PT
PE2	ASTSG PEDIATRIC PT
PEA	ASTSG PEDIATRIC
PEM	MEDSV PEDIATRIC
PEO	MEDSV PEDIATRIC OTH
PFA	PROF – FAMPLAN - ADULT
PFP	PROF-FAMILY PLAN (Modifier 26)
PR1	PT-PROFESSIONAL (Modifier 26)
PR2	PT – PROF - ADULT
PRA	PROFESSIONAL - ADULT
PRO	PROFESSIONAL (Modifier 26)
PT1	1 PTPS SPECIFIC
PT2	2 PTPS SPECIFIC
PT3	3 PTPS SPECIFIC
PT4	4 PTPS SPECIFIC
PT5	5 PTPS SPECIFIC
PT6	6 PTPS SPECIFIC
PT7	7 PTPS SPECIFIC
PT8	8 PTPS SPECIFIC
QTT	QUALIFIED TREATMENT TRAINEE
RNT	RENTAL AID (Modifier RR)
RTL	RENTAL DME (Modifier RR)

Rate type	Description
RWA	RURAL WI CTYS
RWI	RURAL WI CTYS
SCR	SeniorCare-Rate
T09	TRIBAL CASE MNGMNT
T18	MEDICARE
TE1	PT-TECHNICAL (Modifier TC)
TEC	TECHNICAL (Modifier TC)
TFP	TECH-FAMILY PLAN (Modifier TC)
005	BROWN CTY
008	CALUMET CTY
009	CHIPPEWA CTY
011	COLUMBIA CTY
013	DANE CTY
016	DOUGLAS CTY
018	EAU CLAIRE CTY
020	FOND DU LAC CTY
023	GREEN CTY
025	IOWA CTY
030	KENOSHA CTY
031	KEWAUNEE CTY
032	LA CROSSE CTY
035	LINCOLN CTY
037	MARATHON CTY
040	MILWAUKEE CTY
042	OCONTO CTY
044	OUTAGAMIE CTY
045	OZAUKEE CTY
047	PIERCE CTY
051	RACINE CTY
053	ROCK CTY
055	ST CROIX CTY
059	SHEBOYGAN CTY
066	WASHINGTON CTY
067	WAUKESHA CTY
070	WINNEBAGO CTY
094	ILL BORDER CTYS
095	IOWA BORDER CTYS
096	MICH BORDER CTYS
05A	BROWN CTY
08A	CALUMET CTY
09A	CHIPPEWA CTY
11A	COLUMBIA CTY
13A	DANE CTY
16A	DOUGLAS CTY
18A	EAU CLAIRE CTY
20A	FOND DU LAC CTY

Rate type	Description
23A	GREEN CTY
25A	IOWA CTY
30A	KENOSHA CTY
31A	KEWAUNEE CTY
32A	LA CROSSE CTY
35A	LINCOLN CTY
37A	MARATHON CTY
40A	MILWAUKEE CTY
42A	OCONTO CTY
44A	OUTAGAMIE CTY
45A	OZAUKEE CTY
47A	PIERCE CTY
51A	RACINE CTY
53A	ROCK CTY
55A	ST CROIX CTY
59A	SHEBOYGAN CTY
66A	WASHINGTON CTY
67A	WAUKESHA CTY
70A	WINNEBAGO CTY
94A	ILL BORDER CTYS
95A	IOWA BORDER CTYS
96A	MICH BORDER CTYS

3.6 Benefit Adjustment Factor (BAF) Codes

The Benefit Adjustment Factor (BAF) provides the ability to alter an existing allowed amount by a rate, percentage or a series of a rate and percentages to increase or reduce the allowed amount. Please see section 5.2 for additional details and pricing calculations.

BAF code, description and the adjustment factor.

