Indiana Medicaid Resolutions Manual

NAME: **4200 CLAIM PRICED AT ZERO (HDR)**

ERROR TYPE: Batch Edit, Hard Coded

HEADER/DETAIL: Header

OVERRIDABLE: Y

ALLOW DENIAL: Y

DESCRIPTION:

Set this edit when a paid status claim is priced at zero and other factors such as patient liability, TPL, or spend down are not the cause of the payment being reduced to zero.

CRITERIA:

Set this edit when the claim is in a paid status and the paid amount is zero with, EOB 4200.
This edit will set when the allowed amount is zero and is not a result of a cutback from PA, limitation (units or auditing), TPL, Patient Liability, or Waiver liability.
There are three exceptions to this rule, if the TPL, patient liability, or spend down amount is equal to or greater than the final allowed amount, bypass the edit since the claim will be paid at zero.

DISPOSITION:

Note: EOB 9999 with a Do Not Post status is for internal system use only. This EOB is used to avoid potential system processing abends. This EOB is not posted on the RA and the disposition may be ignored.

Claim Type: 0 - All Claim Types **Member Plan:** ALL **Status:** Post

Location	Region	EOB	Disposition
04	00	4200	SUSPEND
04	30	4200	PAY
04	32	4200	PAY
04	33	4200	PAY
04	34	4200	PAY
04	35	4200	PAY
04	36	4200	PAY
04	37	4200	PAY
04	38	4200	PAY

04	70	4200	PAY
04	72	4200	PAY
04	73	4200	PAY
04	74	4200	PAY

Claim Type: A - Inpatient Xover Claims **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
04	00	9999	PAY

Claim Type: B - Professional Xover Claims **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
04	00	9999	PAY

Claim Type: C - Outpatient Xover Claims **Member Plan:** ALL **Status:** Do Not Post

Location	Region	EOB	Disposition
04	00	9999	PAY

EOB: 4200 - PRICING BEING REVIEWED.

ARC Code	ARC Description	Effective Date	End Date
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	20140701	22991231

EOB: 9999 - PROCESSED PER POLICY.

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ARC Code	ARC Description	Effective Date	End Date
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	19950101	22991231

METHOD OF CORRECTION:

For physicians -
Reference Edit 4110-non-anatomical laboratory. The intent is to pay the hospital the entire lab fee and no pay a physician for interpretation.

- Look in the history to see if an outpatient claim exists with the same date of service and procedure code and if so, deny the medical claim.
- If there is not an outpatient claim already paid, then manually price the claim by the fee on file for the date of service. If there is no fee on file and the service is covered, pay at 90 percent.

For Waiver Services billed on a 1500 Healthcare claim form
Perform the following steps

1. If the procedure code billed is a PIC code and has the U7 modifier which indicates waiver services
    - Click on the billing provider number and identify their specialty
    - Once you have determined the specialty of the provider, check the specialty against the table below:
      350-AD Aged and Disabled Waiver
      351-AU Autism Waiver
      352-IM ICF/MR Waiver
      354-MF Medical Fragile Children Waiver

356-TB Traumatic Brain Injury Waiver
357-AL Assisted Living Waiver
359-DD Developmentally Disabled Waiver
360-SS Support Services Waiver
361-SE SED Waiver

2. On the Max Fee pricing window find the waiver code that was billed, check the dates of service to ensure that the rate is within the dates billed.
3. Check the PA window to ensure that there are dollars remaining for the procedure code. If PA has been exhausted, deny the edit 4200.
4. Take the allowed amount rate, and multiply the rate times the units billed.
5. Put the calculated amount in the allowed amount field.
6. DO NOT FORCE the edit 4200. The claim will price according to what was put in allowed field.

For Dental Claims billed on a ADA Dental Form (for date of service 1/1/2011-11/5/2011) Perform the following steps:

1. If the procedure code billed is a PIC code and has the U7 modifier which indicates waiver services
    - Click on the billing provider number and identify their specialty
    - Once you have determined the specialty of the provider, check the specialty against the table below:
      350-AD Aged and Disabled Waiver
      351-AU Autism Waiver
      352-IM ICF/MR Waiver
      354-MF Medical Fragile Children Waiver
      356-TB Traumatic Brain Injury Waiver
      357-AL Assisted Living Waiver
      359-DD Developmentally Disabled Waiver
      360-SS Support Services Waiver
      361-SE SED Waiver
2. On the Max Fee pricing window find the waiver code that was billed, check the dates of service to ensure that the rate is within the dates billed.
3. Check the PA window to ensure that there are dollars remaining for the procedure code. If PA has been exhausted, deny the edit 4200.
4. Take the allowed amount rate, and multiply the rate times the units billed.
5. Put the calculated amount in the allowed amount field.
6. DO NOT FORCE the edit 4200. The claim will price according to what was put in allowed field.

For Dental Claims billed on a ADA Dental Form (for date of service 1/1/2011-11/5/2011) Perform the following steps:

- Go to the project workbook home page
- Under the Provider Title (first area left hand side of window)
- Click on "Customer Service Inquiry Menu"
- Click on the "Dental Cap Audit"

- Type in the member ID and the appropriate year according to dates billed
- Click search
- If the $1000.00 cap is met, deny the claim. Add up all paid details for DOS (dates of service) 1-1-2011 to 11-5-2011. The dental audits 6236 and 6238 were inactivated with dates of service 11/5/2011, so please pay attention to dates of service.
- If the $1000.00 cap is not met, put in a dollar amount to reach the $1000.00 cap limitation.
- Do Not Force 4200, it will continue to suspend.
- Force audit 6000-Manual Pricing if you put an amount in the allowed field greater than zero.

Always check PA to determine if dollars or units have been satisfied. If there are no units or dollars remaining the claim cannot be priced and should be denied. Deny with edit 4200.