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Welcome to the Claims Edit System (for Professional Claims)

The Claims Edit System (Professional)

**Note**
CPT is a registered trademark of the American Medical Association. [Select here](#) for details.

**Preface**

Welcome to the growing number of organizations that are now using Claims Edit System.

This documentation will help you learn how to enter and edit sample claims; access information; import, analyze and review claims; create and validate user-defined fields; crosswalk custom codes; generate worksheets and reports; and modify the analysis process by defining custom rulesets and editing the KnowledgeBase. You will also learn how to maintain system files and set up system security.

**About Optum**

Claims Edit System is published by Optum. Optum is a leading healthcare information company that provides comprehensive financial and management solutions for payers, providers, and self-insured/self-administered employers. As one of the largest coding and reimbursement information organizations, Optum establishes guidelines for coding, reviewing, and auditing medical episodes.

We provide tools to enhance each principal step in the patient encounter data flow for all major participants and in any reimbursement environment. Providers use Optum's products for appropriate coding and preparation of claims, while payers and self-insured/self-administered employers use our products in the claims review process.

Optum has developed proprietary databases and database expertise to provide comparative pricing tools, claims editing systems, and specialty-specific pricing data to the payer market.

**Cost-Effective Healthcare Reimbursement Solutions**

Much of the medical insurance industry is experiencing continuing rapid cost increases, attributable in part to an estimated $7 billion paid annually for miscoded claims. As a result, the insurance industry is increasing its demand for broad-based medical cost containment solutions and medical delivery management tools.

Optum expertise provides Optum clients with comprehensive and integrated solutions to reimbursement through a broad range of cost-containment database and software products, publications, and services. Optum will continue to capitalize on its growing pool of knowledge by offering products and services that help...
our clients manage the cost-effectiveness of healthcare, which can be specifically tailored to your requirements, now and into the future.

**Client Services**

We welcome you as a valued client. Optum’s Client Services provides expert guidance on coding and reimbursement issues affecting health claims payment. Our coding and operative report review service assists payers on complex or difficult claims. If you have questions regarding this product or the information detailed in this documentation, please call Optum’s Client Services at 800-765-6818 to speak with a coding analyst or an account executive.
Overview of Claims Edit System

Product Overview

Claims Edit System is a state-of-the-art system that combines an advanced Rules Engine with Optum’s proprietary Claims Editing KnowledgeBase™.

The result is a system that automatically compares each claim with thousands of government and industry regulations and policies, as well as system and custom rules.

This system works to help your company pay only on “clean” claims and comply with relevant CPT coding guidelines.

Claims Analysis

The major function of Claims Edit System is to look at the data in the claim and checks for errors, omissions and questionable coding relationships. For each claim that is processed, the system thoroughly reviews the entire claim and each line on it for important coding issues such as the following:

- Unbundling
- Rejection of duplicate claims
- Rebundles/Transfers
- Detection of mutually exclusive services
- New patient visit auditing
- Patient diagnosis correlated with procedure appropriateness
- Validation of procedure modifiers
- Detection of multiple procedure reductions
- Place of service editing
- Surgical assistant appropriateness
- Flagging of maximum frequency-per-day
- Age appropriateness of procedures and diagnoses
- Sex-specific procedures and diagnoses versus patient sex

How Claims Data Enters The System

The basic process by which claims flow through the system is as follows:
1. Claims are entered into your host system.

2. The host system performs some key validations.

3. The validated claims continue through processing. At this point, the host system can pass claims to Claims Edit System. Some companies like to send claims to Claims Edit System early in the adjudication process; others like to wait until the very end. Claims Edit System is flexible enough to hook onto your process wherever it is most beneficial to your situation.

4. Once Claims Edit System finishes analyzing the claims, it returns the results to the host system for billing consideration or further processing.

How Claims Edit System Looks at Claims

When a claim enters Claims Edit System, the system looks for key pieces of information (such as the Account ID and/or Plan ID) to determine how the claim should be routed for analysis. (This allows claims meeting different criteria to run against different sets of analytical rules.)

Once the system knows how to route the claim, it compares the data in the claim to the Optum Claims Editing KnowledgeBase™. This KnowledgeBase contains thousands of records to verify the integrity of processed claims. Also, if claims have been filed for the patient in the past, the system may also check for problems between the current claim and the patient’s historical claims.

Flags

When the system examines a claim, it identifies errors, omissions, or questionable coding relationships. Depending on the rules to which the claim has been routed, the system then raises a flag (also called an “edit”)
identifying each problem it identifies. Each raised flag is represented in the analysis results with a three-letter code (a mnemonic), which is often accompanied by a detailed description of the problem.

**Applied Edits**

Once Claims Edit System raises flags for a given claim, the system can handle the flags in either of the following ways:

**Method A: Recommendations Only**

You can configure Claims Edit System to handle flags as recommendations to the host system (i.e., the system that communicates claims data to Claims Edit System). Then, during claims analysis, Claims Edit System can generate a list of specific flags that indicate how and why each claim should be changed. However, with this configuration, Claims Edit System will not change the original claim data in any way. Therefore, the host system must be able to interpret the results from Claims Edit System and then apply the recommended changes to each claim.

**Method B: Apply Edits**

You can also configure Claims Edit System to automatically apply recommendations during claims processing. In this configuration, Claims Edit System not only generates flags, but also executes special rules to apply these edits to the claim. Claims Edit System then transfers the modified claims directly to the host system.
For detailed information about how to establish Apply Edits on your system, refer to the Applied Edits section.

**Rules**

Claims Edit System analyzes claims through several different means, all of which are controlled by rules. A rule is a logical set of instructions that tell the system to check for specific coding or data relationships on a claim. When a claim “breaks” a rule (i.e., fails to meet criteria) the rule also contains commands that tell the system which flag, if any, should be raised against a claim.

When analyzing a claim, Claims Edit System applies various system rules and any user-created rules to determine if the claim agrees with your claim-editing policies. System rules use the coding and clinical logic of the Optum Claims Editing KnowledgeBase™. User-created rules can be created to check any aspects of the claim that meet your needs, raising flags for any special areas of concern.

Rules can be made to check any aspect of the claim, including time and dates, patient history and data, doctor and facility data, diagnosis codes, procedure codes, modifiers, insurance plans, and so forth.

**Rulesets**

Rules are grouped into common families called “rulesets.” Each ruleset corresponds to a specific type of claim for which a specific set of rules should run. For example, the rules needed for Medicare claims are not the same as those needed for Commercial claims. Therefore, to analyze both types of claims correctly, you would need one ruleset to execute the Medicare rules and another ruleset to execute the Commercial rules.
By default, rulesets are provided with Claims Edit System, making the system immediately useful with a set of base rules. These rulesets are:

**Commercial (Professional/Facility) Ruleset**

This ruleset contains system rules for claims analysis that raise standard commercial edits against each claim.

**Medicare (Professional/Facility) Ruleset**

This ruleset contains system rules for claims analysis that raise standard Medicare edits against each claim.

**(Professional/Facility) Apply Edits Ruleset**

This ruleset contains the apply edit rules. This is a system rule that applies results from claims analysis to modified claim lines. It works for every flag in the system that does not use a Special Apply Edits Rule.

In addition to these system rulesets, you can create your own rulesets, picking and choosing the rules you want to be active during claims analysis.

Several rulesets can be active at the same time, being linked to various customers or classes of customers. For example, Medicare providers can be linked with the Medicare System ruleset, while others default to the System ruleset. In addition, you can easily create rulesets for different levels of insurance coverage (basic, premium, HMO, etc.) or for different groups of insureds.

**Rule Manager**

If you want to create your own rules and/or rulesets, you must access the Rule Manager. This module gives you command-level control of the logic within rules and offers more flexibility. You can even create user-defined flags in the Rule Manager, with mnemonics that are up to 20 characters long.

**Recursive Analysis**

During claims analysis, there are times when the rule logic determines that a procedure code needs to be added or changed to a different code. When this occurs, the system could respond in two ways:

- It could raise a flag regarding the needed change and then continue on with the analysis, or
- It could temporarily implement the change and then start the analysis over again to see what effect the change will have on the results. When the system follows this method, it performs a “recursive” analysis.
The rules processing in the system recognizes when changes on the claim necessitate further processing, and that processing occurs as needed, during the initial claim processing cycle.

Claims Edit System will perform a recursive analysis automatically (as needed). Thus, when you analyze claims against a ruleset, the system will perform recursive analyses on the claim until it can successfully apply all rules to the claim without requiring a procedure code change.

**Crosswalks**

Crosswalks serve two main purposes: First, they allow a wide range of industry codes to be mapped to a smaller range of codes that the system can use during claims analysis. Second, they let you add your own unique codes and key words, and then map them to the range of codes the system uses during analysis.

The crosswalks in Claims Edit System are actually lists of cross-references, which can be set up and maintained by a user with administrator permissions. An administrator can add, edit, and delete crosswalk designations for many of the codes entered for a claim (such as Provider Specialty, Type of Service, etc.).
Data Validation and Lookup
Vital portions of claims data are automatically pre-validated before a batch of claims is even analyzed by Claims Edit System. Likewise, when you enter claims manually, the same vital parts of the data are validated as the data is sent to the system. You can use lookup tables to help you locate specific information that you have added to the system or that has been automatically generated.

User-Defined Lists
User-defined lists allow you to create lists of data that are used by rules to check the validity of specific items on a claim.

User-Defined Fields
In some cases, there are categories of data on your claims that are not currently recognized by Claims Edit System. To deal with these cases, you can customize the importation and analysis of these non-standard elements. You can add up to 25 custom fields (up to 50 total for the XMLv2 claim file format, starting with 5.4 SP2-CU01) to which you can link validation lists and crosswalks, and run rules against during claims analysis.

Refer to the User-Defined Fields section for more information.

Reports
One of the most useful management features of Claims Edit System lies in its extensive reporting capability. Reports can help management detect trends for claims with specific procedures and diagnoses, and highlight providers with higher than normal usage. This can be extremely helpful in detecting substandard practices or even detecting fraud or abuse.

You can create various reports, which contain analysis and claim information within parameters that you specify. Reports can be viewed on screen, printed, or exported to other file formats.

Procedure Reduction
You can specify procedure reductions for multiple procedure encounters and bilateral procedures, as well as procedures performed by team surgeons, assistant surgeons, and co-surgeons.

Web Interface
Claims Edit System is web-enabled. This allows you to look up and modify claims interactively in real time. Administrators also use this web interface when running reports, testing rules, crosswalks, user-defined fields
or lists. The web interface also includes a test environment for real-time testing of system modifications, without affecting live data.

**Manual Claim Entry**

To test how the system analyzes certain coding scenarios, you can enter sample claims manually, then analyze them individually. While entering data, you can look up claim information stored in the system (such as patient information, procedure codes, and diagnosis codes).

**Units**

Claims Edit System recognizes the “Days or Units” field of the CMS-1500 form. This indicates either the number of days related to the procedure or the number of minutes a patient is under anesthesia; this information is incorporated into the analysis.

**Analysis Results**

After claims analysis, Claims Edit System makes the results available in various forms, including:

- Printed reports
- On-screen results
- Electronic data

Typically, claims without any errors are quickly cleared for payment. Claims with errors are flagged with either a deny flag or a review flag. Deny flags typically mark the claim for rejection. Review flags are routed back to the claims adjuster who can review or reject the claim interactively in real time using the client software.