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
20	Adjustment of 20% **Applicable Contracts:** DENTL Modifier 80, MEDSV and VISN Modifier 55		.200	Before
50	Adjustment of 50% **Applicable Contracts:** AMBUL Modifier GM, DME Modifier TW		.500	Before
60	Adjustment of 60% of the billed amount. **Applicable Contract:** MEDSV, DME		.600	After
80	Adjustment of 80% **Applicable Contracts:** MEDSV Modifier 54, DME Modifier RA		.800	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
90	Adjustment of 90% **Applicable Contracts:** THERP and REHAB Modifier TF		.900	Before
150	Adjustment of 150% **Applicable Contracts:** MEDSV, ASTSG, RDLGY, VISN Modifiers 50		1.500	Before
80DME	Adjustment of 80% of the billed amount. **Applicable Contracts:** DME		.800	After
80HOSPL	Adjustment of 80% of the maximum allowable fee, when service rendered in a hospital or ambulatory surgical place of service (21, 22, 24) **Applicable Contracts:** MEDSV Refer to Provider *Update* 2012-13 for more information on this policy, including the list of procedure codes impacted.		.800	Before
DNTL10414	Dental Incentive when recipient is under the age of 21.	$104.14		Before
DNTL105	Dental Incentive when recipient is under the age of 21.	$1.05		Before
DNTL10579	Dental Incentive when recipient is under the age of 21.	$105.79		Before
DNTL1062	Dental Incentive when recipient is under the age of 21.	$10.62		Before
DNTL109	Dental Incentive when recipient is under the age of 21.	$1.09		Before
DNTL1098	Dental Incentive when recipient is under the age of 21.	$10.98		Before
DNTL115	Dental Incentive when recipient is under the age of 21.	$1.15		Before
DNTL11609	Dental Incentive when recipient is under the age of 21.	$116.09		Before
DNTL1181	Dental Incentive when recipient is under the age of 21.	$11.81		Before
DNTL1198	Dental Incentive when recipient is under the age of 21.	$11.98		Before
DNTL1207	Dental Incentive when recipient is under the age of 21.	$12.07		Before
DNTL12076	Dental Incentive when recipient is under the age of 21.	$120.76		Before
DNTL1215	Dental Incentive when recipient is under the age of 21.	$12.15		Before
DNTL122	Dental Incentive when recipient is under the age of 21.	$1.22		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL1226	Dental Incentive when recipient is under the age of 21.	$12.26		Before
DNTL1229	Dental Incentive when recipient is under the age of 21.	$12.29		before
DNTL1230	Dental Incentive when recipient is under the age of 21.	$12.30		Before
DNTL1238	Dental Incentive when recipient is under the age of 21.	$12.38		Before
DNTL1250	Dental Incentive when recipient is under the age of 21.	$12.50		Before
DNTL126	Dental Incentive when recipient is under the age of 21.	$1.26		Before
DNTL1281	Dental Incentive when recipient is under the age of 21.	$12.81		Before
DNTL1301	Dental Incentive when recipient is under the age of 21.	$13.01		Before
DNTL13219	Dental Incentive when recipient is under the age of 21.	$132.19		Before
DNTL1333	Dental Incentive when recipient is under the age of 21.	$13.33		Before
DNTL1351	Dental Incentive when recipient is under the age of 21.	$13.51		Before
DNTL137	Dental Incentive when recipient is under the age of 21.	$1.37		Before
DNTL13770	Dental Incentive when recipient is under the age of 21.	$137.70		Before
DNTL13802	Dental Incentive when recipient is under the age of 21.	$138.02		Before
DNTL146066	Dental Incentive when recipient is under the age of 21.	$1,460.66		Before
DNTL14624	Dental Incentive when recipient is under the age of 21.	$146.24		Before
DNTL147	Dental Incentive when recipient is under the age of 21.	$1.47		Before
DNTL1487	Dental Incentive when recipient is under the age of 21.	$14.87		Before
DNTL1497	Dental Incentive when recipient is under the age of 21.	$14.97		Before
DNTL14975	Dental Incentive when recipient is under the age of 21.	$149.75		Before
DNTL1537	Dental Incentive when recipient is under the age of 21.	$15.37		Before
DNTL154	Dental Incentive when recipient is under the age of 21.	$1.54		Before
DNTL1568	Dental Incentive when recipient is under the age of 21.	$15.68		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL161	Dental Incentive when recipient is under the age of 21.	$1.61		Before
DNTL1616	Dental Incentive when recipient is under the age of 21.	$16.16		Before
DNTL164	Dental Incentive when recipient is under the age of 21.	$1.64		Before
DNTL167	Dental Incentive when recipient is under the age of 21.	$1.67		Before
DNTL1677	Dental Incentive when recipient is under the age of 21.	$16.77		Before
DNTL1701	Dental Incentive when recipient is under the age of 21.	$17.01		Before
DNTL171	Dental Incentive when recipient is under the age of 21.	$1.71		Before
DNTL1716	Dental Incentive when recipient is under the age of 21.	$17.16		Before
DNTL1733	Dental Incentive when recipient is under the age of 21.	$17.33		Before
DNTL1741	Dental Incentive when recipient is under the age of 21.	$17.41		Before
DNTL1755	Dental Incentive when recipient is under the age of 21.	$17.55		Before
DNTL1793	Dental Incentive when recipient is under the age of 21.	$17.93		Before
DNTL180	Dental Incentive when recipient is under the age of 21.	$1.80		Before
DNTL1800	Dental Incentive when recipient is under the age of 21.	$18.00		Before
DNTL1813	Dental Incentive when recipient is under the age of 21.	$18.13		Before
DNTL1834	Dental Incentive when recipient is under the age of 21.	$18.34		Before
DNTL18507	Dental Incentive when recipient is under the age of 21.	$185.07		Before
DNTL18794	Dental Incentive when recipient is under the age of 21.	$187.94		Before
DNTL188	Dental Incentive when recipient is under the age of 21.	$1.88		Before
DNTL190	Dental Incentive when recipient is under the age of 21.	$1.90		Before
DNTL1919	Dental Incentive when recipient is under the age of 21.	$19.19		Before
DNTL202	Dental Incentive when recipient is under the age of 21.	$2.02		Before
DNTL2050	Dental Incentive when recipient is under the age of 21.	$20.50		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL2061	Dental Incentive when recipient is under the age of 21.	$20.61		Before
DNTL2096	Dental Incentive when recipient is under the age of 21.	$20.96		Before
DNTL2122	Dental Incentive when recipient is under the age of 21.	$21.22		Before
DNTL216	Dental Incentive when recipient is under the age of 21.	$2.16		Before
DNTL218	Dental Incentive when recipient is under the age of 21.	$2.18		Before
DNTL2183	Dental Incentive when recipient is under the age of 21.	$21.83		Before
DNTL2195	Dental Incentive when recipient is under the age of 21.	$21.95		Before
DNTL2262	Dental Incentive when recipient is under the age of 21.	$22.62		Before
DNTL230	Dental Incentive when recipient is under the age of 21.	$2.30		Before
DNTL2324	Dental Incentive when recipient is under the age of 21.	$23.24		Before
DNTL234	Dental Incentive when recipient is under the age of 21.	$2.34		Before
DNTL235	Dental Incentive when recipient is under the age of 21.	$2.35		Before
DNTL239	Dental Incentive when recipient is under the age of 21.	$2.39		Before
DNTL2437	Dental Incentive when recipient is under the age of 21.	$24.37		Before
DNTL2457	Dental Incentive when recipient is under the age of 21.	$24.57		Before
DNTL246	Dental Incentive when recipient is under the age of 21.	$2.46		Before
DNTL252	Dental Incentive when recipient is under the age of 21.	$2.52		Before
DNTL2520	Dental Incentive when recipient is under the age of 21.	$25.20		Before
DNTL256	Dental Incentive when recipient is under the age of 21.	$2.56		Before
DNTL2563	Dental Incentive when recipient is under the age of 21.	$25.63		Before
DNTL2568	Dental Incentive when recipient is under the age of 21.	$25.68		Before
DNTL2607	Dental Incentive when recipient is under the age of 21.	$26.07		Before
DNTL262	Dental Incentive when recipient is under the age of 21.	$2.62		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL263	Dental Incentive when recipient is under the age of 21.	$2.63		Before
DNTL26312	Dental Incentive when recipient is under the age of 21.	$263.12		Before
DNTL266	Dental Incentive when recipient is under the age of 21.	$2.66		Before
DNTL268	Dental Incentive when recipient is under the age of 21.	$2.68		Before
DNTL2687	Dental Incentive when recipient is under the age of 21.	$26.87		Before
DNTL2727	Dental Incentive when recipient is under the age of 21.	$27.27		Before
DNTL27590	Dental Incentive when recipient is under the age of 21.	$275.90		Before
DNTL278	Dental Incentive when recipient is under the age of 21.	$2.78		Before
DNTL279	Dental Incentive when recipient is under the age of 21.	$2.79		Before
DNTL282	Dental Incentive when recipient is under the age of 21.	$2.82		Before
DNTL283	Dental Incentive when recipient is under the age of 21.	$2.83		Before
DNTL2885	Dental Incentive when recipient is under the age of 21.	$28.85		Before
DNTL2971	Dental Incentive when recipient is under the age of 21.	$29.71		Before
DNTL3018	Dental Incentive when recipient is under the age of 21.	$30.18		Before
DNTL304	Dental Incentive when recipient is under the age of 21.	$3.04		Before
DNTL305	Dental Incentive when recipient is under the age of 21.	$3.05		Before
DNTL3056	Dental Incentive when recipient is under the age of 21.	$30.56		Before
DNTL3241	Dental Incentive when recipient is under the age of 21.	$32.41		Before
DNTL3254	Dental Incentive when recipient is under the age of 21.	$32.54		Before
DNTL327	Dental Incentive when recipient is under the age of 21.	$3.27		Before
DNTL328	Dental Incentive when recipient is under the age of 21.	$3.28		Before
DNTL329	Dental Incentive when recipient is under the age of 21.	$3.29		Before
DNTL335	Dental Incentive when recipient is under the age of 21.	$3.35		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL3400	Dental Incentive when recipient is under the age of 21.	$34.00		Before
DNTL3416	Dental Incentive when recipient is under the age of 21.	$34.16		Before
DNTL342	Dental Incentive when recipient is under the age of 21.	$3.42		Before
DNTL344	Dental Incentive when recipient is under the age of 21.	$3.44		Before
DNTL35029	Dental Incentive when recipient is under the age of 21.	$350.29		Before
DNTL354	Dental Incentive when recipient is under the age of 21.	$3.54		Before
DNTL358	Dental Incentive when recipient is under the age of 21.	$3.58		Before
DNTL3588	Dental Incentive when recipient is under the age of 21.	$35.88		Before
DNTL36	Dental Incentive when recipient is under the age of 21.	$0.36		Before
DNTL3655	Dental Incentive when recipient is under the age of 21.	$36.55		Before
DNTL367	Dental Incentive when recipient is under the age of 21.	$3.67		Before
DNTL368	Dental Incentive when recipient is under the age of 21.	$3.68		Before
DNTL372	Dental Incentive when recipient is under the age of 21.	$3.72		Before
DNTL375	Dental Incentive when recipient is under the age of 21.	$3.75		Before
DNTL3760	Dental Incentive when recipient is under the age of 21.	$37.60		Before
DNTL37747	Dental Incentive when recipient is under the age of 21.	$377.47		Before
DNTL379	Dental Incentive when recipient is under the age of 21.	$3.79		Before
DNTL3818	Dental Incentive when recipient is under the age of 21.	$38.18		Before
DNTL38626	Dental Incentive when recipient is under the age of 21.	$386.26		Before
DNTL389	Dental Incentive when recipient is under the age of 21.	$3.89		Before
DNTL391	Dental Incentive when recipient is under the age of 21.	$3.91		Before
DNTL3946	Dental Incentive when recipient is under the age of 21.	$39.46		Before
DNTL395	Dental Incentive when recipient is under the age of 21.	$3.95		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL396	Dental Incentive when recipient is under the age of 21.	$3.96		Before
DNTL397	Dental Incentive when recipient is under the age of 21.	$3.97		Before
DNTL40074	Dental Incentive when recipient is under the age of 21.	$400.74		Before
DNTL402	Dental Incentive when recipient is under the age of 21.	$4.02		Before
DNTL41646	Dental Incentive when recipient is under the age of 21.	$416.46		Before
DNTL4225	Dental Incentive when recipient is under the age of 21.	$42.25		Before
DNTL423	Dental Incentive when recipient is under the age of 21.	$4.23		Before
DNTL426	Dental Incentive when recipient is under the age of 21.	$4.26		Before
DNTL429	Dental Incentive when recipient is under the age of 21.	$4.29		Before
DNTL431	Dental Incentive when recipient is under the age of 21.	$4.31		Before
DNTL45	Dental Incentive when recipient is under the age of 21.	$0.45		Before
DNTL45329	Dental Incentive when recipient is under the age of 21.	$453.29		Before
DNTL4537	Dental Incentive when recipient is under the age of 21.	$45.37		Before
DNTL4573	Dental Incentive when recipient is under the age of 21.	$45.73		Before
DNTL458	Dental Incentive when recipient is under the age of 21.	$4.58		Before
DNTL459	Dental Incentive when recipient is under the age of 21.	$4.59		Before
DNTL4597	Dental Incentive when recipient is under the age of 21.	$45.97		Before
DNTL4647	Dental Incentive when recipient is under the age of 21.	$46.47		Before
DNTL467	Dental Incentive when recipient is under the age of 21.	$4.67		Before
DNTL474	Dental Incentive when recipient is under the age of 21.	$4.74		Before
DNTL479	Dental Incentive when recipient is under the age of 21.	$4.79		Before
DNTL482	Dental Incentive when recipient is under the age of 21.	$4.82		Before
DNTL496	Dental Incentive when recipient is under the age of 21.	$4.96		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL50	Dental Incentive when recipient is under the age of 21.	$0.50		Before
DNTL501	Dental Incentive when recipient is under the age of 21.	$5.01		Before
DNTL502	Dental Incentive when recipient is under the age of 21.	$5.02		Before
DNTL5103	Dental Incentive when recipient is under the age of 21.	$51.03		Before
DNTL511	Dental Incentive when recipient is under the age of 21.	$5.11		Before
DNTL5117	Dental Incentive when recipient is under the age of 21.	$51.17		Before
DNTL5126	Dental Incentive when recipient is under the age of 21.	$51.26		Before
DNTL515	Dental Incentive when recipient is under the age of 21.	$5.15		Before
DNTL516	Dental Incentive when recipient is under the age of 21.	$5.16		Before
DNTL531	Dental Incentive when recipient is under the age of 21.	$5.31		Before
DNTL532	Dental Incentive when recipient is under the age of 21.	$5.32		Before
DNTL538	Dental Incentive when recipient is under the age of 21.	$5.38		Before
DNTL556	Dental Incentive when recipient is under the age of 21.	$5.56		Before
DNTL563	Dental Incentive when recipient is under the age of 21.	$5.63		Before
DNTL571	Dental Incentive when recipient is under the age of 21.	$5.71		Before
DNTL576	Dental Incentive when recipient is under the age of 21.	$5.76		Before
DNTL591	Dental Incentive when recipient is under the age of 21.	$5.91		Before
DNTL592	Dental Incentive when recipient is under the age of 21.	$5.92		Before
DNTL601	Dental Incentive when recipient is under the age of 21.	$6.01		Before
DNTL603	Dental Incentive when recipient is under the age of 21.	$6.03		Before
DNTL612	Dental Incentive when recipient is under the age of 21.	$6.12		Before
DNTL613	Dental Incentive when recipient is under the age of 21.	$6.13		Before
DNTL63	Dental Incentive when recipient is under the age of 21.	$0.63		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL6411	Dental Incentive when recipient is under the age of 21.	$64.11		Before
DNTL6436	Dental Incentive when recipient is under the age of 21.	$64.36		Before
DNTL647	Dental Incentive when recipient is under the age of 21.	$6.47		Before
DNTL650	Dental Incentive when recipient is under the age of 21.	$6.50		Before
DNTL6506	Dental Incentive when recipient is under the age of 21.	$65.06		Before
DNTL654	Dental Incentive when recipient is under the age of 21.	$6.54		Before
DNTL66	Dental Incentive when recipient is under the age of 21.	$0.66		Before
DNTL664	Dental Incentive when recipient is under the age of 21.	$6.64		Before
DNTL675	Dental Incentive when recipient is under the age of 21.	$6.75		Before
DNTL683	Dental Incentive when recipient is under the age of 21.	$6.83		Before
DNTL702	Dental Incentive when recipient is under the age of 21.	$7.02		Before
DNTL703	Dental Incentive when recipient is under the age of 21.	$7.03		Before
DNTL7099	Dental Incentive when recipient is under the age of 21.	$70.99		Before
DNTL7144	Dental Incentive when recipient is under the age of 21.	$71.44		Before
DNTL715	Dental Incentive when recipient is under the age of 21.	$7.15		Before
DNTL7176	Dental Incentive when recipient is under the age of 21.	$71.76		Before
DNTL722	Dental Incentive when recipient is under the age of 21.	$7.22		Before
DNTL745	Dental Incentive when recipient is under the age of 21.	$7.45		Before
DNTL753	Dental Incentive when recipient is under the age of 21.	$7.53		Before
DNTL78	Dental Incentive when recipient is under the age of 21.	$0.78		Before
DNTL799	Dental Incentive when recipient is under the age of 21.	$7.99		Before
