

Managed Care Organization

Pricing Administration Guide

Version 7.0

Date Last Updated: November 27, 2023

Wisconsin ForwardHealth

TABLE OF CONTENTS

[1 Introduction 2](#_Toc150349997)

[1.1 Introduction 2](#_Toc150349998)

[2 Max Fee Extract Field Layout 3](#_Toc150349999)

[2.1 Legacy Max Fee Extract (HMO\_MAX\_FEE.txt) Field Layout 3](#_Toc150350000)

[2.2 Enhanced Max Fee Extract Field Layout 9](#_Toc150350001)

[2.2.1 ForwardHealth Coverage File Layout (ForwardHealth\_Coverage\_MMIS\_Business\_Rules\_Comprehensive.txt) 10](#_Toc150350002)

[2.2.2 Managed Care Coverage File Layout (MCO\_Carve-in\_Carve-out\_MMIS\_Business\_Rules\_Comprehensive.txt) 16](#_Toc150350003)

[2.2.3 ForwardHealth Pricing File Layout (ForwardHealth\_Pricing\_MMIS\_Business\_Rules\_Comprehensive.txt) 19](#_Toc150350004)

[2.2.4 Group to Code File Layout (GroupToCode\_MMIS\_Business\_Rules\_Comprehensive.txt) 25](#_Toc150350005)

[2.2.5 Code Description File Layout (CodeDescription\_MMIS\_Business\_Rules\_Comprehensive.txt) 26](#_Toc150350006)

[3 Max Fee Extract Code Values and Descriptions 28](#_Toc150350007)

[3.1 Provider Contract Codes 28](#_Toc150350008)

[3.2 Benefit Plan Codes 32](#_Toc150350009)

[3.3 Provider Type and Specialty Codes 32](#_Toc150350010)

[3.4 Pricing Indicator Codes 40](#_Toc150350011)

[3.5 Rate Type Codes 41](#_Toc150350012)

[3.6 Benefit Adjustment Factor (BAF) Codes 44](#_Toc150350013)

[4 Nursing Home Extract Field Layout 70](#_Toc150350014)

[4.1 Field Layout 70](#_Toc150350015)

[5 Professional Pricing 71](#_Toc150350016)

[5.1 Max Fee Pricing 71](#_Toc150350017)

[5.2 Benefit Adjustment Factor Pricing 71](#_Toc150350018)

[5.3 Anesthesia Pricing 73](#_Toc150350019)

[5.4 Contracted Rate Pricing 73](#_Toc150350020)

[5.5 UCC Pricing 73](#_Toc150350021)

[5.6 Manual Pricing 73](#_Toc150350022)

[5.7 Pay as Billed 74](#_Toc150350023)

[5.8 Birth To Three (B-3) 74](#_Toc150350024)

[5.9 Professional Medicare Crossover Pricing 74](#_Toc150350025)

[6 Institutional Pricing 76](#_Toc150350026)

[6.1 Outpatient Pricing 76](#_Toc150350027)

[6.2 DRG Inpatient Pricing 76](#_Toc150350028)

[6.3 Nursing Home Pricing 77](#_Toc150350029)

[6.4 Hospice Pricing 78](#_Toc150350030)

[6.5 Institutional Medicare Crossover Pricing 78](#_Toc150350031)

[Appendix 1 - HIPPS Code Set for Nursing Home Pricing 82](#_Toc150350032)

[7 Change Log 85](#_Toc150350033)

# Introduction

## 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.

# 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.

## 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 |
| 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](https://www.forwardhealth.wi.gov/kw/pdf/2015-64.pdf) 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

## Enhanced Max Fee Extract Field Layout

The Enhanced Max Fee Extract is separated into five separate files, which are packaged in a .zip file and sent to the SFTP server monthly.

(See MMIS\_Business\_Rules\_Comprehensive\_CCYYMMDD.zip.)

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 Comprehensive 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 Comprehensive 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 Comprehensive File:* Provides** rules for determining the Medicaid allowed amount for the service.

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.)