**The KnowledgeBase**

The codes existing in the KnowledgeBase are based on the following assumptions:

- The edited claim represents services by a single provider.
- The edited claim represents services by that single provider to a single patient.

The rules in Claims Edit System cannot be successfully applied to hospital billing claims where all services are posted and dated on a single date of entry. Physician/clinic owned laboratory and radiology practices must post services for the date(s) services are actually rendered for the system to work correctly.
KnowledgeBase Documentation

Optum publishes documentation for the KnowledgeBase (shipped with the KnowledgeBase itself). Part of this documentation is the “Documentation of Edit Rationale” (DOER), which presents the clinical rationale used to develop the edits for the following codes:

- Evaluation and management
- Anesthesia
- Surgery
- Radiology
- Pathology and laboratory
- Medicine

KnowledgeBase Editing

You can edit the KnowledgeBase to customize analysis criteria. To do this you view and edit many coding parameters in the following KnowledgeBase modules:

- Procedures
- Diagnoses
- Modifiers
- Relative Value Units
- Crosswalks
- Medicare MPFS
- System Lists
- Business Data

Multi-tenant Installation

Claims Edit System can be installed as a multi-tenant solution by applying a multi-tenant license. This is done in cases where the software is hosted by one organization so it can be used by other organizations (tenants) that want to benefit from its functions but need to keep their data and configuration information completely separate and secure.
Each tenant user can see only the users, enterprises, custom rules, rulesets, claim data, and configuration settings that apply to their own tenant.

It is not possible to convert an existing system that has been used for claim processing into a multi-tenant system. This can only be done by applying the multi-tenant license to a freshly installed Claims Edit System.

**Overview of Multi-Tenancy Concepts**

The following sections describe how a multi-tenant installation of Claims Edit System differs from a single-tenant installation.

**Tenant**

A tenant is an organization that shares use of the Claims Edit System software with other organizations (tenants). The “tenant” construct was added to the software to ensure that data associated with one tenant can never be viewed or accessed by other tenants. It also allows the software to ensure that claims belonging to one tenant can never be routed to enterprises belonging to another tenant. (This is true only when secure tenant tokens are associated with each submitted claim. Refer to the [Secure Claim Processing](#) section for further details.)

**System User versus Tenant User**

**System Users**

System users are those users who belong to the organization that is hosting the multi-tenant installation of Claims Edit System.

Their primary responsibility is to administer the system by performing global, system-level configuration such as adding new tenants and creating the initial tenant administrator for the tenant, and assisting tenants with any operational issues. Functions that can only be performed by a system user include:

- Tenant management.
- Load the KnowledgeBase and new LCD Contractor policies.
- Install ILOG rule updates.
- Install product licenses.
- Set password requirements and other security policies that will apply globally to the system.
- Configure connections used for claim submission.
- Create new enterprises or disable existing enterprises.
• Manage enterprise mapping for cross claim-type editing
• Claim History Crosswalking - Enable or disable crosswalking of values on history claims.
• Claim Field Settings - Assign default values for claim fields when they are not in the claim.
• Same Provider configuration - Define how a provider is to be uniquely identified.
• Purge claims.

The full enterprise tree is visible, including enterprises for all tenants, but selecting a tenant enterprise does not allow the system user to perform any work in that enterprise. Only enterprise properties and the list of users that are granted rights to work in the enterprise are visible.

To perform work within a tenant enterprise, a system user must use the Work as Tenant function that temporarily allows them to perform functions for a tenant as if they were a tenant user. This ensures that proper audit logs are maintained for actions performed by the system user in the tenant’s enterprise.

**Tenant Users**

Tenant Users are those users who belong to the tenant organization. It is expected that the tenant administrator will create the accounts for all other tenant users. Tenant users are only able to manage users, enterprises, rulesets, claims, and other configuration data that belongs to the tenant. Reports are for a specific enterprise, so report data is also limited to data belonging to the tenant.

The administrative functions that can be granted to a tenant user is a subset of the administrative functions that are available to a system administrator (System user).

Functions that can be performed by tenant users include the following:

• Update tenant organization information and generate a tenant token.
• Role management: Create and modify custom roles. Roles created by one tenant are not visible by any other tenant.
• User management: Users created by one tenant are not visible by any other tenant. However, the Username value for each user account must be globally unique.
• Manage static ILOG rulesets and routes.
• Manage dynamic DDR rules and rulesets and routing configuration. Create custom data-driven rules.
• Manage the code repository by creating overrides and adding custom entries.
• View and analyze claims in the user interface.
• Generate and view reports. View the audit log.
Enterprise Structure in a Multi-tenant system

When Claims Edit System is first installed, the standard enterprise tree shown below will exist. Normally, it is possible to use the Professional Main and/or Facility Main enterprises out of the box for claim processing, but this is not the case for a multi-tenant installation. Claims can only be processed against tenant enterprises.

When a new tenant is created, in addition to the full organization name, a short name is also assigned. Two enterprises are also automatically created under the Professional and Facility Main enterprises: one for Professional Editing and one for Facility Editing. The default names for these enterprises are Professional xxxx and Facility xxxx, where xxxx is the short name assigned to the tenant.

System users are able to see the full enterprise tree including the top-level default enterprises plus all tenant enterprises (refer to the example below). Although the full enterprise tree is displayed, selecting a tenant enterprise does not allow work in that enterprise (managing rules and rulesets, viewing claims, etc.).
In contrast, the top-level default enterprises are hidden from tenant users so that the tenant enterprise tree starts from the two enterprises that were created when the tenant organization was added to the system. Selecting an enterprise opens the Enterprise panel that allows work to be performed.

Important! Tenant administrators cannot add new enterprises to their enterprise tree; this must be done by the system administrator. Therefore, when a tenant needs changes to their enterprise tree, it must be communicated to the system administrator, who will make the change at a relatively safe time. The only risk occurs when a child enterprise is created for an enterprise that already has many claims. All claims are updated and reassigned to the new child enterprise, which can place a heavy burden on the database.
Secure Claim Processing

In configurations where each tenant submits claims directly to multi-tenant Claims Edit System via the Internet, it is very important to ensure that claims for one tenant cannot be routed to enterprises belonging to another tenant. This is accomplished by requiring a “tenant token” to be embedded in each claim. The SYSTEM > Configuration > Tenant Preferences tab is used to configure the use of tenant tokens. The tenant token can be generated by the tenant by using the Organization Settings > Organization screen.

Tenant tokens are only supported by the REST and XMP claim interfaces. It is the responsibility of the client software to insert the token into the claim message. The details regarding how this is done are included in the corresponding interface specification documents.

1. Not all multi-tenant installations use tenant tokens. When claim batches submitted by tenants are received by an intermediate system (such as a clearinghouse) and that intermediate system acts as a proxy to submit all claims on behalf of the tenant, then the management overhead of using separate tokens for every tenant may outweigh the security benefit it provides. If tokens are not used, the client software that assigns the enterprise routing information for each claim must take full responsibility for correct claim routing to tenant enterprises.

2. The Security Token section of the Tenant Organization tab is only displayed when the use of tokens has first been enabled via the SYSTEM > Configuration > Tenant Preferences tab.

User Roles and Permissions

As mentioned in the System User versus Tenant User section above, tenant administrators can only perform a subset of the functions available to system administrators. This is controlled by the privileges assigned to roles that can be assigned to tenant administrators.

When a new role is created by a system user, it must be assigned one of the following three “scope” values:

- System - System Administrator functions.
- Tenant - Tenant Administrator functions.
- Enterprise - Manage rules, rulesets, claims, etc. that are specific to an enterprise.

Tenant administrator functions are a subset of the System Administrator functions. Assigning a role in the Tenant scope ensures that only privileges that tenant administrators are allowed to perform can be assigned to the role. Also, roles with a System scope cannot be assigned to tenant users.
Tenant administrator functions are a subset of the System Administrator functions. Assigning a role a Tenant scope ensures that only privileges that tenant administrators are allowed to perform can be assigned to the role. Also, roles with a System scope cannot be assigned to tenant users.

When a tenant user creates a new role, only the System and Enterprise values are available to assign as the role scope.

**Tenant-Specific Rules and Rulesets**

When custom Data-Driven Rules are created by tenant users (system users are not able to create DDRs unless working as a tenant), they apply only to that one tenant and are only visible to users that belong to that tenant.

System rules (those delivered by Optum in the KnowledgeBase) are visible to all tenants, but each tenant can set the status of each rule (New, Test, Live, Disabled, etc.) for their own tenancy so it does not affect any other tenant.

When a new tenant is created, there are no rulesets initially. Each tenant is responsible for creating the required rulesets. This also includes the routing conditional expression that causes the ruleset to be selected for use by a particular claim. Refer to the Data-Driven Rules – Panel-based UI section for more information.

**Functions Not Included in a Multi-Tenant System**

The following functions are disabled in multi-tenant installations to reduce the possibility of one tenant causing performance problems for other tenants.

- Static data-driven rulesets. Only dynamic data-driven rulesets can be created.
- Classic reports. These are replaced by the panel-based reporting UI.
- Creation of custom ILOG rules. Custom rule creation must be performed using the Data-Driven Rules Management UI.

**Workflow for Setting up a New Tenant**

The following steps outline the workflow for setting up a new tenant:

1. Complete the business agreement with the tenant organization for use of the CES system.
2. System Administrator – Configure the use of tenant tokens for secure claim processing. This step should only be performed if tokens are required for this implementation. Typically, it is only required if clients (tenants) submit claims directly over the Internet.
a. Navigate to the SYSTEM > Configuration > Tenant Preferences tab and change the Enable security tokens property to Enabled.

b. Notify tenants that tokens are now required and that they should create and download the token for their system via the Tenant Organization tab.

3. System Administrator (system user) - Navigate to the SYSTEM > Tenants screen and use the New Tenant button to create the new tenant. In addition to entering organization information supplied by the new tenant, assign a unique tenant short name that will be used to identify the tenant and tenant enterprises (e.g., ABC Group). This operation automatically creates the top-level Professional and Facility enterprises for the tenant. It also creates the initial tenant token if the use of tokens has been enabled.

4. System Administrator - Create a user account for the person in the tenant organization who will be the Tenant Administrator.

   a. Select the tenant in the Tenants panel and select the Work as Tenant button to create the user account. (Navigate to SYSTEM > Organization Settings > User Accounts tab and select the New User Account button.)

   b. Enter the user information and assign the initial password (e.g., ChangeMe123). Note that the user will be requested to change this password the first time they log in.

   c. Assign roles to the user, starting with the Tenant Admin role. When adding roles with an Enterprise scope, grant access to both the default Professional and Facility enterprise.

   d. Select the Save button to add the new user account.

   e. Notify the Tenant Administrator that the account has been set up and what the temporary password is.

5. Tenant Administrator - Log into Claims Edit System.

   a. Change the password to the desired password using the Main Menu > Change Password option.

   b. For each enterprise, select the data-driven rules to be used in rulesets. Refer to the Data-Driven Rules – Panel-based UI section for more information.

   c. Create initial rulesets - Refer to the Data-Driven Rules – Panel-based UI section for information.