DNTL806	Dental Incentive when recipient is under the age of 21.	$8.06		Before
DNTL809	Dental Incentive when recipient is under the age of 21.	$8.09		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL827	Dental Incentive when recipient is under the age of 21.	$8.27		Before
DNTL8292	Dental Incentive when recipient is under the age of 21.	$82.92		Before
DNTL844	Dental Incentive when recipient is under the age of 21.	$8.44		Before
DNTL8485	Dental Incentive when recipient is under the age of 21.	$84.85		Before
DNTL857	Dental Incentive when recipient is under the age of 21.	$8.57		Before
DNTL858	Dental Incentive when recipient is under the age of 21.	$8.58		Before
DNTL862	Dental Incentive when recipient is under the age of 21.	$8.62		Before
DNTL8626	Dental Incentive when recipient is under the age of 21.	$86.26		Before
DNTL878	Dental Incentive when recipient is under the age of 21.	$8.78		Before
DNTL893	Dental Incentive when recipient is under the age of 21.	$8.93		Before
DNTL90	Dental Incentive when recipient is under the age of 21.	$0.90		Before
DNTL906	Dental Incentive when recipient is under the age of 21.	$9.06		Before
DNTL910	Dental Incentive when recipient is under the age of 21.	$9.10		Before
DNTL915	Dental Incentive when recipient is under the age of 21.	$9.15		Before
DNTL92	Dental Incentive when recipient is under the age of 21.	$0.92		Before
DNTL929	Dental Incentive when recipient is under the age of 21.	$9.29		Before
DNTL9478	Dental Incentive when recipient is under the age of 21.	$94.78		Before
DNTL952	Dental Incentive when recipient is under the age of 21.	$9.52		Before
DNTL956	Dental Incentive when recipient is under the age of 21.	$9.56		Before
DNTL965	Dental Incentive when recipient is under the age of 21.	$9.65		Before
DNTL98	Dental Incentive when recipient is under the age of 21.	$0.98		Before
DNTL983	Dental Incentive when recipient is under the age of 21.	$9.83		Before
DNTL984	Dental Incentive when recipient is under the age of 21.	$9.84		Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
DNTL999	Dental Incentive when recipient is under the age of 21.	$9.99		Before
DNTLHOSP	Dental Incentive when recipient is under the age of 21.		.9000	Before
FFPCCS6066	Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 01/01/2024.		.6066	After
FFPCCS6216	Enhanced Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 10/01/2023.		.6216	After
FFPCCS6260	Enhanced Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 07/01/2023.		.6260	After
FFPCCS6510	Enhanced Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 04/01/2023.		.6510	After
FFPCCS6556	Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 01/01/2020 due to COVID-19 pandemic.		.6556	After
FFPCCS6557	Enhanced federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 10/01/2020.		.6557	After
FFPCCS6608	Enhanced Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 10/1/21.		.6608	After
FFPCCS6630	Enhanced Federal share percentage for Comprehensive Community Services (CCS) for dates of process on/after 10/01/2022.		.6630	After
FFPCMKI6216	Enhanced Federal share percentage for Case Management - Kids In Substitute Care (T2023) for dates of process on/after 10/01/2023		.6216	Before
FFPCMKI6260	Enhanced Federal share percentage for Case Management - Kids In Substitute Care (T2023) for dates of process on/after 07/01/2023.		.6260	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
FFPCMKI6510	Enhanced Federal share percentage for Case Management - Kids In Substitute Care (T2023) for dates of process on/after 04/01/2023.		.6510	Before
FFPCMKI6556	Federal share percentage for Case Management – Kids in Substitute Care (T2023) for dates of process on/after 1/1/2020 due to COVID-10 pandemic.		.6556	Before
FFPCMKI6557	Enhanced federal share percentage for Case Management – Kids in Substitute Care (T2023) for dates of process on/after 10/1/2020.		.6557	Before
FFPCMKI6608	Enhanced Federal share percentage for Case Management – Kids In Substitute Care (T2023) for dates of process on/after 10/1/21.		.6608	Before
FFPCMKI6630	Enhanced Federal share percentage for Case Management - Kids In Substitute Care (T2023) for dates of process on/after 10/01/2022.		.6630	Before
FFPCMKID24	Federal share percentage for Case Management - Kids In Substitute Care (T2023) for dates of process on/after 01/01/2024		.6066	Before
FFPCRS6510	Enhanced Federal share percentage for Community Recovery Services (CRS) for dates of process on/after 04/01/2023.		.6510	After
FFPCSMG24	Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 01/01/2024		.6066	Before
FFPCSMG6216	Enhanced Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 10/01/2023		.6216	Before
FFPCSMG6260	Enhanced Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 07/01/2023.		.6260	Before
FFPCSMG6630	Enhanced Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 10/01/2022.		.6630	Before
FFPCSMG6510	Enhanced Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 04/01/2023.		.6510	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
FFPCSMG6556	Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 1/1/2020 due to COVID-19 pandemic		.6556	Before
FFPCSMG6557	Enhanced federal share percentage for Targeted Case Management (T1017) for dates of process on/after 10/1/2020.		.6557	Before
FFPCSMG6608	Enhanced Federal share percentage for Targeted Case Management (T1017) for dates of process on/after 10/1/21.		.6608	Before
FFPMH6066	Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 01/01/2024.		.6066	After
FFPMH6216	Enhanced Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 10/01/2023.		.6216	After
FFPMH6260	Enhanced Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 07/01/2023.		.6260	After
FFPMH6630	Enhanced Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 10/01/2022.		.6630	After
FFPMH6510	Enhanced Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 04/01/2023.		.6510	After
FFPMH6556	Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 1/1/2020 due to COVID-19 pandemic.		.6556	After
FFPMH6557	Enhanced federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 10/1/2020.		.6557	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
FFPMH6608	Enhanced Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 10/1/21.		.6608	After
FFPMHCI1044	Additional 25 percent of State share (general purpose revenue) for eligible Mobile Crisis Providers for dates of service on/after 01/01/2024.		1.044118	After
FFPMHCI1127	Additional 25 percent of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 10/01/2022.		1.1270	After
FFPMHCI1128	Additional 25% of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 10/1/2021.		1.1283	After
FFPMHCI1131	Additional 25 percent of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 12/16/2020.		1.1313	After
FFPMHCI1134	Additional 25 percent of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 04/01/2023.		1.1340	After
FFPMHCI1149	Additional 25 percent of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 07/01/2023.		1.1493	After
FFPMHCI1152	Additional 25 percent of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 10/01/2023.		1.1522	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
FFPMHCI1162	Additional 25 percent of State share (general purpose revenue) for Mental Health (Home/Community, Crisis Intervention, Community Support Program), for dates of process on/after 01/01/2024.		1.1622	After
FFPMHCI6557	Enhanced federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 12/16/2020.		.6557	After
FFPMHCI6952	Federal share percentage for Crisis Intervention services, plus additional 25 percent of State share (general purpose revenue), for dates of service on/after 1/1/20. (Note that the appropriate 'FFPMH####' BAF is to be used prior to dates of service 1/1/2020)		.6952	After
FFPMHCI7417	Federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 1/1/2020 due to COVID-19 pandemic.		.7417	After
FFPMHCI7418	Enhanced federal share percentage for Mental Health (Home/Community, Crisis Intervention, Community Support Program) for dates of process on/after 10/1/2020.		.7418	After
FFPMHCI8500	Enhanced Federal share percentage for eligible Mobile Crisis Providers for dates of service on/after 01/01/2024.		.85	After
FFPRCC6510	Enhanced Federal share percentage for residential care center for dates of process on/after 04/01/2023.		.6510	Before
FFPSBS60	Federal share percentage school based services 60% WI percent date of process from 2004-01-01		.60	Before
FFPSBS6066	Federal share percentage for school based services for dates of process on/after 01/01/2024.		.6066	Before
FFPSBS6216	Enhanced Federal share percentage for school based services for dates of process on/after 10/01/2023.		.6216	Before
FFPSBS6260	Enhanced Federal share percentage for school-based services for dates of process on/after 07/01/2023.		.6260	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
FFPSBS6630	Enhanced Federal share percentage for school based services for dates of process on/after 10/01/2022.		.6630	Before
FFPSBS6510	Enhanced Federal share percentage for school based services for dates of process on/after 04/01/2023.		.6510	Before
FFPSBS6556	Federal share percentage for school based services for dates of process on/after 1/1/2020 due to COVID-19 pandemic.		.6556	Before
FFPSBS6557	Enhanced federal share percentage for school based services for dates of process on/after 10/1/2020.		.6557	Before
FFPSBS6608	Enhanced Federal share percentage for school based services for dates of process on/after 10/1/2021.		.6608	Before
HPSA120	HPSA incentive when modifier AQ is present.		1.20	Before
HPSA12919	HPSA incentive when modifier AQ is present.		1.2919	Before
HPSA12923	HPSA incentive when modifier AQ is present.		1.2923	Before
HPSA12926	HPSA incentive when modifier AQ is present.		1.2926	Before
HPSA12937	HPSA incentive when modifier AQ is present.		1.2937	Before
HPSA13591	HPSA incentive when modifier AQ is present.		1.3591	Before
HPSA14381	HPSA incentive when modifier AQ is present.		1.4381	Before
HPSA14978	HPSA incentive when modifier AQ is present.		1.4978	Before
HPSA150	HPSA incentive when modifier AQ is present.		1.50	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
HPSA15551	HPSA incentive when modifier AQ is present.		1.5551	Before
HPSA15869	HPSA incentive when modifier AQ is present.		1.5869	Before
HPSA16015	HPSA incentive when modifier AQ is present.		1.6015	Before
HPSA16336	HPSA incentive when modifier AQ is present.		1.6336	Before
HPSA16595	HPSA incentive when modifier AQ is present.		1.6595	Before
HPSA17788	HPSA incentive when modifier AQ is present.		1.7788	Before
HPSA18088	HPSA incentive when modifier AQ is present.		1.8088	Before
HPSA18149	HPSA incentive when modifier AQ is present.		1.8149	Before
HPSA18450	HPSA incentive when modifier AQ is present.		1.845	Before
HPSA19167	HPSA incentive when modifier AQ is present.		1.9167	Before
HPSA19647	HPSA incentive when modifier AQ is present.		1.9647	Before
HPSA20044	HPSA incentive when modifier AQ is present.		2.0044	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
HPSA21382	HPSA incentive when modifier AQ is present.		2.1382	Before
HPSA22028	HPSA incentive when modifier AQ is present.		2.2028	Before
HPSA25126	HPSA incentive when modifier AQ is present.		2.5126	Before
HPSA40953	HPSA incentive when modifier AQ is present.		4.0953	Before
HPSA41581	HPSA incentive when modifier AQ is present.		4.1581	Before
OBOT102383	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.023839	After
OBOT102596	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.025962	After
OBOT102648	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.026487	After
OBOT103158	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.03158	After
OBOT103294	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.032943	After
OBOT103407	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.034076	After
OBOT103588	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.03588	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
OBOT103659	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.036598	After
OBOT103903	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.039032	After
OBOT103972	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.039725	After
OBOT104116	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.041168	After
OBOT104210	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.042108	After
OBOT104336	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.043366	After
OBOT104378	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.043783	After
OBOT104413	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.044132	After
OBOT104792	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.047926	After
OBOT104965	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.049656	After
OBOT105219	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.052197	After
OBOT105227	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.05227	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
OBOT105237	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.052377	After
OBOT105325	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.053256	After
OBOT105516	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.055165	After
OBOT105629	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.056291	After
OBOT105808	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.058085	After
OBOT105937	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.059379	After
OBOT106255	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.062553	After
OBOT106883	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.068834	After
OBOT107104	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.071042	After
OBOT107492	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.074926	After
OBOT107649	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.076497	After
OBOT107894	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.078944	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
OBOT107958	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.079583	After
OBOT108249	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.082491	After
OBOT108250	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.082508	After
OBOT108668	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.086681	After
OBOT108700	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.087004	After
OBOT108841	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.088418	After
OBOT109023	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.090233	After
OBOT109167	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.091675	After
OBOT110377	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.103777	After
OBOT110621	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.106211	After
OBOT110377	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.110011	After
OBOT111001	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.049656	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
OBOT111200	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.112007	After
OBOT111530	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.1553	After
OBOT111800	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.118002	After
OBOT112049	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.120494	After
OBOT112972	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.129721	After
OBOT112972	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.129721	After
OBOT113387	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.133873	After
OBOT113683	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.136836	After
OBOT114412	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.144125	After
OBOT115934	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.159342	After
OBOT116624	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.166248	After
OBOT117898	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.17898	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
OBOT118473	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.184738	After
OBOT118887	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.188878	After
OBOT119888	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.198886	After
OBOT129939	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.299394	After
OBOT132249	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.322497	After
OBOT133203	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.332034	After
OBOT133231	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.332317	After
OBOT133985	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.339858	After
OBOT135796	Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present.		1.357961	After
OPXOVER80	Adjustment to 80% of the Billed amount or the T18 MAXFEE amount for Outpatient Crossovers.		0.800	Before
OUTPA62	Adjustment of 62 percent of the BILLED amount for Outpatient		.62	Before
RSUDADOLHI	Residential Substance Use Disorder High Intensity Adolescent		1.360572	After