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

### 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]](#footnote-2) | 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. |
| 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]](#footnote-3) | Alpha-Numeric Character | 100 | Y | I~70;72;73;74 | Identifies the claim media and type of submission. |
| Claim Type[[3]](#footnote-4) | 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]](#footnote-5) | Alpha-Numeric Character | 100 | Y | I~FPW~1-1 | Current Benefit Plan of member. |
| Diagnosis Detail (Any Group)[[5]](#footnote-6) | 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]](#footnote-7) | 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. |
| PRO Type/Specialty[[7]](#footnote-8) | 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]](#footnote-9) | 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]](#footnote-10) | 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. |
| 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]](#footnote-11) | 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]](#footnote-12) | 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. |
| 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]](#footnote-13) | 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. |
| Program Code[[13]](#footnote-14) | 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]](#footnote-15) | 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]](#footnote-16) 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| | | | | | | | | | | | | | |

### 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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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]](#footnote-17) | Alpha-Numeric Character | 100 | Y | E~70;72;73;74 | Identifies the claim media and type of submission. |
| Claim Type[[17]](#footnote-18) | 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]](#footnote-19) | 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]](#footnote-20) | 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]](#footnote-21) | 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]](#footnote-22) | 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. |
| 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]](#footnote-23) 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

### 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. |
| 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]](#footnote-24) | 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]](#footnote-25) | 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 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]](#footnote-26) | 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]](#footnote-27) | 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]](#footnote-28) | Alpha-Numeric Character | 100 | Y | E~BCBPD;BCBEE | Current Benefit Plan of member. |
| Explanation of Benefits (EOB)[[28]](#footnote-29) | 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]](#footnote-30) | Alpha-Numeric Character | 20 | Y | E~101 | Geographic Location Group for performing provider – used for HPSA incentive program. |
| Geographic Location Group – Recipient[[30]](#footnote-31) | 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]](#footnote-32) | 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. |
| Performing Provider Type / Specialty[[32]](#footnote-33) | 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]](#footnote-34) | 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. |
| 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]](#footnote-35) | 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]](#footnote-36) 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

### 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]](#footnote-37) | Varchar2 | 9 | N | Group number which appears on the ‘FFS Coverage’ file. |
| Diagnosis Code[[37]](#footnote-38) | 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

### 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

# Max Fee Extract Code Values and Descriptions

## 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 |
| 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  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](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) 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 chronic asthma, diabetes and/or hypertension. | Modifier HE or HF | C53 |
| 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 |
| 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 |

## 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 |

## 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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](http://codelists.wpc-edi.com/mambo_properties_2.asp?IndexID=7329) |
| 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](http://codelists.wpc-edi.com/mambo_properties_2.asp?IndexID=7333) |
| 31 | Physician | 319 | [General Surgery](http://codelists.wpc-edi.com/mambo_properties_2.asp?IndexID=7327) |
| 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 |
| 33 | Physician Group | 310 | [Allergy & Immunology](http://codelists.wpc-edi.com/mambo_properties_2.asp?IndexID=7329) |
| 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](http://codelists.wpc-edi.com/mambo_properties_2.asp?IndexID=7333) |
| 33 | Physician Group | 319 | [General Surgery](http://codelists.wpc-edi.com/mambo_properties_2.asp?IndexID=7327) |
| 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](https://www.forwardhealth.wi.gov/kw/pdf/2016-51.pdf) 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 |
| 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 |
| 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](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) for more information) |
| 82 | Comprehensive Community Services (CCS) | 851 | Regional Non-Lead  (refer to ForwardHealth *Update* [2014-42](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) for more information) |
| 82 | Comprehensive Community Services (CCS) | 852 | Regional Pop/Shared/51.42  (refer to ForwardHealth *Update* [2014-42](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) for more information) |
| 82 | Comprehensive Community Services (CCS) | 853 | Non-Regional Matching Funds  (refer to ForwardHealth *Update* [2014-42](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) for more information) |
| 82 | Comprehensive Community Services (CCS) | 854 | Non-Regional DQA  (refer to ForwardHealth *Update* [2014-42](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) for more information) |
| 82 | Comprehensive Community Services (CCS) | 855 | Non-Regional Both  (refer to ForwardHealth *Update* [2014-42](https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf) 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 |

## 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. |
| **SYSMAN** | The system suspends the claim for manual pricing. |
| **UCCALL** | The system utilizes the providers UCC. |

## 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 |
| 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) |
| 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 |
| 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 |