6. Tenant Administrator - Add other tenant users.

   a. Navigate to the Organization Settings > User Accounts tab. Use the New User Account button to add an account for each person in the tenant organization that will need to access the Claims Edit System.

   b. If custom roles are needed, use the User Roles tab to create custom roles with the right set of privileges.
7. Tenant Administrator - If needed, set up secure claim submission.

   a. Navigate to the Organization Settings > Organization tab. Use the Copy token to clipboard or the Download token link to obtain a copy of the token for your tenancy.

   b. Deliver the token to the person in the tenant organization that is able to configure the token into the client software that submits claims to Claims Edit System.

   The way in which the tenant token is configured in the client software varies from client to client and is outside the scope of this document.

---

**Overview of User Roles in Claims Edit System**

The work you perform in Claims Edit System is likely to fall under one of the following categories:

**Policy Coordination**

People in these roles work to ensure that Claims Edit System will process claims correctly according to the needs of your business. They look at the rules behind specific plans and policies and ensure the rules in Claims Edit System can match these policies. Where system rules are inadequate, they design custom rules to make up for the discrepancy.

**Claims Processing**

People in these roles use Claims Edit System to enter data, process claims, route claims, view results, or manage other people involved with these tasks.

**Security & Configuration Administration**

People in these roles manage user access. They define permissions and set up login passwords for specific users within specific roles. They also manage the technology infrastructure surrounding Claims Edit System, the host system, and the corporate network.

---

For detailed information about all of the pre-defined roles that come with Claims Edit System, refer to the Defining Roles section in the System Security section.

The roles described above are only generalized descriptions of how the pre-defined roles in Claims Edit System may fit within your organization.
Getting Started

Accessing the Claims Edit System and Logging In

When you first log in to the system, you are actually starting one component of the system called the web client, which communicates with other parts of the system using internet protocols and services.

To access Claims Edit System:

1. Open your web browser.

| Note | Claims Edit System has been certified using Internet Explorer 10 as the browser. If you have an earlier version of this browser installed on your machine, we recommend upgrading to Internet Explorer 10 or later if possible. If you have a newer version of the browser, make sure you run Claims Edit System in **compatibility mode**. |

2. Enter the URL to connect to Claims Edit System web server. (If you are unsure about the correct URL, contact your network administrator.)

To log in the first time to Claims Edit System:

If no one has ever logged into Claims Edit System before, and you are the first person to set up the system, use the following “one-time login” procedure:

1. Type the word **setup** in the User ID text box. **Important note**: Although the password may be changed, this user ID should not be changed from **setup** at any time for any reason.

2. Type the word **setup** in the Password text box. (The password appears as asterisks.)

| Important! | Remember that all passwords and user IDs in Claims Edit System are case-sensitive (i.e., atom is not the same as Atom or ATOM). |

3. Read the CONFIDENTIALITY AND USE NOTICE, and then select the **Submit** button if you agree to the terms of the notice.

   By selecting the **Submit** button, your action indicates that you have read and agree to the terms contained in this notice. If you do not agree to the terms in the notice, close your browser without continuing. You may not use the program legally if you do not agree to the terms of the notice.

4. Once you select the **Submit** button, the system prompts you to change your password. (Refer to the Changing Your Password section for information about how to change your password.) From this point on, the system will no longer accept the original password, and you must define user records for anyone
else that must access the system. (Refer to the Defining User Records section for information about how to create login access for other users.)

After you use this one-time login procedure to access the system, be sure to set up a new user access record for yourself. (Refer to the Defining User Records section for further information.)

To log in to Claims Edit System:

1. Type your assigned username in the User ID text box.

2. Type your password in the Password text box. (The password appears as asterisks.)

3. Read the CONFIDENTIALITY AND USE NOTICE, and then select the Submit button if you agree to the terms of the notice. By selecting the Submit button, your action indicates that you have read and agree to the terms contained in this notice. If you do not agree to the terms in the notice, close your browser without continuing. You may not use the program legally if you do not agree to the terms on the notice.

Unsuccessful login

If your username or password is entered incorrectly, entered in the wrong case, or is not in the system, an error message appears when you select the Submit button. Retype your login information correctly.

If you are entering your login information correctly, in the appropriate case, and still receive an error, contact your system administrator. (Refer to the User Password Security section for details about how to set up user names and passwords.)

Changing Your Password

To change your password:

1. Select Change Password in the Main Menu.

2. Enter information in the following fields:

| Important! | Remember that all passwords in Claims Edit System are case-sensitive (i.e., atom is not the same as Atom or ATOM). Also, it is important that you enter a password that conforms to your system password requirements (i.e., what characters are allowed, how many characters, etc.). If you are unsure about your system requirements, contact your administrator for assistance. |
### Field Description

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Password</td>
<td>Enter your current password (as defined previously by yourself or your administrator).</td>
</tr>
<tr>
<td>New Password</td>
<td>Enter the new password.</td>
</tr>
<tr>
<td>Confirm Password</td>
<td>Enter the new password again, exactly as you entered it in the New Password field.</td>
</tr>
</tbody>
</table>

3. Select **Save** when you finish.

### Displaying Versions of the System

Sometimes it is helpful to view the current version numbers for basic elements of the system.

**To display current versions of system elements:**

1. From the Main Menu, open the **System Versions** screen.
2. On this screen, the system displays information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engine</td>
<td>This field displays the current version of Claims Edit System, plus the internal “build” version (used by Optum).</td>
</tr>
<tr>
<td>KnowledgeBase</td>
<td>This field displays the version of the KnowledgeBase loaded on your system.</td>
</tr>
<tr>
<td>Database</td>
<td>This field displays the version of the database software your system is using.</td>
</tr>
<tr>
<td>LCD</td>
<td>This field displays the version of any LCDs (Local Coverage Determinations) loaded on your system.</td>
</tr>
</tbody>
</table>

### Audit Log

Every time a user performs an action in Claims Edit System (such as customizing a rule, running a report, importing claims, etc.), the system records that action in a log. You can view this log of user actions through the **Audit Log** module.
To view the Audit Log:

1. Open the **System Settings** module from the **Main Menu**.

2. Open the **Audit Log** module. A screen displays where you can define selection criteria for the items you want to view in the log.

3. To view the entire log, leave the selection criteria blank and select the **Find** button. The system then displays a list of items, beginning with the most-recent actions. If you want to refine the search to a more restricted list, enter the desired selection criteria in any of the following fields, then select the **Find** button:

<table>
<thead>
<tr>
<th><strong>Field</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>User</td>
<td>To restrict the list to actions involving a specific user, enter the desired user login name in this field.</td>
</tr>
<tr>
<td>Audit Date Range</td>
<td>To restrict the list to actions occurring within a specific range of dates, enter the desired date range in these fields.</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>Use this dropdown menu to restrict the list to any of the following actions:</td>
</tr>
<tr>
<td></td>
<td>• <em>All</em> - Includes all actions (i.e., no restriction by this criterion).</td>
</tr>
<tr>
<td></td>
<td>• <em>Add</em> - Restricts the list to actions of adding a new item.</td>
</tr>
<tr>
<td></td>
<td>• <em>Edit</em> - Restricts the list to actions of editing an existing item.</td>
</tr>
<tr>
<td></td>
<td>• <em>Delete</em> - Restricts the list to actions of deleting an existing item.</td>
</tr>
<tr>
<td></td>
<td>• <em>Disable</em> - Restricts the list to actions of temporarily disabling an existing item.</td>
</tr>
<tr>
<td></td>
<td>• <em>View</em> - Restricts the list to actions of viewing an existing item.</td>
</tr>
<tr>
<td></td>
<td>• <em>Enable</em> - Restricts the list to actions of enabling a disabled item.</td>
</tr>
<tr>
<td><strong>Category</strong></td>
<td>Use this dropdown menu to restrict the list to any of the following categories:</td>
</tr>
<tr>
<td></td>
<td>• <em>All</em> - Includes all categories (i.e., no restriction by this criterion)</td>
</tr>
<tr>
<td></td>
<td>• <em>Rule</em> - Restricts the list to actions involving rules</td>
</tr>
<tr>
<td></td>
<td>• <em>Rules</em> - Restricts the list to actions involving rules</td>
</tr>
<tr>
<td></td>
<td>• <em>Business Data</em> - Restricts the list to actions involving business data</td>
</tr>
<tr>
<td></td>
<td>• <em>LCD</em> - Restricts the list to actions involving Local Coverage Determin-</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• actions (LCD)</td>
<td></td>
</tr>
<tr>
<td>• Config - Restricts the list to actions involving configurations</td>
<td></td>
</tr>
<tr>
<td>• Claims - Restricts the list to actions involving claims</td>
<td></td>
</tr>
<tr>
<td>• Routes - Restricts the list to actions involving routes</td>
<td></td>
</tr>
<tr>
<td>• Presentation List - Restricts the list to actions involving presentation list</td>
<td></td>
</tr>
</tbody>
</table>

**Audit Log Panel-based UI**

**Application Version and Audit Log Compatibility**

<table>
<thead>
<tr>
<th>Application Version</th>
<th>KnowledgeBase Version</th>
<th>Audit Log UI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Edit System: 5.4 CU04+</td>
<td>2018 Q1A+ KnowledgeBase</td>
<td>Panel-based UI</td>
</tr>
<tr>
<td>Claims Edit System: 5.4 CU02v3 or earlier</td>
<td>2018 Q1A+ KnowledgeBase</td>
<td>Panel-based UI and Legacy UI</td>
</tr>
<tr>
<td>Claims Edit System: 5.4 CU04+</td>
<td>2017 Q4B or earlier KnowledgeBase</td>
<td>No access</td>
</tr>
</tbody>
</table>

**Navigation**

**Audit Log Legacy UI**

**To view the Audit Log Legacy UI:**
1. Log in to Claims Edit System.
2. Select **System Settings** on the Main Menu.
3. Select **Audit Log** on the System Settings screen. The Audit Log Legacy UI will display.
4. Refer to the **Audit Log** section for more information about the Audit Log Legacy UI.
After 2018 Q1A KnowledgeBase+ is loaded, the Action and Category values for new User Management audit logging will be blank in the Legacy UI if 5.4 CU04+ or 5.3.1 CU10+ is not installed.

Audit Log panel-based UI

The Audit Log panel-based UI allows the view of actions related to User, Role and Membership changes.

To view the Audit Log panel-based UI:

1. Log in to Claims Edit System.
2. Select Professional Editing on the Main Menu.
3. Select any enterprise.
4. Select the Rules icon.
5. Select Manage Data-Driven Rulesets.

- If the Claim Processing setting has previously been set to New dynamic DDR rulesets, the panel-based UI will display.
- If the Legacy UI displays, select Dynamic DDR Rulesets in the top right corner of the screen.

6. Under the SYSTEM section at the top of the navigation panel, select Audit Log. Audit Log functionality in the panel-based UI will display.

Important! In a multi-tenant environment, Audit Logging is available at both System and Tenant levels. System users can view audit log entries for system and tenant level actions. Tenant users can view audit log entries for only that tenant. Refer to the Multi-tenant Installation section for more details.