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
RSUDADOLLO	Residential Substance Use Disorder Low Intensity Adolescent		1.400641	After
RSUDIDISHI	Residential Substance User Disorder High Intensity Intellectual Disability		1.135214	After
RSUDIDISLO	Residential Substance User Disorder Low Intensity Intellectual Disability		1.150240	After
RSUDPREGHI	Residential Substance User Disorder High Intensity Pregnant		1.135214	After
RSUDPREGLO	Residential Substance User Disorder Low Intensity Pregnant		1.150240	After
TJ10767	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0767	Before
TJ10768	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0768	Before
TJ10769	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0769	Before
TJ10770	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.0770	Before
TJ11330	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.133	Before
TJ11950	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.195	Before
TJ12012	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.2012	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
TJ12963	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.2963	Before
TJ13225	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV and CHIRO		1.3225	Before
TJ13342	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.3342	Before
TJ13607	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.3607	Before
TJ13830	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.383	Before
TJ14826	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.4826	Before
TJ15074	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5074	Before
TJ15126	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5126	Before
TJ15374	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5374	Before
TJ15977	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.5977	Before
TJ16372	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.6372	Before
TJ16701	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.6701	Before

BAF Code	BAF Description	Rate	Percent in decimal	Calculate Code (Before/ After)
TJ17819	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.7819	Before
TJ18357	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		1.8357	Before
TJ20940	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		2.094	Before
TJ34128	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		3.4128	Before
TJ34650	Group, child and/or adolescent incentive when modifier TJ is present. **Applicable Contracts:** MEDSV		3.4650	Before
U1ADMIN1051	Add an administration fee of $10.51 for selected procedure codes.		0	After
U1ADMIN394	Add an administration fee of $3.94 for selected procedure codes.	$3.94		After

4 Nursing Home Extract Field Layout

4.1 Field Layout

Below is the field layout for the nursing home rate extract. Record sort order will be by county code and provider ID.

Field	Data Type	Max Length*	Description
County Code	Character	10	County code used to identify a geographical/political area in the state.
County Name	Character	12	Name of the specific county.
Provider ID	Character	10	Provider identification number.
Provider ID Type	Character	3	Identifies type of provider ID value, either NPI for National Provider Identifier or MCD for a proprietary provider ID if no NPI is on file for provider.
Proprietary Provider ID	Character	9	Proprietary provider ID.
Provider Name	Character	50	Provider's business or personal name. Personal names will be in format of LASTNAME (25 characters) FIRSTNAME (13 characters) MIDDLEINITIAL (1 character).
Revenue Code	Character	4	Code that identifies a specific accommodation or ancillary service.
Condition Code	Character	2	Code that identifies conditions relating to an institutional claim that may affect payer processing.
Rate	Number	8	Nursing home rate amount. Format is 999999.99.
Effective Date	Date	8	First date of service the rate is effective. Format is CCYYMMDD.
End Date	Date	8	Last date of service the rate is effective. Format is CCYYMMDD.

*Max Data Length including special characters such as decimals.

File Format: Text Delimited
Field Delimiter: Vertical Bar -> |
Frequency: First of every month.
Records included: The date of extract run is within the effective date and end date of an active provider rate record.
Record field order:
County Code|County Name|Provider ID|Provider ID Type|Proprietary Provider ID|Provider Name|Revenue Code|Condition Code|Rate|Effective|End

5 Professional Pricing

5.1 Max Fee Pricing

This method is identified by the pricing indicator MAXFEE. The max fee is a standard, statewide, maximum rate that can be paid for a procedure. The following calculation is used:

Allowed Amount = (Max Fee Rate * Units Allowed)

Allowed Amount = Lesser of Billed Amount or Allowed Amount

For dates of service on and after October 1st, 2016, certain dental services for rendering providers in specific counties will receive enhanced reimbursement rates as outlined in the Resources for Dental Service Providers page on the ForwardHealth Portal: https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/dentist/Dental_pilot.htm.spage

5.2 Benefit Adjustment Factor Pricing

The Benefit Adjustment Factor (BAF) provides the ability to alter an existing allowed amount by a percentage or a series of percentages to increase the allowed amount or reduce it. This type of adjustment works in conjunction with pricing methodologies to apply a percentage to the allowed amount.

The BAFs can also be used to pay additional set amounts that are not service related. The set amount for a BAF is added or subtracted from the calculated allowed amount after the specific pricing methodology was applied.

The combination of percentages and incentive amounts are allowable as well as applying multiple BAFs per single pricing methodology. The BAF provides a before/after flag that controls whether the BAF is applied before the allowed amount is compared to the billed amount. If the flag is set to "after", the BAF is applied to the allowed amount after the allowed amount is set to the lesser of the billed or allowed amount where applicable. The following calculation is used.

If the Benefit Adjustment Factor Before/After flag is set to **Before**:

1. Allowed Amount = (Max Fee Rate * Units Allowed)
2. Allowed Amount = (Allowed Amount * BAF Percentage) ***OR*** (Allowed Amount + BAF Incentive Amount)
3. Allowed Amount = Lesser of Billed Amount or Allowed Amount

Example:7
ASTSG|Medical-Assistant
Su|14301|Y||I~01/000;09/000;31/000;33/000||MAXFEE|C04|50|170.94|0.0|150|20100901|22991231|I~01;03;04;05;06;07;08;09;11;15;20;21;22;23;24;25;26;31;32;33;49;50;51;54;56;57;60;61;71;72;99

Claim billed amount: $300.00

Claim billed quantity: 1.0

Modifier billed: 50

Calculation:
1. Allowed Amount $170.94 = ($170.94 * 1.0)
2. Allowed Amount $256.41 = ($170.94 * 1.5)
3. Allowed Amount $256.41 = (Lesser of $300.00 or $256.41)
(

If the Benefit Adjustment Factor Before/After flag is set to **After**:
1. Allowed Amount = (Max Fee Rate * Units Allowed)
2. Allowed Amount = Lesser of Billed Amount or Allowed Amount
3. Allowed Amount = (Allowed Amount * BAF Percentage) ***OR*** (Allowed Amount + BAF Incentive Amount)

Example:
MHCSP|Mntl Hlth-Comm Sprt|H0039|B||I~80/651;80/653;80/655;80/656||MAXFEE|C35|HM|5.63|0.0|FFPMH6016|20040101|22991231|I~01;03;04;05;06;07;08;09;11;12;13;14;15;20;22;23;26;34;49;50;56;57;60;71;72;99

Claim billed amount: $5.00

Claim quantity billed: 1.0

Modifier billed: HM

Calculation:
1. Allowed Amount $5.63 = (5.63 * 1.0)
2. Allowed Amount $5.00 = (lesser of $5.00 or $5.63)
3. Allowed Amount $3.00 = ($5.00 * .6016)

Note: Each BAF code can only be assigned either a percentage or an incentive amount. The calculation above is used accordingly. For specific situations, additional criteria are outlined below for applying the BAF.

