Professional Payment Methodology		
A	ANES B U (ANESTHESIA UNITS)	• Anesthesia base units: o Calculate the time units = claim line units / 15 and add 1 if there is a remainder. o Calculate the allowed charge = (procedure anesthesia base units + time units) * plan anesthesia conversion factor. o Set the allowed charge source to anesthesia.
B	BILL CHRG (BILLED CHARGES)	o The allowed charge is the claim line's submitted charge. o Set the allowed charge source to billed.
C	MAX-SUSP (MAXIMUM FEE BFORE SUSPENSION)	o Calculate the allowed charge = procedure max fee * claim line units. o If the claim line's submitted charge is more than the allowed charge, post exception 334. o Set the allowed charge source to max fee. (This posts to procedure code 99070, this is a miscellaneous supply
D	FEE-N-INJ (INJECTION PRICING)	o Locate the injection fee (System Parameter 178) for the date of service. o Calculate the allowed charge = (procedure fee * claim line units) + injection fee. o Set the allowed charge source to fee plus injection.
E	ENCOUNTER (ENCOUNTER RATE)	o The allowed charge is the procedure fee. o Set the allowed charge source to encounter rate. (When enounter pays there are more lines on the encounter that needs to be captured, this is to process utilization, some enounters
F	FEE-SCHED (FEE SCHEDULE)	o Calculate the allowed charge = procedure fee * claim line units. o Set the allowed charge source to fee schedule. If any calculations resulted in a greater amount than the billed charge, there is some "lesser of" logic built in where the system will determine if the system pays the billed charge or the calculated
G	FEE-SCH-PC (FEE SCHEDULE COMPONENT)	o These fee schedules have been terminated effective 08/31/10. Calculations will be done using standard modifier logic as described in step 10. This should remain for historical purposes. Removed the outliers
H	FEE-SCH-TC (FEE TECHNICAL COMPONENT)	o These fee schedules have been terminated effective 08/31/10. Calculations will be done using standard modifier logic as described in step 10 (See exhibit C).
I	PCENT-CHRG (PERCENT OF CHARGES)	o Calculate the allowed charge = (claim line submitted charge * procedure percent) / 100. o Set the allowed charge source to percent. (This is mostly used for transplants and possibly for dental pricing

J	REL-VALUE (RELATIVE VALUE UNITS)	Relative value units*Conversion factor. The Conversion factor is set by the plan. This is basically RBRVS but it is specific for radiology. Take 90% of Medicare's fee/Conversion factor= relative value; then, that value, round the tenths and multipy by the conversion factor to get the price.
K	OB Units	o Locate the conversion factor (System Parameter 177 or the OB conversion factor from the benefit plan) for the date of service. o Calculate the allowed charge = claim line units * (procedure factor * OB conversion factor). o Set the allowed charge source to RBRVS units.
L	REL-VAL-PC (RELATIVE VALUE PC)	(Professional Component) o If the claim line's procedure is in range 10000 – 69999 (surgery) calculate the allowed charge = procedure relative value units * claim line units * plan surgery conversion factor. o If the claim line's procedure is in range 70000 – 79999 (radiology) calculate the allowed charge = procedure relative value units * claim line units * plan radiology conversion factor. o Set the allowed charge source to relative value, RVU-PC or RVU-TC. o Post exception 372 of the surgery or radiology conversion factor
M	REL-VAL-TC (RELATIVE-VALUE TC)	(Technical Component) o If the claim line's procedure is in range 10000 – 69999 (surgery) calculate the allowed charge = procedure relative value units * claim line units * plan surgery conversion factor. o If the claim line's procedure is in range 70000 – 79999 (radiology) calculate the allowed charge = procedure relative value units * claim line units * plan radiology conversion factor. o Set the allowed charge source to relative value, RVU-PC or RVU-TC.
N	BY-REPORT (BY REPORT)	o If the allowed charge source is manually priced, go to the next step. o If the allowed charge source is "prior auth unit price", calculate the allowed charge = prior auth rate * claim line units. o Otherwise: o Move zero to the allowed charge. o Move space to the allowed charge source. o Post exception 438, procedure requires manual review.
O	MNOT-ALLOW (NOT ALLOWED)	o Move zero to the allowed charge. o Move space to the allowed charge source. o Post exception 439. (This is used for something that is not allowed. It is used for codes we don't want covered. This is the only way to mark something as