Audit Log Filters

The Filter criteria displays on the Audit Log panel. Four filter options are available:

<table>
<thead>
<tr>
<th>Selection</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Range</td>
<td>This allows a search using from and through date. The end date should not be a future date.</td>
</tr>
</tbody>
</table>
Selection | Description
--- | ---
Username | This allows a search by username. It is a free text box where you can enter the full name or the partial name.
Activity | Includes various options based on the actions performed within the application. A user is able to select All or None.
Category | Includes various options based on the categories within the application. A user is able to select All or None.
Scope | This includes all enterprises for the activities within the application, including system-level activities. A user is able to select All or None, and expand and collapse the list.

**Note**
Select filter criteria to populate it on the Audit Log screen. In the Activity filter, similar activities such as Add/Create, Edit/Override and Delete/Remove have been grouped as Add, Edit and Delete.

### Audit Log Result Columns
The following result columns display after filters have been applied.

<table>
<thead>
<tr>
<th>Selection</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Provides the date and time stamp information. This column is sortable.</td>
</tr>
<tr>
<td>User</td>
<td>Displays the username of who performed the actions in Claims Edit System.</td>
</tr>
<tr>
<td>Activity</td>
<td>Displays user actions.</td>
</tr>
<tr>
<td>Message</td>
<td>Displays a short description of the action performed. Examples include user login, user logout, claim analysis, and claim views. A DDR rule expression change does not display the modified rule expression; instead, it displays “User (XXXX): Modified DDR rule (RuleID-Rule Name).”</td>
</tr>
<tr>
<td>Category</td>
<td>Displays the category of the user action. In general, it denotes the module where the change has been made.</td>
</tr>
<tr>
<td>Scope</td>
<td>Displays the enterprise of the audit activity. Will show “System” or “Blank” if the activity was not associated with an enterprise.</td>
</tr>
</tbody>
</table>
For a multi-tenant system, an additional filter called “Tenant short name” displays for users with the “System Admin” role. This filter allows the “setup” user or the users with the “System Admin” role to view the Audit Log results filtered for tenants (for a multi-tenant user only).

Audit Log Details panel

To view the entire Audit Log message, select an item. A new panel opens with the Audit Log details, outlined in the table below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Provides the date and time stamp information.</td>
</tr>
<tr>
<td>User</td>
<td>Displays the username of who performed the actions in the system.</td>
</tr>
<tr>
<td>Activity</td>
<td>Displays user actions.</td>
</tr>
<tr>
<td>Message</td>
<td>Displays a short description of the action performed.</td>
</tr>
<tr>
<td>Category</td>
<td>Displays the category of the user action.</td>
</tr>
<tr>
<td>Item</td>
<td>Displays the sub-category of the user action.</td>
</tr>
<tr>
<td>Tenant (for a multi-tenant system)</td>
<td>Displays the Tenant Name of the user action.</td>
</tr>
<tr>
<td>Level</td>
<td>Displays the log level. In general, it denotes the type of audit logging.</td>
</tr>
</tbody>
</table>

Audit logging of Dynamic DDR actions

Prerequisites

- Viewing audit logging of DDR actions requires the loading of 2018 Q4A+ KnowledgeBase.
The Audit Log panel-based UI captures the following Add/Edit/Delete/Copy actions of Dynamic DDR:

- Rulesets
- Active Rules
- Inactive Rules
- New/Updated Rules
- Properties
- Claim Routing
- Route Properties
- Exceptions
- Flags

**Exporting a CSV File**

The user can export the generated Audit Log report to a CSV file.

**To export the Audit Log to a CSV file:**

1. Select the **Tools** gear menu dropdown arrow and select **Export listing to spreadsheet**.
2. Select **Save** to view the exported file.

**Navigating in the Claims Edit System**

Within Claims Edit System, the system displays screens similar to the following:

The following elements can help you navigate to various parts of Claims Edit System:

*Link Back To Main Menu*
A link back to the main menu appears near the upper left portion of the screen (regardless of where you move in the system). You can use this link to quickly jump back from lower-level screens. Simply place your cursor over the link and select. The system will go back to the Main Menu.

**Module Icons**

To move into the various modules of Claims Edit System, simply select the desired icon. The system then goes to the screen associated with that icon.

**Pull-Down Menus**

Another way you can move from module to module is to use the dropdown menus (located in the upper banner toward the right). When you hold the mouse over a dropdown menu, the system displays a list of modules beneath it. You can then move directly where you want by selecting the desired module on the list.

**Switching Enterprises**

An enterprise is an exclusive domain that can be accessed only by users assigned to that enterprise. This makes the data secure from users who should not be allowed to view or work with that data. The system displays the name of your current enterprise in the upper-right portion of the screen.
If you have access to more than one enterprise, you can switch over to another enterprise as follows:

**To switch enterprises:**

1. Place your cursor over the current enterprise (displayed in the upper-right portion of the screen). The enterprise name becomes a hyperlink.

2. Select the hyperlink. The system then displays an expandable tree listing the enterprises you have access to.

3. Select the desired enterprise from those listed. The system will then move you from the original enterprise into the one you selected.

**Same Provider Configuration**

During claims analysis, some rules require the system to recognize when separate references to "Provider" are actually referring to the same provider. You can use this screen to define (for the system) what to look for in making this determination.

To use Same Provider Configuration in the panel-based UI, refer to the [Same Provider Configuration – Panel-based UI](#) section.

**To access a Same Provider Configuration:**

1. Open the Settings module from the Enterprise entry-level screen.

2. Select Same Provider Configuration. The system displays a list of any existing configurations.

| Note | There is one system configuration on the list: Default Same Provider (and Default Same Provider NPT for Professional). |

- Default Same Provider = Billing Provider ID and Billing Specialty
- Default Same Provider NPT = Billing Provider ID
To add a new Same Provider Configuration:

1. Access the Same Provider Configuration screen (as described above).
2. Select the Add button.
3. Enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Enter a unique name to identify this configuration.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter a brief description that identifies the purpose of this configuration.</td>
</tr>
<tr>
<td>Type</td>
<td>From this dropdown, select one of the following options:</td>
</tr>
<tr>
<td></td>
<td>• Same Provider NPT: Indicates the configuration applies to New and Established Patient Data-Driven Rules.</td>
</tr>
<tr>
<td></td>
<td>• Same Provider: Indicates the configuration applies to Data-Driven Rules that contain logic for same provider.</td>
</tr>
<tr>
<td>Claim Fields</td>
<td>In this area, you define which claim fields the system must use to identify “Same Provider.” This area contains two columns: Available and Selected. The Available column lists potential claims fields you can use, while the Selected column lists those you choose.</td>
</tr>
</tbody>
</table>

To select a claim field:

a. Select the desired item in the Available column.

b. Select the right-arrow button (between the columns) to move your choice over to the Selected column.

When you select more than one item, the system will require all for a positive result. For example, if you select Provider ID and Servicing Physician ID, then both the same Provider ID and Servicing Physician ID must be present to meet the criteria.

Note Other things to keep in mind when creating a new configuration:
User-Defined Fields will not display as available fields unless they are marked as visible within User-Defined Fields. (Refer to the User-Defined Fields section for details.) All of the available fields that are listed above in Same provider NPT Configuration are available within the NPT table. When you purge claims and you select the option to retain new patient history data, the system stores all possible fields for editing NPT and EST in the table for any future changes to Same Provider Configuration.

When you select more than one item, the system will require all for a positive result. For example, if you select Provider ID and Servicing Physician ID, then both of them (the same Provider ID and Servicing Physician ID) must be present to meet the criteria.

**Note**

Other things to keep in mind when creating a new configuration:

User-Defined Fields will not display as available fields unless they are marked as visible within User-Defined Fields. (Refer to the User-Defined Fields section for details.) All of the available fields that are listed above in Same provider NPT Configuration are available within the NPT table. When you purge claims and you select the option to retain new patient history data, the system stores all possible fields for editing NPT and EST in the table for any future changes to Same Provider Configuration.

4. When you finish defining the configuration, select **Save**.

**Important!**

Merely creating a new configuration does not make it active in the system. After you create a configuration, you must also add it to the desired Claim Routes before the system can use it. (Refer to the Claim Routes section for details.) You can create more than one Same Provider Configuration of each type. This allows you to use different fields for editing, based on your requirements.

**To edit an existing Same Provider Configuration:**

1. Access the **Same Provider Configuration** screen (as described above).
2. Select the checkbox next to the item you want to edit.
3. Select **Edit**. The configuration options display.
4. Enter the desired configuration options (also described above).

5. Select Save when finished.

**To delete an existing Same Provider Configuration:**

1. Access the Same Provider Configuration screen (as described above).

2. Select the checkbox next to the item you want to delete.

3. Select Delete, then confirm.

| Important! | You cannot delete a configuration if it is in use (within a claim route). |
Security and User Management

Security System Overview

In Claims Edit System, there are two parts to system security:

**Data Security**

Data is simply the information that exists in Claims Edit System (such as claim records, patient records, crosswalks, etc.). As part of the security system, you can allow users to access some of these items while preventing them from accessing others. To do this, you separate your data into divisions called enterprises, then assign each user to the appropriate enterprise.

Enterprises are like separate companies (or divisions of a company). Users with access to one enterprise will not be able to see any information input by users in another enterprise. For this reason, creating enterprises lets you keep your records separate and secure. (Refer to the Defining Enterprises section for more information.)

**Permissions**

Permissions are rights to perform specific tasks in Claims Edit System. Just as enterprises control access to data, permissions control usage of data. In other words, even if users have the ability to retrieve data, they must also have permission to view and work with that data. Thus, a permission is a specific setting that defines exactly what work a user can do. For instance, you can give some users permission to add claims, others permission to analyze them, and still others permission to create rules for claims analysis.

In Claims Edit System, users do not have individual permissions. Instead, all users inherit their permissions from the roles they have been assigned. (A role is an entity that lets you assign permissions to an entire group of users. Refer to the Defining Roles section for more information.)

Establishing Security for your Organization

In Claims Edit System, it is a three-step process to customize security for the needs of your organization:

- **Define Enterprises** that restrict data as needed by specific companies, divisions, or departments.
- **Define Roles** (corresponding to job functions) for which a set of permissions apply to an entire group of users. Optum provides a number of pre-defined roles that you can use for this purpose, or you can create your own custom roles if needed.
- **Define an access record** for each user that must use the system. This record assigns each user to specific enterprises and roles.
Defining Enterprises

Often there will be personnel using your system who perform the same work but on different sets of data. For example, there may be several claim processors (all of whom process claims the same way) but they may be assigned to work with a unique set of accounts while being prevented from accessing any other accounts.

With enterprises, you can divide data into exclusive domains that can be accessed only by users assigned to that enterprise. This makes the data secure from other users who should not be allowed to view or work with that data.

Claims Edit System features three default enterprises:

- **System Data/Enterprise** - This is a view-only enterprise, which means users logged into it cannot change any settings or data while they remain in this enterprise. It is the main progenitor of all other enterprises in the system. It provides a pristine environment for upgrades.

- **Global Enterprise** - This enterprise has no peer (i.e., another enterprise defined at the same level in the hierarchy). It is reserved for settings that should apply to all enterprises in the system. Therefore, any changes to the settings in this enterprise will automatically apply to all other enterprises in your system.