BIRTH TO 3 (Therapy services)

If the modifier TL is billed, and

the POS is 04, 12 or 99, and

the PT/PS is 17/000 74/000 77/000 78/000 79/000, and

the recipient is under the age of 3, the BAF amount is added to the allowed amount.

If the recipient is 3 and over, the BAF amount is not added to the allowed amount.

HPSA Codes

If the HPSA modifier AQ is billed, and the recipients address is in the list of allowable HPSA zip codes, then the HPSA BAFs will apply.

5.3 Anesthesia Pricing

This method is identified by the pricing indicator code ANESTH. The max fee rate and relative value is used in this method. The following calculation for this method is used:

1 Units = 1 min

Units = (Units Allowed / 15.00*) (Round to the hundredth).

Allowed Amount = (Max Fee Rate * (Relative Value + Units))

Allowed Amount = Lesser of Billed Amount or Allowed Amount

**15.00 is the typical relative value for most anesthesia procedure codes, but certain codes may have a different relative value based on published values.*

5.4 Contracted Rate Pricing

The pricing indicator code is MAXFEE. The contracted max fee allowed amount is always paid, even if it is greater than the billed amount. The following is the calculation used for this pricing:

Allowed Amount = (Max Fee Rate * Units Allowed)

The following contracts are applicable to this pricing:

- MHCSP - Mental Health Community Support Program
- MHHC - Mental Health - Mental Health and Substance Abuse Services in the Home or Community for Adults
- CSMGT - Case Management
- MHCI - Mental Health - Crisis Intervention
- SBS - School Based Services

5.5 UCC Pricing

This method is referred to as Usual and Customary Charge pricing. The rates will be provided separately from the rate extract file. Locate the provider's number and procedure code/modifier max fee rate, and then apply the following calculation for this method:

Allowed Amount = (UCC Rate * Units Allowed)

Allowed Amount = Lesser of Billed Amount or Allowed Amount

The following contracts are applicable to this method:

- DTMED - Day Treatment Medical
- REHAB - Therapy - Rehabilitation Centers - Occupational, Physical and Speech Therapy
- MHRCC - HealthCheck Other - Residential Care Centers

5.6 Manual Pricing

This method is identified by the pricing indicator code SYSMAN. Manual pricing is utilized when the procedure code is new and/or does not have enough charge history to permit determining a reimbursement rate. This method is also utilized for non-service specific

"unlisted" procedure code that requiring a review of claim narratives to appropriately reimburse the provider for the services. The following calculation for this method is used:
Allowed Amount = allowed amount as determined

5.7 Pay as Billed

This method is identified by the pricing indicator code BILLED. Pay as billed pricing is utilized when the procedure code is new and/or does not have enough charge history to permit determining a reimbursement rate. This method is usually accompanied by a Benefit Adjustment Factor (BAF) that calculates a percentage of the billed amount. The following calculation for this method is used:
Allowed Amount = pay as billed

5.8 Birth To Three (B-3)

This method is an incentive for providers to render therapeutic services for children under the age of three who meet criteria and are enrolled in the Wisconsin Birth To 3 program. Birth To 3 services are identified by the presence of modifier TL within the THERP and REHAB contracts. Procedures listed with an entry for the TL modifier will receive an additional incentive amount of $21.50, once per date of service, per member, per discipline (Occupational therapy, Physical therapy, Speech and language pathology), when all of the following criteria are met:

- Procedure code listed in extract with entry for TL modifier
- Modifier TL submitted on claim detail containing the procedure code
- Place of service on detail equals one of the following:
  - 04 (Homeless Shelter)
  - 12 (Home)
  - 99 (Other Place of Service)
- The rendering provider type is one of the following:
  - 04 (Rehabilitation Agency)
  - 17 (Therapy Group)
  - 74 (Speech & Hearing Clinic)
  - 77 (Physical Therapy)
  - 78 (Occupational Therapist)
  - 79 (Speech-Language Pathology)

5.9 Professional Medicare Crossover Pricing

NOTES:

- Not all reimbursement amounts may appear in the max fee extracts/schedules. For procedure codes not listed and other pricing inquiries, please contact the HMO Support Help Desk at: VEDSHMOSupport@wisconsin.gov.
- Medicare Sequestration amounts are based on their inclusion on the Explanation Of Medicare Benefits (EOMB) using Claim Adjustment Reason Code (CARC) 253. Refer to the CMS website (https://www.cms.gov) for more information on the Medicare Sequestration.

PROFESSIONAL CROSSOVER CLAIMS (Claim Type B)

1. Determine the max fee on file for the procedure code.
2. Combine the coinsurance or co-payment, and psychiatric reduction amounts on that detail.
3. Determine the amount that Medicare paid on that detail plus the Medicare Sequestration.
4. Subtract the Medicare Paid amount and Sequestration from the Max Fee.
    a. If the number is negative, then the claim will pay zero coinsurance, co-payment, and psychiatric reduction. Set the allowed amount to zero. Go to step 6.
    b. If the number is positive, go to step 5.
5. Compare the positive number from step 4 to the sum in step 2. Set the allowed amount to the lesser of these amounts.
6. Add the detail deductible to the allowed amount.
7. Subtract cost share amounts (i.e., Medicaid co-payment, spend down).
8. Add all detail allowed amounts to the header deductible amount (if applicable). The allowed amount should now be the paid amount on the claim.

PROFESSIONAL CROSSOVER CLAIM EXEMPTIONS

Crossover claims are sometimes exempt from part b cutback. In this case, professional claims will pay the full coinsurance, co-payment, psychiatric reduction, and deductible. Professional crossover claims are exempt under the following conditions:

a. The pricing indicator is “BILLED”, “SYSMAN”, or “MANUAL”.
b. The detail modifier is QX, QZ, QS, QK, AA, or AD for Anesthesia.
c. The detail modifier is RR for DME rental.

6 Institutional Pricing

6.1 Outpatient Pricing

There are two methods of reimbursement associated with outpatient hospital claims. The following calculations are used depending on the provider's rate:

1. Allowed Amount = (Detail Billed Amount * Provider's Percentage)

    Note: If the provider has a rate of percent, the lab procedure codes are typically paid based on the Max Fee rates for that detail. The following is the calculation used:

    Allowed Amount = (Max Fee Rate * Units Allowed)

    Allowed Amount = Lesser of Billed Amount or Allowed Amount

2. Allowed Amount = (Per Diem Rate * Detail unduplicated dates)

The provider rates can be located on the ForwardHealth Website

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/hospital/drg/drg.htm.spage.

A file can be downloaded and contains the following information for locating the rate:

Hospital name, city, rate per visit, % of charges paid, effective date, end date.

NOTE: For dates of service on and after January 1st, 2015, most HMO Encounter submissions may utilize Enhanced Ambulatory Patient Grouping (EAPG) pricing methodologies in addition to continuing to utilize some maximum allowable fee pricing for services such as laboratory services. For additional information on this transition to EAPG pricing methodologies, please refer to the following:

ForwardHealth Portal EAPG Home Page:
https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/html/EAPG/EAPGHome.htm.spage#

For specific inquiries regarding EAPG pricing on HMO Encounter submissions, please send to: VEDSEAPGHMO@wisconsin.gov

6.2 DRG Inpatient Pricing

APR-DRG pricing logic for dates of discharge on and after January 1st, 2017:
Pricing policy documentation for the new All Patient Refined Diagnosis Related Group (APR DRG) for claims with a date of discharge on and after January 1st, 201 can be found on the ForwardHealth Portal Forward Health APR DRG MCO Technical Documentation site at:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage#fhaprdrgmco

Previous pricing logic for dates of discharge prior to January 1st, 2017:
Inpatient pricing utilizes a DRG grouper process and is provided by Information Resource Products (IRP) a third party vendor. The grouper requires specific information received from

the claim and from recipient data retrieved from the recipient subsystem to assign a DRG code per claim. Once a DRG code is assigned to the claim, the following is the calculation used for this pricing:

DRG Base Rate Calculation

DRG Allowed Amount = (Provider Base Rate * D-DRG Weight)

Cost Outlier Process

After every detail is processed, calculate the cost outlier amount as follows:

Cost Outlier Allowed amount = SUM (Billed Amount if the detail is in paid status)

Outlier = ((Cost Outlier Allowed Amount * P-Cost/Charge Rate) – (DRG Allowed Amount – P-Outlier Trim Point))

Outlier Allowed = (Outlier * (P-Paid Percentage + D-DRG Supplemental Percentage))

DRG Pricing Calculation

If the calculated Outlier allowed amount is greater than zero, add it to the DRG allowed amount.

If the calculated Outlier allowed amount is not greater than zero, the DRG allowed amount is not modified.

Allowed Amount = DRG Allowed Amount

The provider rates and weights can be located on the ForwardHealth Website https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/hospital/drg/drg.htm.spage. Files can be downloaded and contains the following information for locating the rates and weights:

Rates:
City, hospital name , DRG base rate (calculated by adding together Base Rate ,Capital Amount , and Educational Amount), cost to charge ratio, trim point, var cost factor , disproportionate percentage, effective date, end date.

DRG weights:
DRG, description of DRG, weight

6.3 Nursing Home Pricing

Nursing home stays are priced using individual nursing home provider rates. The rates per nursing home are available for download through the portal here:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/NursingHomeRateSchedule.aspx

The following is the calculation used for this pricing:

Allowed Amount (1) = (Units Allowed * Provider's Per Diem Rate)

Effective for dates of service on/after 1/1/2022, Per diem rates for Non-Developmentally Disabled level of care members are calculated using individual nursing home provider allowances and case mix indices (CMIs) from the HIPPS [Health Insurance Prospective Payment System] code submitted on the claim detail. The formula for the per diem rate calculation is:

Non-DD Per Diem Rate = (Nursing CMI x CMN DC Nursing)
+ (NTA CMI x CMN DC Other)
+ Support Services Allowance
+ Property Allowance
+ Property Tax Allowance
+ Incentives

Case Mix Neutral Direct Care (CMN DC) Nursing, CMN DC Other, Support Services Allowance, Property Allowance, Property Tax Allowance, and Incentives values are all provider specific. These rates are available through the portal link mentioned above.