P	REV-REQUIR (REVIEW REQUIRED)	o If the allowed charge source is manually priced, go to the next step. o If the allowed charge source is prior auth rate, (not applicable to institutional outpatient claims) o Calculate the allowed charge = prior auth unit price * claim line units. o Go to Step 10. o Move zero to the allowed charge and post exception 440.
Q	PRICE-PROC (PRICE USING PROC)	• If the procedure factor code found is P (price using procedure) and the claim line procedure is blank, post exception 398, otherwise, locate the procedure record for the line item procedure code using X (outpatient LOC). The line item plan code is used to
R	MAX-EMERG (MAXIMUM FEE FOR EMERGENCY)	
S	RBRVS UNIT (RBRVS UNITS)	o Locate the conversion factor (System Parameter 176 or the RBRVS conversion factor from the benefit plan) for the date of service. o Calculate the allowed charge = claim line units * (procedure
T	PRICED APC (PROCEDURE PRICED BY APC)	This means that only the hospital can bill. If a professional claim bills this, it denys. Any "s" in the system should be flipped over to
U	DELETD CPT (PROC DELETED FROM CPT/HCPCS)	CPT puts out a new guidance book each year where they add, delete, and modify. If deleted, the code is ended, and it is updated
V	PRICE NDC (PRICE BY NDC)	This is used for pysician administerd drugs - it has been removed. It might be different if there is a PA. So, if there is a PA with pricing this is priced off of the PA. If there is a PA without pricing - this
PMPM	Per Member Per Month	This usually refers to providers who have earned accredidation with the NCQA company who specialize in Patient Centered
Institutional Payment Methodology		
OPPS	Outpatient Services	This includes hospital, critical access, general hospital, ASC, ambulatory surgical center, Comprehensive outpatient rehab facility (CORF)

LOC	Inpatient Services	Inpatient Services refers to: Critical Access Hospitals, general, psychiatic, rehab Per Diem. This applies to rehabilitation. Level of Care Pricing: "Levels of Care" Model is also referred to as Tiered Pricing, the Levels of Care model has levels or tiers into which a variety of services are grouped. The hospital is divided into different areas depending on the intensity of care and observation you require. System will need to calculate payments based on levels of care. Within LOC, there are different levels (less than 24 hour stay, transfer... and each hospital that participates will have their own specialized rate (a High Cost Outlier), and there are also state-wide rates for non-participating providers) There are also different rates since based on cost reporting, so what it actually costs. For example, a non-participating provider in Colorado would probably receive a different rate than CRMC here would receive. These non-participating costs can be found in the provider charge files (display four). High Cost Outlier: When the total charges on a claim exceed the established outlier threshold for a given
ESRD	End Stage Renal Disease	Pays 9% of billed charges by line - Jesse wonders if this could be
Encounter	FQHC/RHC	Paid by encounter - housed on provider charge file
HH	Home Health	Pays by revenue code off of the fee schedule, pays off of PA
Hospice	Hospice	Pays on UB with Revenue Code and PA For nursing home hospice - they must have a PA on file. For regular
HIS	Indian Health Services (IHS)	Pays off of encounter rate within the provider charge file. There is
NH	Nursing Home	Pays off of revenue code. Extraordinary care must have a revenue code and a PA. Swing bed is the same as the nuring home and pays off revenue code, just a different taxonomy. If LT101 is required, there must be a PA. There are edits looking for LT101 and patient contribution (calculated by eligibility, can be found on client screens in MMIS)
PRTF	Psychiatric Residential Treatment Facility (PRTF)	This is a non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligibile individuals under 21.

ICF-ID	Intellectual Disability (benefit to provide comprehensive and indivudualized health care and rehabilitation services to individuals to promote their functional status.)	There is a rate on the provider file. They have a separate taxonomy. Resembles nursing home payment methodology.