- **Main Enterprise** - This is the base enterprise for your organization. If your company has no need to restrict any users from any data, you can simply assign all users to this enterprise. However, if your company needs a more regimented approach, you can create “child” enterprises (below the Main Enterprise), where each child owns unique settings and data. This is the level at which claims will appear if no child enterprises are created. Claims are available in the lowest enterprise of the tree structure.
Important! The main enterprise actually has a more precise name than the one described above. If you have purchased the Professional Claims Editor (which processes CMS-1500 claims), it will be called the “Professional Main Enterprise.” Similarly, if you have purchased the Facility Claims Editor (which processes UB claims for hospitals), it will be called the “Facility Main Enterprise.”

Parental Hierarchy in Enterprises

When you add children to an enterprise, each child inherits certain data properties from its parent. However, the way in which a child inherits claims data is different from the way it inherits everything else. Therefore, before you add children to any enterprise, it is important to understand the difference between these claims data and other types of data.

Inheritance of Native (Internal) Data

Native data consists of settings and properties that are stored within the system, rather than brought in through an external connection. There are two varieties of native data in Claims Edit System:

- **User-Updated Data**: Data that remains stored in the system and does not change unless someone intentionally modifies it. For example, user-defined lists would fall into this category because you can add or modify these lists directly in Claims Edit System, and the changes remain stored as part of the system. The same is true for rules, overrides and most of the user-defined tables you use to affect claims analysis.

- **System-Updated Data**: Data that cannot be modified manually but can only be changed by running an update. For example, KnowledgeBase data would fall into this category because you change the data by
• running a periodic update. You cannot directly modify the KnowledgeBase, although you can create overrides, which act as substitute entries for this data. (Refer to the Overrides section for details.) The same is true for most of the system lists you use to affect claims analysis.

The way enterprises inherit this kind of data is that any property possessed by a parent is automatically inherited by all of its children, but not by its own parent or any of its siblings. Therefore, when a user logs in to a parent, any change he/she makes to the native data (or other settings) is automatically inherited by all of the children, but not by its parent or any of its siblings. In addition, if a user logs into a “leaf” enterprise (i.e., an enterprise at the end of a branch, which has no children of its own), any change made to this kind of data will apply only within that enterprise.

Important! The principle of parental inheritance has a partial exception when it comes to user-defined system lists. You can specify the enterprises to which the lists should be visible, but this option is only available when creating the list. All usable data entered at the child enterprise level is visible only to that child enterprise and any of its children. Data entered at the child level is not visible at the parent level.

Inheritance of Claims Data

Claims data do not originate in Claims Edit System, but rather come into the system from an external connection. The data originate in the host system and migrate into Claims Edit System through connections (defined in the Connections module).

In Claims Edit System, enterprises that are parents cannot access claims data. Rather, users with rights to access a “parent” must log in at the “leaf” level to view or manipulate claims data. This makes inheritance a bit more complicated. For example, suppose you have an enterprise that starts out as a leaf (Enterprise A, below). As a leaf, this enterprise has a Routing ID to tell the system that sets of claims should be directed to that enterprise.
If you then created a child to this enterprise, it would no longer be eligible to access claims data because it would no longer be a "leaf" enterprise. Therefore, the Routing ID would be moved to the child, which would become the new leaf on this particular branch.

At this point in our example, Enterprise A no longer has a Routing ID. Therefore, if you created another child branching from this enterprise, there would be no Routing ID to inherit and the second child would have none.
Therefore, since Enterprise D cannot inherit the Routing ID from its parent, you would have to go into the enterprise and manually enter a Routing ID.

### Routing Claims to an Enterprise

The host system sends claims to Claims Edit System using an import message format. (Refer to the Message Format section for an overview of the formats that can be used.) As a part of the message format, each claim has a specific Security ID assigned to it. The Security ID on a claim equates to the Routing ID for an enterprise. Therefore, once a claim enters Claims Edit System it looks at the Security ID on that claim to determine which enterprise it should go through. This works in the following manner:

- If the system finds a Routing ID to match the Security ID, it sends that claim to the corresponding enterprise.
- If the system finds a Routing ID that does not match the Security ID, the system raises an error, which prevents further processing.
- If the Security ID on the claim is left blank (unpopulated), one of two things will happen:
  - If the IMF message format is used, the system sends that claim to the enterprise holding the Default Routing ID.
  - If the message format used is anything other than IMF, the system raises an error, which prevents further processing.
Default Routing (Applies to the IMF Message Format Only)

For systems that transmit claims using the Optum IMF (Import Message Format), the Default Routing ID handles any claim with a blank (unpopulated) Security ID. When you first install Claims Edit System, the Default Routing ID is associated with the Main Enterprise. For professional claims, this routing ID is named Professional_Default. For facility claims, it is named Facility_Default.

As mentioned in the section on Parental Hierarchy, an enterprise can no longer receive claims data if you add a child to that enterprise. This is true for a main enterprise as well. Therefore, if you add a child to a main enterprise, the system moves its routing ID to the child. The child then becomes the enterprise that receives default claims.

Important! As you create new enterprises, it is very important to keep track of the Default Routing ID. If you were to manually create a new child...
Important! enterprise, and then change the inherited Default Routing ID to something else, you would accidentally eliminate the Default Routing ID from the system. Therefore, any claims with a blank (unpopulated) Security ID could not be processed by the system.

Creating Enterprises

Before you begin: Be sure to outline your enterprise structure before setting up the structure in the system. Once you add an enterprise in the system, you cannot delete it. Contact Technical Support if you ever need an enterprise removed from your system.

Important! Optum strongly recommends that you stop claim processing when creating a new enterprise. Not doing so can cause claims to stop processing.

Note that the system considers both the Claim Type and Enterprise ID (Routing ID) when routing claims. This means there is not a problem if you use both the Professional and Facility editing modules and you specify the same Enterprise ID for both.

To create an enterprise:

1. Log in to the parent enterprise where you want to add the new child.

Important! You must be an administrator with permissions to create new enterprises within this enterprise. Otherwise you will not be able to complete the procedure below. (Refer to the Defining User Records section for more information about permissions).

2. Open the Settings module from the Enterprise entry-level screen.


4. Select New Enterprise.

5. Enter the information in the following fields:
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise Name</td>
<td>Enter a name that describes the new enterprise. Enterprise names are not case-sensitive and can consist of up to 50 alphanumeric characters.</td>
</tr>
<tr>
<td>Routing ID</td>
<td>Enter an identifier used to route claims from the host system to the appropriate enterprise. The routing ID is not case-sensitive, and can consist of up to 30 alphanumeric characters. <strong>Be sure the Routing ID you enter here matches exactly the one your host system will send to Claims Edit System as a part of the claims data</strong>. Otherwise, the system will raise an error when you try to process data. If you are unsure about what Routing ID to use, contact your Configuration Administrator for assistance.</td>
</tr>
<tr>
<td>Enterprise Description</td>
<td>Enter a brief description of the enterprise.</td>
</tr>
<tr>
<td>Parent of this Enterprise</td>
<td>You cannot edit this field. It displays the name of the immediate parent of your enterprise.</td>
</tr>
<tr>
<td>Claim Flow Management</td>
<td>This field indicates which modules of the system will receive claims through this enterprise. The following options are available:</td>
</tr>
<tr>
<td></td>
<td>• Clinical Editing - You cannot edit this setting. A checkmark here indicates the enterprise will send claims through the main module to identify clinical edits.</td>
</tr>
<tr>
<td></td>
<td>• Overpayment Analysis - A checkmark here indicates the enterprise will send claims to the Overpayment Detection module (if available on your system). Refer to the Overpayment Detection section for details.</td>
</tr>
<tr>
<td></td>
<td>• Pricing and Grouping - A checkmark here indicates the enterprise will send claims to the Prospective Payment module (if available on your system).</td>
</tr>
<tr>
<td><strong>Note</strong></td>
<td>The Clinical Editing option is the only one available without a license. The other two (Overpayment Analysis and Pricing and Grouping) require a separate license key before you can use.</td>
</tr>
</tbody>
</table>
### Field Description

| Note | them. Thus, even if you select the checkbox for those two options, the system will not invoke them unless you first add the corresponding license key. (Refer to the Product Licensing section for details.) |

---

**To override a default entry:**

1. Select the checkbox next to the item you want to override.
2. Select **Override**.
3. In the popup dialog, select a setting from the dropdown menu.
4. Select **Save**.

You can also remove an override:

**To remove an override:**

1. Select the checkbox next to the override you want to remove.
2. Select **Remove Override**. The system then returns the item to the default setting.

After you create the new enterprise, the system automatically assigns you rights to work in that enterprise. All other users must be given rights to work in that enterprise (refer to the Defining User Records section for details).

### Modifying Enterprises

**To modify the settings for an enterprise:**

1. Log in to the enterprise you want to modify (or one of its progenitors).
2. Open the **Settings** module from the **Enterprise** entry-level screen.
3. Select **Enterprise Management**.
4. From the list of enterprises, select to open the one you want to modify.
5. Modify any of the fields.
Important! If you modify the **Routing ID** field, the system prompts you with a message warning you that any change to this field could affect claims processing. When this message displays, you must confirm that the change you have made is correct.

6. When you finish modifying the settings, select the **Save** button.

## Cross-Claim Enterprise Grouping

### About Cross-Claim Editing

There are two main modules in Claims Edit System: the Professional Editing module (which processes claims according to the CMS-1500 claim form) and the Facility Editing module (which processes according to the Uniform Billing [UB] claim form). Each module is sold separately, and many clients only purchase one or the other. However, some clients have both modules on their system. When this is the case, it is possible for those clients to write special rules that work with both professional and facility claims (i.e., cross-claim editing).

### About Enterprise Groups

Both main modules of Claims Edit System (i.e., Professional and Facility) are made up of enterprises. An “enterprise” is an exclusive domain that exists to protect a block of data. Only users assigned to an enterprise can access the data associated with that enterprise. This makes the data secure from users who should not be allowed to view or work with that data. (Refer to the **Defining Enterprises** section for details.)

When clients have both the Professional module and the Facility module on their system, they can build relationships between professional and facility enterprises. These relationships are known as “enterprise groups.” Each enterprise group can contain one enterprise from the professional module and/or one from the facility module. If either of these enterprises have children (refer to the **Parental Hierarchy** section), those children are considered “inherited” members of that group through the parent. For this reason, any child enterprise that has become “inherited” cannot be included in a different group (as that would cause an overlap of enterprises).

### Managing Enterprise Groups

**To create an enterprise group:**

1. Open the **System Settings** module from the **Main Menu**.

2. Open the **Enterprise Group Configuration** module. The Enterprise Group Settings screen displays.
3. Select the **Add** button. The Add Enterprise Group screen displays.