The CMI paid will depend on the HIPPS code submitted. The nursing case mix index varies based on the third digit of the HIPPS code and the non-therapy ancillary (NTA) case mix index varies based on the fourth digit of the HIPPS code. ForwardHealth uses the PDPM HIPPS code set established by CMS:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/Downloads/hippsuses.pdf

See Appendix 1 for the valid HIPPS code set.

6.4 Hospice Pricing

Hospice claims are priced based on the procedure code. The rates are dependent on the provider's or recipient's county.
The following codes utilize the max fee method. The rate type will distinguish the different rates by county:

- Procedure codes G0155, G0299, T2042, T2043 are based on the recipient's county.
- Procedure codes T2044, T2045 are based on the provider's county.

Effective for claims processed on and after January 1st, 2016, procedure code T2042 will also be reimbursed based on the member's routine home days in addition to the member's county.

Rural Counties include: Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Clark, Crawford, Dodge, Door, Dunn, Florence, Forest, Grant, Green Lake, Iron, Jackson, Jefferson, Juneau, Lafayette, Langlade, Lincoln, Manitowoc, Marinette, Marquette, Monroe, Oneida, Pepin, Polk, Portage, Price, Richland, Rusk, Sauk, Sawyer, Shawano, Taylor, Trempealeau, Vernon, Vilas, Walworth, Washburn, Waupaca, Waushara, Wood, and Menominee

6.5 Institutional Medicare Crossover Pricing

NOTES:

- Not all reimbursement amounts may appear in the max fee extracts/schedules. For procedure codes not listed and other pricing inquiries, please contact the HMO Support Help Desk at: VEDSHMOSupport@wisconsin.gov.
- Medicare Sequestration amounts are based on their inclusion on the Explanation Of Medicare Benefits (EOMB) using Claim Adjustment Reason Code (CARC) 253. Refer to the CMS website (https://www.cms.gov) for more information on the Medicare Sequestration.

EAPG Eligible Outpatient Crossovers (CT C)
For EAPG eligible crossover claims pricing and payment will occur at the detail. If the Medicare dollars are received at the claim header the system will automatically spread the dollars to the details using a percent of billed calculation prior to pricing. After the calculated claim detail Medicaid allowed amount is arrived at using one of the pricing methods below, Part B cutback will be performed.

The actual pricing method applied at the detail will be determined by the reimbursement rules, either at the procedure code level or the revenue code level. The pricing methods applied to outpatient crossovers other than EAPG on and EAPG eligible claim are MAXFEE and/or percent of BILLED.

The criteria used for determining if a claim is EAPG eligible follows. Claims matching all of the criteria below are considered EAPG Eligible. If the criteria are not met, the claims will be considered EAPG Exempt.

Billing Provider Type	"01" or "58"
Header From DOS	FDOS on or after 01/01/2015.

EAPG Pricing Methodology
The EAPG pricing method calls the 3M EAPG grouper/pricer software to determine the allowed amount on each of the claim details that are to be priced under the EAPG pricing method. All the paid status details that are to be priced under EAPG are sent to the grouper at one time. The EAPG pricing method works the same for both straight outpatient claims (claim type = O) and outpatient crossovers (claim type = C).

1. The EAPG software will first edit the input and, if there are no major errors, group the details assigning an EAPG to each. Laboratory services are excluded from EAPG processing.
2. The software will determine if any of the details is to be packaged receiving a zero weight and a zero allowed and paid amount at the detail level.
3. The weight for each EAPG is retrieved and stored at the detail for processing.
4. The EAPG software will determine is any discounting (significant procedure, repeat ancillary, or bilateral) is to be applied to the weight at the detail.
5. After all calculations against the weights have been completed the allowed amount for the detail will be calculated by multiplying the weight by the provider EAPG rate (stored on the provider's EAPG schedule which is used by the EAPG software for processing).

MAXFEE Pricing Methodology
Under the MAXFEE pricing method the system will price the service using the max fee on file. See the Pricing Manual for more information on the MAXFEE pricing method and the guidelines for applying this pricing method to outpatient and outpatient crossover claims and encounters.

BILLED Pricing Methodology
Under the BILLED pricing method the system will price the service using the billed amount on the detail. A Benefit Adjustment Factor (BAF) may also be configured to adjust the allowed amount up or down by some percentage (for example, most service priced in this manner are reimbursed 80% of the billed amount). See the Pricing Manual for more information on the Pay as Billed pricing method and the guidelines for applying this pricing method to outpatient and outpatient crossover claims and encounters.

Calculate Medicare Part B Cutback
There are a couple different outcomes to determining how Medicaid will pay the coinsurance or co-payment (outpatient claims do not have psychiatric reduction). Deductible and Blood Deductible (not likely to be present in production on outpatient claims) are always paid in full.

1. Combine the detail Medicare coinsurance and co-payment amounts.
2. Subtract the detail Medicare Paid and Sequestration amount from the allowed amount at the detail.
    a. If the number is negative, then the detail will pay zero coinsurance or co-payment. Set the allowed amount to zero. Go to step 4.
    b. If the number is positive, go to step 3.
3. Compare the positive number from step 2 to the sum in step 1. Set the detail allowed amount to the lesser of these amounts.
4. Add the detail Medicare deductible and blood deductible (if applicable) to the detail allowed amount.
5. Subtract cost share amounts (i.e., Medicaid co-payment, spend down).
6. The detail allowed amount should now be the paid amount on the claim.

Non-EAPG Eligible Outpatient Crossovers (CT C)
EAPG exempt outpatient crossover claims are priced at the detail level and paid at the header level using information summed from all claim details. The provider Hospital Outpatient Rate is used to compare to the Medicare Paid and Sequestration amount to determine part b cutback. There are different outcomes to determining how Medicaid will pay the coinsurance or co-payment (outpatient claims do not have psychiatric reduction). Deductible and Blood Deductible (not likely to be present in production on outpatient claims) are always paid in full.

1. Determine the price from the Provider file.
2. Combine the sum of all detail and header coinsurance or co-payment amounts. Note that if the provider has no applicable Hospital Outpatient Rate the sum of the detail and header coinsurance or copayment amounts will be the allowed amount – go to Step 5.
3. Sum the header and detail Medicare Paid amounts plus the Medicare Sequestration.
4. Subtract the Medicare Paid amount sum and Sequestration from the Provider's price[38].
    a. If the number is negative, then the claim will pay zero coinsurance or co-payment. Set the allowed amount to zero. Go to step 6.
    b. If the number is positive, go to step 5.
5. Compare the positive number from step 4 to the sum in step 2. Set the allowed amount to the lesser of these amounts.
6. Add the deductible and blood deductible (if applicable) to the allowed amount.

7. Subtract cost share amounts (i.e., Medicaid co-payment, spend down).
8. The allowed amount should now be the paid amount on the claim.

[1]For ESRD claims (PT 30) where the dialysis revenue codes are denied for managed care there may be payable administrative drug procedure codes on certain details. If so the summed allowable maxfee amount for all of those details will be used in Step 4 instead of the Provider's price.

INPATIENT AND NURSING HOME CROSSOVER CLAIMS (Claim Type A)

Nursing Home Crossover claims (CT A) are not subject to part b cutback and will always pay the full coinsurance, co-payment, deductible, and blood deductible in full.

Effective for process dates after September 12, 2011, Inpatient Crossover claims (CT A, TOB '1xx') are processed through the DRG Grouper and then priced & paid at the header level using a 'Part A' cutback process. The provider DRG (or Inpatient) Rate is used to compare to the Medicare Paid plus the Medicare Sequestration amount to determine part A cutback. Unlike the part B cutback process, Medicare Deductible and Blood Deductible (if present) is not paid in full; rather it is included in the cutback comparison logic.

1. Determine the DRG rate (weight) from the provider file.
2. Determine rate information from the Provider file.
3. Subtract the (header) Medicare Paid and Sequestration amount from the Provider's price.
    a. If the number is negative, then the claim will pay zero. Set the allowed amount to zero.
    b. If the number is positive, go to step 4.
4. Compare the positive number from step 3 to the sum of the (header) Medicare coinsurance, copayment, deductible and blood deductible. Set the allowed amount to the lesser of these amounts.
5. Subtract cost share amounts (i.e., Medicaid co-payment, spend down).
6. The allowed amount should now be the paid amount on the claim.

INSTITUTIONAL CROSSOVER CLAIM EXEMPTIONS

Crossover claims are sometimes exempt from part b cutback. In this case, outpatient Claims will pay the full coinsurance, co-payment, and deductible. Outpatient crossover claims are exempt under the following conditions:

a. The provider type/specialty is not one of the following:
   PT 01/Spec 010, PT 30/Spec 080, PT 30/Spec 300, PT 30/Spec 301, PT 58/Spec 010, PT 58/Spec 712, PT 58/Spec 713, PT 67/Spec 010, PT 67/Spec 080, PT 67/Spec 801, PT 67/Spec 802, PT 67/Spec 803.
b. The revenue code is 253, 820, or 821 and the provider has an "out of state" or "border" status.