## 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| FFPCRS6510 | Enhanced Federal share percentage for Community Recovery Services (CRS) for dates of process on/after 04/01/2023. |  | .6510 | After |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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 |
| 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. |  | 102.3839 | After |
| OBOT102596 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 102.5962 | After |
| OBOT102648 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 102.6487 | After |
| OBOT103158 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.158 | After |
| OBOT103294 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.2943 | After |
| OBOT103407 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.4076 | After |
| OBOT103588 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.588 | After |
| OBOT103659 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.6598 | After |
| OBOT103903 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.9032 | After |
| OBOT103972 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 103.9725 | After |
| OBOT104116 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.1168 | After |
| OBOT104210 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.2108 | After |
| OBOT104336 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.3366 | After |
| OBOT104378 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.3783 | After |
| OBOT104413 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.4132 | After |
| OBOT104792 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.7926 | After |
| OBOT104965 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 104.9656 | After |
| OBOT105219 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.2197 | After |
| OBOT105227 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.227 | After |
| OBOT105237 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.2377 | After |
| OBOT105325 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.3256 | After |
| OBOT105516 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.5165 | After |
| OBOT105629 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.6291 | After |
| OBOT105808 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.8085 | After |
| OBOT105937 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 105.9379 | After |
| OBOT106255 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 106.2553 | After |
| OBOT106883 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 106.8834 | After |
| OBOT107104 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 107.1042 | After |
| OBOT107492 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 107.4926 | After |
| OBOT107649 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 107.6497 | After |
| OBOT107894 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 107.8944 | After |
| OBOT107958 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 107.9583 | After |
| OBOT108249 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 108.2491 | After |
| OBOT108250 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 108.2508 | After |
| OBOT108668 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 108.6681 | After |
| OBOT108700 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 108.7004 | After |
| OBOT108841 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 108.8418 | After |
| OBOT109023 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 109.0233 | After |
| OBOT109167 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 109.1675 | After |
| OBOT110377 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 110.3777 | After |
| OBOT110621 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 110.6211 | After |
| OBOT111001 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 111.0011 | After |
| OBOT111200 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 111.2007 | After |
| OBOT111530 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 115.53 | After |
| OBOT111800 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 111.8002 | After |
| OBOT112049 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 112.0494 | After |
| OBOT112972 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 112.9721 | After |
| OBOT112972 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 112.9721 | After |
| OBOT113387 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 113.3873 | After |
| OBOT113683 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 113.6836 | After |
| OBOT114412 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 114.4125 | After |
| OBOT115934 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 115.9342 | After |
| OBOT116624 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 116.6248 | After |
| OBOT117898 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 117.898 | After |
| OBOT118473 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 118.4738 | After |
| OBOT118887 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 118.8878 | After |
| OBOT119888 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 119.8886 | After |
| OBOT129939 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 129.9394 | After |
| OBOT132249 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 132.2497 | After |
| OBOT133203 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 133.2034 | After |
| OBOT133231 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 133.2317 | After |
| OBOT133985 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 133.9858 | After |
| OBOT135796 | Office Based Opioid Treatment (OBOT) $5 incentive when HG modifier is present. |  | 135.7961 | 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 |
| 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 |
| 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 |
| 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

# Professional Pricing

## 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](https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/dentist/Dental_pilot.htm.spage) page on the ForwardHealth Portal:

<https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/dentist/Dental_pilot.htm.spage>

## 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.

## 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.*

## 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

## 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

## 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

## 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

## 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)

## 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](mailto: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.
   * 1. 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.
     2. 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:

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

# Institutional Pricing

## 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#](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](mailto:VEDSEAPGHMO@wisconsin.gov)

## 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](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage#fhaprdrgmco) 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

## 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.

## 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

## 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](mailto: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.
   * + - 1. 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.
         2. 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]](#footnote-39).
   * + - 1. 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.
         2. 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.

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.
4. If the number is negative, then the claim will pay zero. Set the allowed amount to zero.
5. If the number is positive, go to step 4.
6. 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.
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.

**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:

1. 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.