4. Define the following settings for the enterprise group:

<table>
<thead>
<tr>
<th>Setting</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise Group Name</td>
<td>Enter a unique name for the enterprise group.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter a brief description to identify the purpose of the enterprise group.</td>
</tr>
<tr>
<td>Professional Enterprise Name</td>
<td>This area displays a list of enterprises that have been created in the Professional module. Select an enterprise, and the name of the enterprise will display under Selected Enterprise. If you make a mistake, select the <strong>Reset</strong> button to clear the selection.</td>
</tr>
<tr>
<td>Facility Enterprise Name</td>
<td>This area displays a list of enterprises that have been created in the Facility module. Select an enterprise, and the name of the enterprise will display under Selected Enterprise. If you make a mistake, select the <strong>Reset</strong> button to clear the selection.</td>
</tr>
</tbody>
</table>

5. When finished, select **Save**.

**To edit an existing enterprise group:**

1. Open the **System Settings** module from the Main Menu.
2. Open the **Enterprise Group Configuration** module. The Enterprise Group Settings screen displays.
3. From the list of enterprise groups, select the checkbox next to the group you want to edit.
4. Select **Edit** at the top of the screen. The Add Enterprise Group screen displays, showing the existing settings for that group.
5. Make changes to the settings, then select **Save**.

**To delete an enterprise group:**

1. Open the **System Settings** module from the Main Menu.
2. Open the **Enterprise Group Configuration** module. The Enterprise Group Settings screen displays.
3. From the list of enterprise groups, select the checkbox next to the groups you want to delete.
4. Select **Delete** at the top of the screen. The system then deletes the selected groups.
About Cross-Claim Type Editing (CCT)

Cross-Claim Type Editing is the ability to compare different claim types against one another (for example, PE to FE or FE Inpatient to FE Outpatient). It offers:

- Ability to analyze across Professional Editor and Facility Editor claims.
  - Identify when a radiology procedure is billed in Professional without a modifier and the same procedure code is billed in Facility for the same date of service.
- Ability to compare inpatient and outpatient claims.
  - Identify when an inpatient claim is billed on the same date of service as an outpatient claim
- Ability to choose the enterprise to map for analysis.
  - For example, Enterprise A facility claims should only compare to Enterprise A professional claims.
- Cross-Claim Type Editing ILOG verbalizations can be added to custom rules to use this functionality. In addition, Cross-Claim Type Editing DDR statements can be selected and added to custom DDR rules.

Example Use Case

This edit is designed to determine when a Facility/Provider billed both an inpatient claim and a professional claim where the date of service of the inpatient claim is the same as the professional claim. If a facility intentionally or otherwise bills for a professional service when the patient was actually admitted, it normally will not be paid as it is considered double billing.

Claim 1: For Patient A, Facility B bills an inpatient facility visit for 1/09/19 – 1/11/19

Claim 2: For Patient A, Facility B bills a professional visit for 1/10/19

Interface Considerations

If history is not passed in, history will be read from the database. If the history is passed in and does not contain claims matching the cross-claim criteria, it will look in the database for claims.

- If history is filtered from the interface, meaning only professional claim history is sent in with a professional current claim or only facility claim history is sent in with a facility current claim, the history in the database will be used for cross-claim editing.

<table>
<thead>
<tr>
<th>Interface</th>
<th>CCT with History Passed In</th>
<th>CCT with Database History</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMF - Epic Tapestry</td>
<td>No. Because of the differences between</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Interface

<table>
<thead>
<tr>
<th>Interface</th>
<th>CCT with History Passed In</th>
<th>CCT with Database History</th>
</tr>
</thead>
<tbody>
<tr>
<td>iKA</td>
<td>the PE and FE message formats, a mixture of PE and FE claims cannot be sent in as history.</td>
<td></td>
</tr>
<tr>
<td>X12/837</td>
<td>No. The ability to send in history with the current claim is not available.</td>
<td>Yes</td>
</tr>
<tr>
<td>XMLv2 - Amisys, HealthEdge, QNXT, GE</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Facets</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

### Overpayment Detection

The Overpayment Detection module helps you identify potential fraud, waste and abuse. You can use this tool to prospectively review claims and reveal potential ways a provider might be (intentionally or unintentionally) using incorrect billing methods.

Many times adjudication systems and claims editing systems only contain nationally sourced edits. In contrast, the Overpayment Detection Module uses non-sourced flags created from previous fraud, waste and abuse scenarios found in market research. By default (i.e., out of the box) the system sets all Overpayment Detection flags to a review status. However, you can customize these edits to match your policies and procedures. It is up to you to determine how to use the information found within the Overpayment Detection Module.

Overpayment Detection is a separate module (sold separately from the Professional and/or Facility modules of the Claims Edit System). To purchase the module, contact your Optum Customer Service representative.

### Overpayment Detection Claim Map

This functionality is designed to work with the Overpayment Detection System (ODS), which must be purchased as a separate module. If you have not purchased Overpayment Detection, the icon for this module will not be active on your system.

With the Overpayment Detection Claim Map, you can determine how to pass Claims Edit System claims from specific professional and/or facility enterprises to an enterprise within the Overpayment Detection module. This enables you to write rules that look at specific professional or facility claims collectively within an enterprise.
Prerequisite Tasks

Before you can work with an Overpayment Detection Claim Map, you must first do the following:

a. Create at least one enterprise within the Overpayment Detection module. (Refer to the Enterprises section for details.)

b. Create at least one cross-claim enterprise group. (Refer to the Cross-Claim Enterprise Grouping section for details.)

Working with Claim Maps

Once these entities are in place, you can create and manage claim maps as described below:

To create a new claim map:

1. Open the System Settings module from the Main Menu.
2. Open the ODS Claim Map module.
4. Enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODS Claim Map Name</td>
<td>Enter a unique name for the claim map.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter a brief description to identify the purpose of the claim map.</td>
</tr>
<tr>
<td>Enterprise Group</td>
<td>This dropdown menu lists available enterprise groups created on your system. Select the enterprise group you want to work with in this claim map.</td>
</tr>
<tr>
<td>ODS Enterprise</td>
<td>This dropdown menu lists enterprises created within the Overpayment Detection module. Select the enterprise you want to work with in this claim map.</td>
</tr>
</tbody>
</table>

5. Select Save. The system then creates a new claim map linking the ODS Enterprise with the Professional and/or Facility enterprises belonging to the enterprise group.
To edit an existing claim map:
1. Open the **System Settings** module from the Main Menu.
2. Open the **ODS Claim Map** module. The system displays a list of all existing claim maps.
3. Select the checkbox next to the claim map you want to edit.
4. Select **Edit**.
5. Modify the settings as needed.
6. Select **Save** to exit and retain your changes.

To delete a claim map:
1. Open the **System Settings** module from the Main Menu.
2. Open the **ODS Claim Map** module. The system displays a list of all existing claim maps. Select the checkbox next to the claim map you want to delete.
3. Select **Delete**.
4. Confirm that you want to delete the selected item. The system then deletes the claim map.

**Analyze Claims**

In addition to the Add, Edit, and Delete buttons, there is also a button called Analyze Claims. This button is disabled and is intended for future use.

**Enterprise Properties**

Enterprise Properties allows changes to certain enterprise-specific properties. Available enterprise properties include DDR Flag Prefix, DDRERR and Error Edits (ERR).

**DDR Flag Prefix**

When a value is added to the DDR Flag prefix, the value is displayed as a prefix to each Data-Driven flag that appears on a claim line. This prefix allows both a Data-Driven flag and an ILOG flag that are the same to appear on the same line.

Depending on the client’s configuration, the flags may or may not be returned to the host system.
For example, if the DDR NPT flag is on profile, and if Return Profile Results is not checked in the Connection Configuration, the profile edits will not be returned. If Return Profile Results is checked, the results will be returned.

**DDRERR**

When a DDRERR edit is created, it will search the enterprise hierarchy beginning with the claim’s enterprise to find the value for the DDRERR enterprise property. The value found for this property will be applied to the edit’s Error Status.

**Error Edit Level information**

The global enterprise has the following enterprise properties (in either SQL server or Oracle):

- ErrorEditLevel with a value of 20000
- ErrorEditStatus with a value of R (for Review)

These enterprise properties can be changed in the global enterprises and/or overridden in child enterprises.

When an ERR edit is created, it will search up the enterprise hierarchy beginning with the claim’s enterprise to find the value for ErrorEditLevel and ErrorEditStatus enterprise properties. The values found for these properties will be applied to the edit’s ErrorLevel and Status respectively.

If the ERR occurs before the claim has been assigned to an enterprise, the settings found in the global enterprise will be used.

**Defining Roles**

A role is an entity that lets you assign permissions to an entire group of users. Every role has two parts: a set of permissions and a set of users.
When a user becomes assigned to a role, they inherit all of the permissions defined for that role. Similarly, when a permission is defined for a role, every user assigned to that role will automatically inherit the new permission.

**Role Permissions**

Permissions are rights to perform specific tasks within the system. In Claims Edit System, permissions are associated with specific modules (or screens).

If a user has the permission to work with a given screen, the system will allow them to open that screen by selecting the icon. If the user does not have this permission, they will not be able to open that screen, and the corresponding icon will not display.

For example, if a user has permission to work with the Procedures screen, they would be able to access the Procedures screen by drilling down through the menu structure as shown below:

![Diagram showing menu structure and access to Procedures screen]

However, if the user did not have the permission to access the Procedures screen, they would not see the menu icon to launch the Procedures screen.

Permissions for a given screen in Claims Edit System can be assigned four ways:
## Permission Description

<table>
<thead>
<tr>
<th>Permission</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read</td>
<td>This type of permission gives the user rights to access the screen and view the associated data, but not to modify the data.</td>
</tr>
<tr>
<td>Create</td>
<td>Gives the user rights to create new items associated with the screen, but not to modify or delete existing items.</td>
</tr>
<tr>
<td>Update</td>
<td>Gives the user rights to modify existing items associated with the screen, but not to delete them or add new items.</td>
</tr>
<tr>
<td>Delete</td>
<td>Gives the user rights to delete existing items associated with the screen.</td>
</tr>
</tbody>
</table>

## System Roles and Permissions

In Claims Edit System, you do not assign permissions to individual users. Rather, users inherit permissions from the roles they are assigned. Five pre-defined roles come with Claims Edit System:
**Business Administrator:** Contains permissions to manage data and implement business decisions in the system. The default permissions belonging to this role are as follows:

<table>
<thead>
<tr>
<th>Claims</th>
<th>Code Repository</th>
<th>LCD</th>
<th>Rules</th>
<th>Reports</th>
<th>Settings</th>
<th>System Settings</th>
<th>KB Utilities</th>
<th>Provider Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>claims</td>
<td>cci</td>
<td>fe</td>
<td>claim routes</td>
<td>icd-10 to icd-9</td>
<td>=</td>
<td>applied edits</td>
<td>kb utilities</td>
<td>provider comparison</td>
</tr>
<tr>
<td>claims history</td>
<td>cms ruv</td>
<td>fe frequency history</td>
<td>ingenix ruv</td>
<td>ingenuity ruv</td>
<td>=</td>
<td>audit log</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe claims</td>
<td>code relationships</td>
<td>max frequency</td>
<td>list and crosswalk</td>
<td>list and crosswalk</td>
<td>=</td>
<td>connection configuration</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe frequency history</td>
<td>diagnosis</td>
<td>modifiers</td>
<td>max frequency</td>
<td>max frequency</td>
<td>=</td>
<td>enterprise configuration</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>frequency history</td>
<td>fee apc</td>
<td>mpfs</td>
<td>modifiers</td>
<td>mpfs</td>
<td>=</td>
<td>enterprise group configuration</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>new patient history</td>
<td>fee cms ruv</td>
<td>mpfs</td>
<td>max frequency</td>
<td>mpfs</td>
<td>=</td>
<td>ods claim map</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>ods claims</td>
<td>fee diagnosis</td>
<td>mpfs</td>
<td>modifiers</td>
<td>mpfs</td>
<td>=</td>
<td>product license</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>icd-10 to icd-9</td>
<td>fee icd-10 to icd-9</td>
<td>procedure</td>
<td>max frequency</td>
<td>procedure</td>
<td>=</td>
<td>purge claims</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe ingenix ruv</td>
<td>fee max frequency</td>
<td>providers</td>
<td>max frequency</td>
<td>providers</td>
<td>=</td>
<td>rules install</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe list and crosswalk</td>
<td>fee modifier</td>
<td>providers</td>
<td>rules</td>
<td>providers</td>
<td>=</td>
<td>security settings</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe mpfs</td>
<td>fee mpfs path</td>
<td>rules</td>
<td>roles</td>
<td>rules</td>
<td>=</td>
<td>user/role management</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe mpfs ruv</td>
<td>procedure</td>
<td>rulesets</td>
<td>roles</td>
<td>rulesets</td>
<td>=</td>
<td>system version</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
<tr>
<td>fe procedure</td>
<td>fe revenue</td>
<td>rules</td>
<td>roles</td>
<td>rules</td>
<td>=</td>
<td>system version</td>
<td>mgnt</td>
<td>exactly</td>
</tr>
</tbody>
</table>