Appendix 1 - HIPPS Code Set for Nursing Home Pricing

Physical/Occupational Therapy		
HIPPS Code	Description	CMI
A	TA - PT/OT CASE MIX GROUP	NA
B	TB - PT/OT CASE MIX GROUP	NA
C	TC - PT/OT CASE MIX GROUP	NA
D	TD - PT/OT CASE MIX GROUP	NA
E	TE - PT/OT CASE MIX GROUP	NA
F	TF - PT/OT CASE MIX GROUP	NA
G	TG - PT/OT CASE MIX GROUP	NA
H	TH - PT/OT CASE MIX GROUP	NA
I	TI - PT/OT CASE MIX GROUP	NA
J	TJ - PT/OT CASE MIX GROUP	NA
K	TK - PT/OT CASE MIX GROUP	NA
L	TL - PT/OT CASE MIX GROUP	NA
M	TM - PT/OT CASE MIX GROUP	NA
N	TN - PT/OT CASE MIX GROUP	NA
O	TO - PT/OT CASE MIX GROUP	NA
P	TP - PT/OT CASE MIX GROUP	NA
Z	DEFAULT CODE - SNF PDPM	NA

Speech Language Pathology		
HIPPS Code	Description	CMI
A	SA - SLP CASE MIX GROUP	NA
B	SB - SLP CASE MIX GROUP	NA
C	SC - SLP CASE MIX GROUP	NA
D	SD - SLP CASE MIX GROUP	NA
E	SE - SLP CASE MIX GROUP	NA
F	SF - SLP CASE MIX GROUP	NA
G	SG - SLP CASE MIX GROUP	NA
H	SH - SLP CASE MIX GROUP	NA
I	SI - SLP CASE MIX GROUP	NA
J	SJ - SLP CASE MIX GROUP	NA
K	SK - SLP CASE MIX GROUP	NA

L	SL - SLP CASE MIX GROUP	NA
Z	DEFAULT CODE - SNF PDPM	NA

Nursing		
HIPPS Code	Description	CMI
A	ES3 - NURSING CASE MIX GROUP	3.84
B	ES2 - NURSING CASE MIX GROUP	2.9
C	ES1 - NURSING CASE MIX GROUP	2.77
D	HDE2 - NURSING CASE MIX GROUP	2.27
E	HDE1 - NURSING CASE MIX GROUP	1.88
F	HBC2 - NURSING CASE MIX GROUP	2.12
G	HBC1 - NURSING CASE MIX GROUP	1.76
H	LDE2 - NURSING CASE MIX GROUP	1.97
I	LDE1 - NURSING CASE MIX GROUP	1.64
J	LBC2 - NURSING CASE MIX GROUP	1.63
K	LBC1 - NURSING CASE MIX GROUP	1.35
L	CDE2 - NURSING CASE MIX GROUP	1.77
M	CDE1 - NURSING CASE MIX GROUP	1.53
N	CBC2 - NURSING CASE MIX GROUP	1.47
O	CA2 - NURSING CASE MIX GROUP	1.03
P	CBC1 - NURSING CASE MIX GROUP	1.27
Q	CA1 - NURSING CASE MIX GROUP	0.89
R	BAB2 - NURSING CASE MIX GROUP	0.98
S	BAB1 - NURSING CASE MIX GROUP	0.94
T	PDE2 - NURSING CASE MIX GROUP	1.48
U	PDE1 - NURSING CASE MIX GROUP	1.39
V	PBC2 - NURSING CASE MIX GROUP	1.15
W	PA2 - NURSING CASE MIX GROUP	0.67
X	PBC1 - NURSING CASE MIX GROUP	1.07
Y	PA1 - NURSING CASE MIX GROUP	0.62
Z	DEFAULT CODE - SNF PDPM	0.62

Non-Therapy Ancillary		
HIPPS Code	Description	CMI
A	NA - NTA CASE MIX GROUP	3.06
B	NB - NTA CASE MIX GROUP	2.39
C	NC - NTA CASE MIX GROUP	1.74
D	ND - NTA CASE MIX GROUP	1.26

E	NE - NTA CASE MIX GROUP	0.91
F	NF - NTA CASE MIX GROUP	0.68
Z	DEFAULT CODE - SNF PDPM	0.68

Assessment Indicator		
HIPPS Code	Description	CMI
NA	INTERIM PAYMENT ASSESSMENT	NA
1	5-DAY	NA
6	OBRA ASSESSMENT	NA
Z	DEFAULT CODE - SNF PDPM	NA

Change Log

The following table reviews the major edits and modifications:

Date / Version	Section	Edit
April 1, 2008 Version 1.0	Created Document	
May 28, 2008 Version 1.1	Updates	➢ Page 2 – Updated examples and added "max fee" ➢ Page 3 – Typo; from = to + ➢ Page 3 – BAF max field length ➢ Page 4 – Updated record example ➢ Page 6 – Updated BP list to include BCBEE ➢ Page 28 – Added NH extract field layout ➢ Page 32 – Updated source for NH rates
July 8, 2008 Version 1.2	Updates	➢ Page 3 – Added "end of record" ➢ Page 5 and 6 – Updated contract table to include contract criteria ➢ Page 12 and 13 – Updated rate type table to include modifiers for specific rate types ➢ Page 14 through 25 – Updated BAF table to include applicable contracts ➢ Page 31 – Added rural hospice counties
November 1, 2008 Version 1.2	Updates	➢ TOC – Updated with current page numbers ➢ Page 2 – Updated age field length ➢ Page 5 – Updated Provider Contract table and added rate type column and criteria. ➢ Page 8 – Clarified PT/PS values for a performing provider. ➢ Page 14 – Removed a discontinued rate type KSC ➢ Page 14 – Updated rate type table to include current rate types and criteria ➢ Page 16 – Updated list with current BAF's ➢ Page 29 – Clarified BAF methodology

Date / Version	Section	Edit
January 29, 2009 Version 1.3	Updates	➢ TOC – Updated with current page numbers ➢ Page 4 – Updated Field Layout for the BC+ BM Billing Indicator ➢ Page 5-6 – Updated Examples to include new BC+ values ➢ Page 9 – Updated Benefit Plan list
August 6, 2009 Version 1.4	Updates	➢ Page 8 – Updated MEDSV rate type ➢ Page 9-10 – Added additional provider contracts and descp. ➢ Page 10 – Added new benefit plan
November 2, 2009 Version 1.5	Updates	➢ Page 25-26, 29 – Added new BAFs: FFPCCS6021, FFPMH6021, FFPCSMG09, FFPCMKID09, U1ADMIN394 ➢ Page 19 – Added new Rate Types: PE1, PE2, PEA, PEM, PEO
January 7, 2010 Version 1.6	Updates	➢ Miscellaneous grammatical changes ➢ Page 31-35 – Updated pricing methods
February 2, 2010 Version 1.7	Updates	➢ Page 9 – Updated descp MHPW and added new contract DMSJB ➢ Page 13 – Added new PT/PS 25/251 ➢ Page 18-19 – Added additional rate types ➢ Page 26 – Added additional BAFs
March 1, 2010 Version 1.8	Updates	➢ All – Changes EDS references to HP. ➢ Page 25 – Added additional BAF FFPCCS5841.
August 1, 2010 Version 1.9	Updates	➢ Page 4-5 – Updated field layout ➢ Pages 5-10 – Updated record examples
October 4, 2010 Version 2.0	Updates	➢ Pages 5-8 – Updated record examples ➢ Page 12 – Added LTC and MHCRS to contract code tables. ➢ Page 14 – Added new PT/PS 13/130 ➢ Page 18 – Added new pricing indicator BILLED ➢ Page 19-21 – Updated rate types to include C06, C55, C56 and CMC ➢ Page 27-29 – Updated BAF table with the new Federal Share BAFs and Dental BAF. ➢ Pages 34-35 – Added examples of the BAF calculations. ➢ Page 37 – Added pay as billed pricing method.

Date / Version	Section	Edit
October 20, 2010 Version 2.1	Updates	➢ Pages 21-32 – Updated BAF list to include new MEDSV, DME, WCDK, CRS BAFs. Also removed some duplicate/obsolete BAFs.
November 10, 2010 Version 2.2	Updates	➢ Pages 5-8 – Updated all extract layout examples
January 3, 2012 Version 2.3	Updates	➢ All pages – Reorganized/alphabetized tables as applicable, including the update of values to match those currently present in max fee extract. ➢ Page 37 – Inserted pricing methodology for Birth To 3 program.
April 19, 2012 Version 2.4	Updates	➢ Page 9 – Update DMSJB contract-specific provider to identify J & B Medical vendor provider type/specialty. ➢ Page 12 – Added information pertaining to new ESRD reimbursement policy, including URL of relevant Medicaid Provider *Update*.
July 16, 2012 Version 2.5	Updates	➢ Cover – Updated ForwardHealth fiscal agent physical address ➢ Page 22 – Added 80HOSPL BAF for hospital/ASC place of service-based reimbursement reduction ➢ Page 29 – Added new SBS federal share BAF.
October 12, 2012 Version 2.6	Updates	➢ Pages 28-29 – Added new mental health, CCS, and case management BAFs.
February 28, 2013 Version 2.7	Updates	➢ Page 10 – Added HIVHH to list of Provider Contracts. ➢ Page 21 – Added QTT rate type for Qualified Treatment Trainee providers. ➢ Page 37 – Clarified rounding unit for anesthesia pricing.
January 7, 2014 Version 2.8	Updates	➢ Pages 11-12 – Updated/clarified provider contracts listing to include outpatient hospital (OUTPA) to document max fee reimbursement on laboratory services. ➢ Page 18 – Added specialty 784 (PIHP) to PT 65 (HMO/MCO) provider type listing. ➢ Page 20 – Added rate type LAC for OUTPA provider contract laboratory services. ➢ Page 24 – Removed obsolete DNTL170 benefit adjustment factor (BAF). ➢ Pages 28-29 – Added benefit adjustment factors (BAFs) for FY 2014 federal share programs (mental health/school based services). Removed obsolete BAFs.
April 21, 2014 Version 2.9	Updates	➢ Pages 4, 12-13 – Added statement to BadgerCare Plus plans that are obsolete as of April 1st, 2014. ➢ Page 18 – Added new provider specialty for HealthCheck "Other"
August 20, 2014 Version 3.0	Updates	➢ Pages 10-11, 19 – Added clarification regarding obsolete CCS, Crisis Intervention, and CSP provider specialties, and added new CCS provider type/specialties. ➢ Page 30 – Added BAF for SBS program for claims processed on/after October 1st, 2014.