1. 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

|  |  |  |
| --- | --- | --- |
| **HIPPS Code 1 - Physical/Occupational Therapy** | | |
| HIPPS Code Value | Description | Case Mix Index |
| A | TA - PT/OT CASE MIX GROUP | N/A |
| B | TB - PT/OT CASE MIX GROUP | N/A |
| C | TC - PT/OT CASE MIX GROUP | N/A |
| D | TD - PT/OT CASE MIX GROUP | N/A |
| E | TE - PT/OT CASE MIX GROUP | N/A |
| F | TF - PT/OT CASE MIX GROUP | N/A |
| G | TG - PT/OT CASE MIX GROUP | N/A |
| H | TH - PT/OT CASE MIX GROUP | N/A |
| I | TI - PT/OT CASE MIX GROUP | N/A |
| J | TJ - PT/OT CASE MIX GROUP | N/A |
| K | TK - PT/OT CASE MIX GROUP | N/A |
| L | TL - PT/OT CASE MIX GROUP | N/A |
| M | TM - PT/OT CASE MIX GROUP | N/A |
| N | TN - PT/OT CASE MIX GROUP | N/A |
| O | TO - PT/OT CASE MIX GROUP | N/A |
| P | TP - PT/OT CASE MIX GROUP | N/A |
| Z | DEFAULT CODE - SNF PDPM | N/A |
| **HIPPS Code 2 - Speech Language Pathology** | | |
| A | SA - SLP CASE MIX GROUP | N/A |
| B | SB - SLP CASE MIX GROUP | N/A |
| C | SC - SLP CASE MIX GROUP | N/A |
| D | SD - SLP CASE MIX GROUP | N/A |
| E | SE - SLP CASE MIX GROUP | N/A |
| F | SF - SLP CASE MIX GROUP | N/A |
| G | SG - SLP CASE MIX GROUP | N/A |
| H | SH - SLP CASE MIX GROUP | N/A |
| I | SI - SLP CASE MIX GROUP | N/A |
| J | SJ - SLP CASE MIX GROUP | N/A |
| K | SK - SLP CASE MIX GROUP | N/A |
| L | SL - SLP CASE MIX GROUP | N/A |
| Z | DEFAULT CODE - SNF PDPM | N/A |
| **HIPPS Code 3 - Nursing** | | |
| A | ES3 - NURSING CASE MIX GROUP | 4.06 |
| B | ES2 - NURSING CASE MIX GROUP | 3.07 |
| C | ES1 - NURSING CASE MIX GROUP | 2.93 |
| D | HDE2 - NURSING CASE MIX GROUP | 2.4 |
| E | HDE1 - NURSING CASE MIX GROUP | 1.99 |
| F | HBC2 - NURSING CASE MIX GROUP | 2.24 |
| G | HBC1 - NURSING CASE MIX GROUP | 1.86 |
| H | LDE2 - NURSING CASE MIX GROUP | 2.08 |
| I | LDE1 - NURSING CASE MIX GROUP | 1.73 |
| J | LBC2 - NURSING CASE MIX GROUP | 1.72 |
| K | LBC1 - NURSING CASE MIX GROUP | 1.43 |
| L | CDE2 - NURSING CASE MIX GROUP | 1.87 |
| M | CDE1 - NURSING CASE MIX GROUP | 1.62 |
| N | CBC2 - NURSING CASE MIX GROUP | 1.55 |
| O | CA2 - NURSING CASE MIX GROUP | 1.09 |
| P | CBC1 - NURSING CASE MIX GROUP | 1.34 |
| Q | CA1 - NURSING CASE MIX GROUP | 0.94 |
| R | BAB2 - NURSING CASE MIX GROUP | 1.04 |
| S | BAB1 - NURSING CASE MIX GROUP | 0.99 |
| T | PDE2 - NURSING CASE MIX GROUP | 1.57 |
| U | PDE1 - NURSING CASE MIX GROUP | 1.47 |
| V | PBC2 - NURSING CASE MIX GROUP | 1.22 |
| W | PA2 - NURSING CASE MIX GROUP | 0.71 |
| X | PBC1 - NURSING CASE MIX GROUP | 1.13 |
| Y | PA1 - NURSING CASE MIX GROUP | 0.66 |
| Z | DEFAULT CODE - SNF PDPM | 0.66 |
| **HIPPS Code 4 - Non-Therapy Ancillary** | | |
| A | NA - NTA CASE MIX GROUP | 3.24 |
| B | NB - NTA CASE MIX GROUP | 2.53 |
| C | NC - NTA CASE MIX GROUP | 1.84 |
| D | ND - NTA CASE MIX GROUP | 1.33 |
| E | NE - NTA CASE MIX GROUP | 0.96 |
| F | NF - NTA CASE MIX GROUP | 0.72 |
| Z | DEFAULT CODE - SNF PDPM | 0.72 |
| **HIPPS Code 5 - Assessment Indicator** | | |
| 0 | INTERIM PAYMENT ASSESSMENT | N/A |
| 1 | 5-DAY | N/A |
| 6 | OBRA ASSESSMENT | N/A |
| Z | DEFAULT CODE - SNF PDPM | N/A |

# 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 |
| 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. |
| 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. |
| 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. |
| 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. |
| 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 |
| 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 3.2 updated Benefit Plan code listing * Page 45 – Section 3.3 added Provider Specialty * Page 46 – Section 3.4 updated Pricing Indicator listing * Page 67 – 70 Section 3.6 added BAF codes |
| April 4, 2023  Version 6.2 | Updates | * Page 67 – 71 Section 3.6 added BAF codes |
| July 6, 2023  Version 6.3 | Updates | * Page 42 – Section 3.3 added Provider Specialty * Page 67 – 72 Section 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 3.6 added BAF codes |
| November 3, 2023  Version 6.5 | 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 |