*Categories: Read (View Only) | Create | Update Existing (Write) | Delete/Remove | No Permissions*
ods pe claim routes
ods pe manage rules
reduction record
- **System Administrator**: Contains permissions to install Claims Edit System and to configure communication with the host system (e.g., setting up import and export directories, real time vs. batch connection, etc.). The default permissions belonging to this role are as follows:

<table>
<thead>
<tr>
<th>Claims</th>
<th>icd-10 to icd-9...</th>
<th>ingenix rvu</th>
<th>list and crosswalk</th>
<th>max frequency</th>
<th>mpfs</th>
<th>mpfs rvu</th>
<th>procedure</th>
<th>providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>•</td>
<td>•</td>
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<th>Code Repository</th>
<th>LCD</th>
<th>Rules</th>
<th>Reports</th>
<th>Settings</th>
<th>System Settings</th>
<th>KB Utilities</th>
<th>Provider Comparison</th>
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</tbody>
</table>

**Permissions**:  
- **R** = Read (View Only)  
- **C** = Create New  
- **U** = Update Existing (Write)  
- **D** = Delete/Remove  
- **E** = No Permissions  

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- **Claim Reviewer**: Contains permissions to analyze claims and review the flags raised during analysis. This includes the ability to manage claims, test analyze claims, look at disclosure information (edit rationale), and determine or change the final claim disposition. The default permissions belonging to this role are as follows:

  - Read (View Only) | Create New | Update Existing (Write) | Delete/Remove | No Permissions

<table>
<thead>
<tr>
<th>Claims</th>
<th>fe-10 to fe-9...</th>
<th>ingenix rvu-ft</th>
<th>list and crosswalk-ft</th>
<th>max frequency-ft</th>
<th>modifiers-ft</th>
<th>mpfs-ft</th>
<th>mpfs rvu-ft</th>
<th>procedure-ft</th>
<th>providers-ft</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Repository</td>
<td>fe lcl custom fl/mac</td>
<td>edit-ft</td>
<td>fe lcl overrides-ft</td>
<td>lcl custom carrier edit-ft</td>
<td>lcl overrides-ft</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rules</td>
<td>claim routes-ft</td>
<td>fe claim routes-ft</td>
<td>fe manage rules-ft</td>
<td>fe reduction record-ft</td>
<td>manage rules-ft</td>
<td>manage rulesets-ft</td>
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<tr>
<td>LCD</td>
<td>fe claims</td>
<td>claims history-ft</td>
<td>fe claims history-ft</td>
<td>fe frequency history-ft</td>
<td>frequency history-ft</td>
<td>new patient history-ft</td>
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</tbody>
</table>

| Reports         | report-ft |
| Settings        | claim field settings-ft | enterprise management-ft | enterprise properties-ft | ods enterprise mgmt-ft | user defined fields-ft |
| Change Password | change password-ft |
| System Settings | applied edits-ft | audit log-ft | connection configuration-ft | enterprise group config-ft | ods claim map-ft | product license-ft | purge claims-ft | rules install-ft | security settings-ft | user/role management-ft |
| System Version  | system version-ft |
| KB Utilities    | kb utilities-ft |
| Provider Comparison | provider comparison-ft |
Customer Service Representative (CSR): Contains permissions to interpret claims analysis for business needs such as responding to customer inquires. The default permissions belonging to this role are as follows:

- = Read (View Only) |  = Create New |  = Update Existing (Write) |  = Delete/Remove |  = No Permissions

<table>
<thead>
<tr>
<th>Claims</th>
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</table>
| claims | ... | ... | ...
| claims history | ... | ... | ...
| fe claims | ... | ... | ...
| fe frequency history | ... | ... | ...
| frequency history | ... | ... | ...
| new patient history | ... | ... | ...
| ods claims | ... | ... | ...

<table>
<thead>
<tr>
<th>Code Repository</th>
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</thead>
</table>
| cci | ... | ... | ...
| cms rnu | ... | ... | ...
| code relationships | ... | ... | ...
| diagnosis | ... | ... | ...
| fe apc | ... | ... | ...
| fe cms rnu | ... | ... | ...
| fe diagnosis | ... | ... | ...
| fe icd-10 to icd-9 | ... | ... | ...
| fe ingenix rnu | ... | ... | ...
| fe list and crosswalk | ... | ... | ...
| fe max frequency | ... | ... | ...
| fe modifier | ... | ... | ...
| fe mpfs rnu | ... | ... | ...
| fe procedure | ... | ... | ...
| fe revenue | ... | ... | ...

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| list and crosswalk | ... | ... | ...
| max frequency | ... | ... | ...
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| mpfs rnu | ... | ... | ...
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<tr>
<th>Reports</th>
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<th>Settings</th>
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</thead>
</table>
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| enterprise management | ... | ... | ...
| enterprise properties | ... | ... | ...
| ods enterprise mgnt | ... | ... | ...
| user defined fields | ... | ... | ...

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<tr>
<th>Change Password</th>
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</table>
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<tr>
<th>System Settings</th>
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</thead>
</table>
| applied edits | ... | ... | ...
| audit log | ... | ... | ...
| connection configuration | ... | ... | ...
| enterprise group config | ... | ... | ...
| ods claim map | ... | ... | ...
| product license | ... | ... | ...
| purge claims | ... | ... | ...
| rules install | ... | ... | ...
| security settings | ... | ... | ...
| user/role management | ... | ... | ...

<table>
<thead>
<tr>
<th>System Version</th>
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</table>
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<table>
<thead>
<tr>
<th>KB Utilities</th>
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| kb utilities | ... | ... | ...

<table>
<thead>
<tr>
<th>Provider Comparison</th>
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</table>
| provider comparison | ... | ... | ...

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• **KnowledgeBase Administrator:** Contains permissions to administer all KnowledgeBase configuration tasks. The default permissions belonging to this role are as follows:

  - Read (View Only) | Create New | Update Existing (Write) | Delete/Remove | No Permissions

<table>
<thead>
<tr>
<th>KB Utilities</th>
<th>All Other Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>kb utilities</td>
<td>permissions</td>
</tr>
</tbody>
</table>

• **KnowledgeBase Viewer:** Contains permissions to view all KnowledgeBase configuration tasks. The default permissions belonging to this role are as follows:

  - Read (View Only) | Create New | Update Existing (Write) | Delete/Remove | No Permissions

<table>
<thead>
<tr>
<th>KB Utilities</th>
<th>All Other Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>kb utilities</td>
<td>permissions</td>
</tr>
</tbody>
</table>

• **Reports Administrator:** Contains permissions to administer all reports tasks. The default permissions belonging to this role are as follows:

  - Read (View Only) | Create New | Update Existing (Write) | Delete/Remove | No Permissions

<table>
<thead>
<tr>
<th>Reports</th>
<th>All Other Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>report</td>
<td>permissions</td>
</tr>
</tbody>
</table>

• **Report Viewer:** Contains permissions to view all reports configuration tasks. The default permissions belonging to this role are as follows:

  - Read (View Only) | Create New | Update Existing (Write) | Delete/Remove | No Permissions

<table>
<thead>
<tr>
<th>Reports</th>
<th>All Other Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>report</td>
<td>permissions</td>
</tr>
</tbody>
</table>

**Additional Roles Used by the System**

In some cases, you may see the following roles listed among the system roles:

• BRES Admin
• Login
• rtsAdministrator
- rtsUser
- rtsConfigManage

These roles are used by the system only, and should not be assigned to users.

**Creating Custom Roles**

In addition to these pre-defined roles, you may want to create your own roles to fit the needs of your organization.

**To create a new role:**

1. Open the **System Settings** module from the Main Menu screen.
2. Select the **New Role** button.
3. Enter the information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Name</td>
<td>Enter a name that describes the new role. Role names are not case-sensitive, and can consist of up to 50 alphanumeric characters.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter a brief description of the role.</td>
</tr>
<tr>
<td>Permissions</td>
<td>Define the list of system permissions you want to assign to this role.</td>
</tr>
<tr>
<td></td>
<td>a. Select the checkbox for each permission you want to add to the role.</td>
</tr>
<tr>
<td></td>
<td>b. When you finish, select <strong>Save</strong>.</td>
</tr>
</tbody>
</table>

**Modifying Roles**

**To modify an existing role:**

1. Open the **System Settings** module from the Main Menu screen.
2. Select the **Roles and Permissions** icon.
3. From the list of roles, select a role.
4. Modify the settings as needed.

5. Select Save.

## Defining User Records

Before a user can log in to the system, they must have a user record. This record defines the username, password, and permissions for the user.

Some clients use an identity management tool (such as Microsoft Active Directory) to control access to their system. In this kind of setup, usernames and passwords exist in the Identity Management System (IMS) - not in Claims Edit System. Thus, the login information you enter must be the same as it is defined for you in the IMS.

### To create a new user record:

1. Open the **System Settings** module from the Main Menu screen.
2. Select the **User Management** icon. A list displays of current user records.
3. Select **New User**.
4. Enter the information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>User ID</td>
<td>Enter the login name for the user.</td>
</tr>
<tr>
<td>Password</td>
<td>Enter the password for the user. (Refer to the User Password Security section for more information.)</td>
</tr>
<tr>
<td>Status</td>
<td>In this field, indicate whether the user can log in to Claims Edit System. Active status means this User Record is available for use, and the login will work. Inactive status means the record is locked, and cannot be used at this time. (Refer to the Locking/Unlocking User Records section for more information.)</td>
</tr>
<tr>
<td>User Name</td>
<td>Enter the name of the user who will use this login ID.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Roles</td>
<td>Use this field to assign pre-defined roles to the user. (Refer to the Defining Roles section for more information.) By default, the system leaves this field empty - with no roles assigned. Select the checkbox for each role you want to assign at this time.</td>
</tr>
<tr>
<td>Enterprise Membership</td>
<td>Use this field to indicate which enterprises this user should belong to. (Refer to the Defining Enterprises section for more information.) Select the checkbox for each enterprise you want to assign at this time.</td>
</tr>
</tbody>
</table>

5. When you finish, select the **Save** button.

**To modify an existing user access record:**

1. Open the **System Settings** module from the Main Menu screen.
2. Select the **User Management** icon.
3. From the list, select the user record you want to modify.

| Important! | If you see a user record named *rulesinstall*, do not modify this record in any way. This record is for use only by Optum technical support to assist with certain installation tasks when necessary. |

4. Change the settings as needed.
5. When you finish, select the **Save** button.

**User Password Security**

When you add a new user to the system (refer to the Defining User Records section), you must assign a password to allow that user to log in. There are several factors to consider regarding these passwords, such as:

- What are the minimum and maximum number of characters allowed?
- Which characters are allowed and which are prohibited?
- When will the password expire and how often must the user change it?