Date / Version	Section	Edit
October 17, 2014 Version 3.1	Updates	➢ Page 19 – Updated description for provider type 80 to remove CCS (CCS is now certified under provider type 82). ➢ Pages 29-30, 32 – Updated Benefit Adjustment Factors (BAFs) list to include new BAFs for FY 2015 and new Outpatient BILLED BAF.
January 14, 2015 Version 3.2	Updates	➢ Pages 10, 20 – Removed Provider Contract MHADC (Autism Evaluation) and associated Rate Type C31 from respective listings. ➢ Page 39 – Corrected misspelling on Pay As Billed description. ➢ Page 40 – Added note regarding EAPG pricing implementation, along with reference and contact information.
July 13, 2015 Version 3.3	Updates	➢ Page 22 – Added T18 to Rate Type table. ➢ Page 32 – Added OPXOVER80 to Benefit Adjustment Factor table.
October 14, 2015 Version 3.4	Updates	➢ Cover – Updated Hewlett Packard Enterprise Logo/Company Name. ➢ Pages 29-30 – Update Benefit Adjustment Factors (BAFs) list to include new BAFs for FY 2016.
January 13, 2016 Version 3.5	Updates	➢ Page 17 – Added new behavioral treatment provider type 34 and specialties 400-404. ➢ Page 24 – Removed BAF DNTL 1117 from listing. ➢ Page 30 – Corrected title of BAF for mental health claims processed on/after 10/1/15 (should be FFPMH5823).
April 6, 2016 Version 3.6	Updates	➢ Page 5 – Added Routine Home Days field to Max Fee layout. ➢ Pages 6-8 – Added delimiter to existing max fee layout examples, and added new example displaying Routine Home Days field. ➢ Page 10 – Added additional contract specific rate types for HOSPC provider contract. ➢ Page 21 – Added HIV/AIDS Health Home rate type C57. ➢ Pages 22-23 – Added new HOSPC provider contract rate types. ➢ Pages 31-33, 38 – Updated HPSA BAFs to remove obsolete modifiers QB and QU. ➢ Page 39 – Clarified anesthesia relative value usage. ➢ Page 42 – Added Routine Home Days to the Hospice Pricing outline and removed Green County from the list of rural counties for hospice pricing.
November 4, 2016 Version 3.7	Updates	➢ Page 23 – Corrected Rate Type for Sheboygan County. ➢ Pages 30-31 – Update Benefit Adjustment Factors (BAFs) list to include new BAFs for FY 2017.

Date / Version	Section	Edit
January 4, 2017 Version 3.8	Updates	➢ Page 11 – Added Certified Nurse Midwives (MIDWF) provider contract to provider contract listing. ➢ Page 17 - Added new provider type 35 (Licensed Midwife) to provider type listing. ➢ Page 21 – Added rate type C68 (CERT PROF MIDWIVES) to rate type listing. ➢ Page 29 – Removed obsolete DNTL6728 and DNTL7637 BAFs from BAF listing. ➢ Page 37 – Added reference to new increased dental reimbursement for providers in certain counties to Max Fee Pricing section. ➢ Page 41 – Added reference to new APR DRG reimbursement methodology for inpatient hospital pricing.
April 3, 2017 Version 3.9	Updates	➢ All – Revised document to replace HPE logo and verbiage with DXC Technology. ➢ Page 9 – Added new provider contract CRMGT to listing. ➢ Page 20 – Added new WIMCR provider type 83 to listing. ➢ Page 21 – Corrected spelling of 'Miscellaneous' in for rate type C52. ➢ Page 21 – Added new rate type C69 to listing.
July 17, 2017 Version 3.10	Updates	➢ Pages 41, 44-48 - Added Medicare crossover pricing information for professional and institutional claims.
October 2, 2017 Version 4.0	Updates	➢ Pages 14-19 – Updated description of provider specialty 080. ➢ Pages 30-31 – Updated Benefit Adjustment Factors (BAFs) list to include new BAFs for FY 2018.
January 8, 2018 Version 4.1	Updates	➢ Page 9 - Added C4K provider contract. ➢ Page 20 – Corrected specialty number for WIMCR Non-Lead 2 specialty. ➢ Page 21 - Added C4K provider contract rate type C71. ➢ Page 22 - Added PT/PS Specific rate type PT7. ➢ Page 28 – Removed obsolete Benefit Adjustment Factor (BAF) DNTL360.
April 11, 2018 Version 4.2	Updates	➢ Page 19 – Added FQHC specialty 081 to provider type/specialty listing. ➢ Page 24 – Updated descriptions of BAFs 60 and 80 to incorporate DME provider contract use.
July 9, 2018 Version 4.3	Updates	➢ Page 10 – Updated provider contract HCMCR to indicate change in use of contract for CMC benefit. ➢ Page 21 – Removed rate type C18 from Rate Type Codes section. This rate type is used for the HCMCR contract, which is being removed from the max fee extract due to its modified use for the CMC benefit.
October 2, 2018 Version 4.4	Updates	➢ Page 9 – Updated CSMGT contract information to reflect changes for tribal case management reimbursement. ➢ Page 10 – Removed contract HCMCR from contract listing. ➢ Page 22 – Added new rate type T09 for tribal case management. ➢ Pages 30-31 – Updated Benefit Adjustment Factors (BAFs) list to include new BAFs for FY 2019.

Date / Version	Section	Edit
January 16, 2019 Version 4.5	Updates	➢ Page 29 – Removed BAF DNTL806 from Benefit Adjustment Factor listing. ➢ 44 – Added procedure codes G0199 and G0255 to hospice pricing list based on member's county of residence.
April 1, 2019 Version 4.6	Updates	➢ Page 10 – Corrected mis-spelling on MED rate type description.
July 19, 2019 Version 4.7	Updates	➢ Page 42 – Corrected mis-spelling on Medicare crossover pricing indicator BILLED.
October 14, 2019 Version 4.8	Updates	➢ All – Minor formatting to entire document for consistency of text spacing. ➢ Page 30-31 – Updated Benefit Adjustment Factors (BAFs) list to include new BAFs for FY 2020.
January 9, 2020 Version 4.9	Updates	➢ Page 20 – Added new SUD provider type 84 to listing. ➢ Page 31 – Updated Benefit Adjustment Factors (BAFs) list to include new BAF for Crisis Intervention.
April 8, 2020 Version 5.0	N/A	No updates this quarter.
July 13, 2020 Version 5.1	Updates	➢ Page 20 – Added new EVV provider type 85 and specialties 858, 859 and 860 to listing. ➢ Pages 31 and 32 – Updated Benefit Adjustment Factors (BAFs) list to include new BAFs for COVID-19 pandemic.
October 6, 2020 Version 5.2	Updates	➢ Pages 31 and 32 – Updated Benefit Adjustment Factors (BAFs) list to include new BAFs and remove obsolete BAFs.
January 11, 2021 Version 5.3	Updates	➢ Page 13 – Updated Contract code listing ➢ Pages 16 and 20 – Updated PT/PS listing ➢ Pages 21 and 22 – Updated Pricing Indicator Codes ➢ Pages 31 and 32 – Updated BAF listing ➢ Updated File header and formatting from DXC to Gainwell
May 4, 2021 Version 5.4	N/A	➢ No updates this quarter.
July 28, 2021 Version 5.5	Updates	➢ Page 13 – Section 3.3 Added PT 07/70 to Provider Types listing.
October 8, 2021 Version 5.6	Updates	➢ Page 11 – Section 3.1 added CCFWM contract ➢ Page 34 – Updated BAF listing
January 25, 2022 Version 5.7	Updates	➢ Page 9 – Updated DTMED rate type value ➢ Page 15 – Added CRT Provider type code ➢ Pages 22-23 – Updated available rate type values ➢ Pages 30-33 – Updated available BAF codes ➢ Page 48 – Updated Nursing Home Pricing Section for HIPPS Pricing. ➢ Page 53 – Added Appendix 1 to list out HIPPS code set
May 26, 2022 Version 5.8	Updates	➢ Pages 30 – 32 Removed absolute BAF codes ➢ Pages 38 – 43 Added new BAF codes
July 21, 2022 Version 5.9	Updates	➢ Pages 28 – 30 Added Rate Type codes ➢ Pages 35 – 61 Added new DNTL, OBOT BAF codes

Date / Version	Section	Edit
September 22, 2022 Version 6.0	Updates	➢ Added Section 2.2 for the file layouts of the enhanced max fee extract files.
January 9, 2023 Version 6.1	Updates	➢ Page 35 – Section 3.3.2 updated Benefit Plan code listing ➢ Page 45 – Section 3.3.3 added Provider Specialty ➢ Page 46 – Section 3.3.4 updated Pricing Indicator listing ➢ Page 67 – 70 Section 3.3.6 added BAF codes
April 4, 2023 Version 6.2	Updates	➢ Page 67 – 71 Section 3.3.6 added BAF codes
July 6, 2023 Version 6.3	Updates	➢ Page 42 – Section 3.3.3 added Provider Specialty ➢ Page 67 – 72 Section 3.3.6 added BAF codes
October 2, 2023 Version 6.4	Updates	➢ Page 11 – Section 2.2.1 Update Max length of Procedure code ➢ Page 17 - Section 2.2.2 Update Max length of Procedure code ➢ Page 20 – Section 2.2.3 Update Max length of Procedure code ➢ Page 67 – 89 Section 3.3.6 added BAF codes
November 3, 2023 Version 7.0	Updates	➢ Page 9 – Section 2.2 updated file names ➢ Page 10 – 16 Section 2.2.1 updated file name and added new fields ➢ Page 17 – 18 Section 2.2.2 updated file name and added new fields ➢ Page 20 – 24 Section 2.2.3 updated file name and added new fields ➢ Page 25 – Section 2.2.4 updated file name ➢ Page 26 – Section 2.2.5 updated file name and added new code descriptions
December 6, 2023 Version 7.1	Updates	➢ Page 35 – Section 3.3.3 added Provider Type and Specialty ➢ Page 55 – 56 Section 3.3.6 added BAF codes
January 8, 2024 Version 7.2	Updates	➢ Page 34 – 35 Section 3.3.3 added Provider Type and Specialty ➢ Page 57 – 59 Section 3.3.6 added BAF codes
March 13, 2024 Version 7.3	Updates	➢ Page 83 – 85 Appendix 1 updated HIPPS codes.
April 1, 2024 Version 7.4	Updates	➢ Page 65 – Section 3.3.6 added BAF codes
May 16, 2024 Version 7.5	Updates	➢ Page 9 – Section 2.2 Update Enhanced Max Fee data.