1. For descriptions of Provider Contract values, see rows in ‘Code Description’ file with Code Set Name of PR\_CONTRACT. [↑](#footnote-ref-2)
2. For descriptions of Claim Region values, see rows in ‘Code Description’ file with Code Set Name of REGION. [↑](#footnote-ref-3)
3. For descriptions of Claim Type values, see rows in ‘Code Description’ file with Code Set Name of CLM\_TYPE. [↑](#footnote-ref-4)
4. For descriptions of Current Benefit Plan values, see rows in ‘Code Description’ file with Code Set Name of BNFT\_PLAN. [↑](#footnote-ref-5)
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. [↑](#footnote-ref-6)
6. For descriptions of Diagnosis Header values, see rows in ‘Code Description’ file with Code Set Name of DIAG\_GRP. [↑](#footnote-ref-7)
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. [↑](#footnote-ref-8)
8. For descriptions of Place of Service values, see rows in ‘Code Description’ file with Code Set Name of PLACE\_SVC. [↑](#footnote-ref-9)
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. [↑](#footnote-ref-10)
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. [↑](#footnote-ref-11)
11. For descriptions of Diagnosis Header Primary Group values, see rows in ‘Code Description’ file with Code Set Name of DIAG\_GRP. [↑](#footnote-ref-12)
12. For descriptions of Medicare Disclaimer, see rows in ‘Code Description’ file with Code Set Name of MCARE\_DISC. [↑](#footnote-ref-13)
13. For descriptions of Program Code values, see rows in ‘Code Description’ file with Code Set Name of PGM\_CODE. [↑](#footnote-ref-14)
14. For descriptions of Support Indicator values, see rows in ‘Code Description’ file with Code Set Name of SUPP\_IND. [↑](#footnote-ref-15)
15. Provider Contract Billing Rules [↑](#footnote-ref-16)
16. For descriptions of Claim Region values, see rows in ‘Code Description’ file with Code Set Name of REGION. [↑](#footnote-ref-17)
17. For descriptions of Claim Type values, see rows in ‘Code Description’ file with Code Set Name of CLM\_TYPE. [↑](#footnote-ref-18)
18. For descriptions of Place of Service values, see rows in ‘Code Description’ file with Code Set Name of PLACE\_SVC. [↑](#footnote-ref-19)
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. [↑](#footnote-ref-20)
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. [↑](#footnote-ref-21)
21. For descriptions of Provider Contract values, see rows in ‘Code Description’ file with Code Set Name of PR\_CONTRACT. [↑](#footnote-ref-22)
22. Assignment Plan [↑](#footnote-ref-23)
23. For descriptions of Provider Contract values, see rows in ‘Code Description’ file with Code Set Name of PR\_CONTRACT. [↑](#footnote-ref-24)
24. For descriptions of Rate values, see rows in ‘Code Description’ file with Code Set Name of RATE\_TYPE. [↑](#footnote-ref-25)
25. For descriptions of Claim Region values, see rows in ‘Code Description’ file with Code Set Name of REGION. [↑](#footnote-ref-26)
26. For descriptions of Claim Type values, see rows in ‘Code Description’ file with Code Set Name of CLM\_TYPE. [↑](#footnote-ref-27)
27. For descriptions of Current Benefit Plan values, see rows in ‘Code Description’ file with Code Set Name of BNFT\_PLAN. [↑](#footnote-ref-28)
28. For descriptions of Explanation of Benefits values, see rows in ‘Code Description’ file with Code Set Name of EOB. [↑](#footnote-ref-29)
29. For descriptions of Geographic Location Group – Performing Provider values, see rows in ‘Code Description’ file with Code Set Name of GEO\_LOC. [↑](#footnote-ref-30)
30. For descriptions of Geographic Location Group – Recipient values, see rows in ‘Code Description’ file with Code Set Name of GEO\_LOC. [↑](#footnote-ref-31)
31. For descriptions of Place of Service values, see rows in ‘Code Description’ file with Code Set Name of PLACE\_SVC. [↑](#footnote-ref-32)
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. [↑](#footnote-ref-33)
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. [↑](#footnote-ref-34)
34. For descriptions of Hospital Class values, see rows in ‘Code Description’ file with Code Set Names HOSP\_CLASS. [↑](#footnote-ref-35)
35. Provider Contract Reimbursement Rules [↑](#footnote-ref-36)
36. For descriptions of Diagnosis Group values, see rows in ‘Code Description’ file with Code Set Name of DIAG\_GRP. [↑](#footnote-ref-37)
37. For descriptions of Diagnosis Code values, see rows in ‘Code Description’ file with Code Set Name of DIAGNOSIS. [↑](#footnote-ref-38)
38. [↑](#footnote-ref-39)