The way you answer these (and similar) questions will determine password security on your system.
Some clients control access to their system by using an Identity Management System (IMS) such as Microsoft Active Directory. With an IMS, the username and password a user needs to access Claims Edit System is stored in the IMS, not in Claims Edit System. Therefore, all security settings must be handled in the IMS.

If your system does not use an IMS, password security settings will be handled by Claims Edit System. Therefore, Claims Edit System contains several important settings to control password security. (For example, what is the minimum and maximum length of a password, what special characters are required, when does it expire, etc.) Once you configure these settings, any password you enter must conform to specific criteria.

### Configuring the password policy

**To configure the password policy:**

1. From the Main Menu, open the System Settings screen.
2. Select User ID/Password Settings. The Security Settings screen then displays.
3. On the User ID/Password tab, enter information in the following fields:

<table>
<thead>
<tr>
<th>User ID Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Length</td>
<td>Enter the minimum number of characters that must exist in a valid user login ID.</td>
</tr>
<tr>
<td>Maximum Length</td>
<td>Enter the maximum number of characters that must exist in a valid user login ID.</td>
</tr>
<tr>
<td># of Unique Characters Required</td>
<td>Indicate how many unique characters must be used in a valid user login ID. A unique character is one that does not repeat any previously used character. Thus, the first time any character appears in a User ID, the system considers it to be unique. However, any time that same character appears again in the User ID, those additional instances are non-unique.</td>
</tr>
<tr>
<td>User ID Unique Characters Required</td>
<td>Select this checkbox to activate the requirement for “unique characters” (defined in the previous field).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Password Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Length</td>
<td>Enter the minimum number of characters that must exist in a valid user login ID.</td>
</tr>
<tr>
<td>Password Field</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maximum Length</td>
<td>Enter the maximum number of characters that must exist in a valid password.</td>
</tr>
<tr>
<td># of Unique Characters Required</td>
<td>Indicate how many unique characters must be used in a valid password. (Refer to the explanation of “unique” characters above.)</td>
</tr>
<tr>
<td>Days Before Password Must Be Changed</td>
<td>Enter the number of days you will allow a password to remain valid. After this number of days passes, the password will expire, and the system will ask the user to create a new password. (Refer also to the # of Grace Logins After Expiration section below.)</td>
</tr>
<tr>
<td>Days Before Password Can Be Reused</td>
<td>This field works with the # of Consecutive Passwords That Must Be Unique field (see below) to restrict the use of previously used passwords. In this field, enter the number of days that must pass before a user can reuse an expired password. For example, if you enter 30 in this field, users must wait at least 30 days before they can reuse the password that just expired.</td>
</tr>
<tr>
<td># of Grace Logins After Expiration</td>
<td>Once a password expires (refer to the Days Before Password Must Be Changed section above), enter the number of times a user can continue to use the expired password before he/she must either create a new password or become locked out of the system.</td>
</tr>
<tr>
<td>New Password Required at First Login/After Reset</td>
<td>When you select Yes in this dropdown box, the system forces users to enter a new password after they log in for the first time, or after their password has been reset by an administrator.</td>
</tr>
<tr>
<td>Must Contain a Number</td>
<td>Select this checkbox if you want to require at least one numeric value in the password.</td>
</tr>
<tr>
<td>Must Contain a Lowercase Character</td>
<td>Select this checkbox if you want to require at least one lowercase character in the password.</td>
</tr>
</tbody>
</table>
| Must Contain an Uppercase Character    | Select this checkbox if you want to require at least one
<table>
<thead>
<tr>
<th>Password Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>uppercase character in the password.</td>
</tr>
<tr>
<td>Must Contain a Special Character</td>
<td>Select this checkbox if you want to require at least one special character in the password. (A special character is a symbol such as #, &amp;, @, ©, etc.)</td>
</tr>
<tr>
<td>Must not contain 2 consecutive characters</td>
<td>Select this checkbox to require that a password not contain two consecutive characters.</td>
</tr>
<tr>
<td>May Contain User ID</td>
<td>Select this checkbox if you want to allow the password to include the User ID. Leave it unchecked if you want to prevent this (for greater security).</td>
</tr>
<tr>
<td># of Consecutive Passwords That Must Be Unique</td>
<td>This field works with the Days Before Password Can Be Reused field (see above) to restrict the use of previously used passwords. In this field, enter the number of times a user must enter a new password before they can reuse an expired password. For example, if you enter “3” in this field, users must create a new password three times before they can reuse the password that just expired.</td>
</tr>
</tbody>
</table>

4. On the Account Timeout tab, enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes of Inactivity Before User is Logged Out</td>
<td>Enter the number of minutes the system can remain idle before it automatically logs out an inactive user.</td>
</tr>
<tr>
<td>Days of Inactivity Before Account is Deactivated</td>
<td>Enter the number of days users can neglect to log in before the system automatically deactivates their user access. (Refer to the Defining User Records section for information on how to re-establish a user in the system.)</td>
</tr>
<tr>
<td>Failed Login Attempts Before Account is Locked</td>
<td>Enter the number of times a user can attempt to use an invalid password before the system locks them out.</td>
</tr>
<tr>
<td># of Minutes During Which Failed Login Attempts Will Accumulate</td>
<td>Once a user enters an invalid password, the system starts a timer and begins tracking additional login failures. In this field, enter the number of minutes that must pass before this timer resets. If this number is set to zero, the system will never reset the timer, but will continue to track failed login attempts until the user exceeds the limit.</td>
</tr>
</tbody>
</table>
Field | Description
---|---
# of Minutes to Lock Accounts | When a user becomes locked out of the system, enter the number of minutes that must pass before the system automatically releases the lock. If this number is set to zero, the system will keep a lock on the user record until a system administrator manually releases the lock.

5. When you finish defining these settings, select Save.

**Setting a New Password for a User**

Once you have defined the password policy, you can enter passwords for specific users.

To set a new password for a user:

1. From the Main Menu, open the System Settings screen.
2. Open the User Management module.
3. From the list, select a user record.
4. In the Password field, enter a password.

**Important!** Remember that all passwords in Claims Edit System are case-sensitive. They are also subject to the password policies described above.

5. When you finish, select the Save button.

**Locking/Unlocking User Records**

In Claims Edit System, there are three ways a user can become locked out of the system:

- The user allows his/her password to expire without changing it before the number of grace logins has been reached.
- The user exceeds the allowed number of successive login attempts with an incorrect password.
- An administrator manually locks out the user by changing the status of their User Access Record to Inactive.

When any of these events occur, the user must contact a system administrator to have their access restored.
To lock or unlock a user login:

1. From the Main Menu, open the System Settings screen.
2. Open the User Management module.
3. From the list, select the record for a user.
4. In the Status field, use the dropdown menu to set the status as needed. Active status means this User Access Record is available for use, and the login will work for the user. Inactive status means the record is locked, and cannot be used at this time.
5. When you finish, select Save.

User Management Panel-based UI

The panel-based User Management component of the interface provides an enhanced user experience with capabilities made available by installing the 5.4 SP1-CU03+ cumulative update.

This update also has a prerequisite of the CES_KB_2017_Q4B_5.0-5.4. Refer to the User Management Panel-based UI Migration Mapping section for information about Migration Mapping, User Management Permission Privilege Mapping and System Role Descriptions.

| Note | The CES_KB_2017_Q4B_5.0-5.4 or any later KB can be loaded at any time prior to installing the SP1-CU03 cumulative update. The KB does not have any dependency on the cumulative update. It is only the cumulative update that requires a KB version that includes the enhanced User Management component. |

Overview of User Management Concepts

User Management is based on the following terms, each of which must be clearly understood to effectively manage users within Claims Edit System.

User Account

A user account must be created for each person allowed to log in to Claims Edit System. It holds information about the user such as their name; the username they will use to log in to the system; their password; various status information such as whether the account is enabled, disabled, or locked; and when their password will expire.
Privilege

A privilege corresponds to a set of functions within Claims Edit System that an individual may be granted access to. Some privileges grant access to a single function. For example, the Load KB privilege allows the user to load a KnowledgeBase via the SmartLoad Import screen. Other privileges grant access to multiple functions. For example, the Manage claim data privilege allows a user who is assigned the privilege to load CSV files containing Frequency History, New Patient History, or Claim History into the system, each of which is accessed via a different user interface screen.

There are two privilege types: System- and Enterprise-level privileges. For details about these privileges, refer to the User Management Panel-based UI Migration Mapping section.

Role

A role is a named collection of logically connected privileges. A role should correspond to the work functions of different people that use Claims Edit System within your organization. Claims Edit System provides a number of default roles (e.g., System Admin, Rule Developer, Claim Manager, etc.). However, the ability to create a custom role exists.

Scoping of Roles

The scope of a role can be either System or Enterprise. This is determined by the types of privileges that are associated to the role. Therefore, a role can contain only System privileges or Enterprise privileges but not a mixture of both types.

When a role is created, first the scope must be selected as System or Enterprise. The list of corresponding System or Enterprise privileges will then display. For more details about the different System and Enterprise privileges, refer to the User Management Panel-based UI Migration Mapping section.

<table>
<thead>
<tr>
<th>Note</th>
<th>When upgrading to 5.3.1 SP2-CU10 and above, or 5.4 SP1-CU03 and above, the “Business Admin” role will no longer be available. The “Business Admin” role will be automatically converted to “System Admin” post-migration. If a user needs the same privileges as that of “Business Admin,” a custom role can be created in the panel-based User Management UI.</th>
</tr>
</thead>
</table>

| Important! | In a multi-tenant environment an additional role scope of Tenant is provided. Refer to the Multi-Tenant Installations User Roles and Permissions section for more details. |
Accessing or Viewing User Accounts

To access a user account:

1. On Claims Edit System's main menu, select System Settings.
2. Select User Accounts.

The System Configuration menu displays the tabs described in the table below. Selecting a user within the User Accounts tab displays additional detail and options depending on the permissions for this user.

<table>
<thead>
<tr>
<th>Tab</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>About</td>
<td>Product: Name of Product</td>
</tr>
<tr>
<td></td>
<td>Version: Engine build number for KnowledgeBase</td>
</tr>
<tr>
<td></td>
<td>System Rules: Number of Data-Driven Rules</td>
</tr>
<tr>
<td></td>
<td>Custom Rules: Number of Custom Data-Driven Rules</td>
</tr>
<tr>
<td>Memory</td>
<td>Memory Management: Setting required to use LCD in Data-Driven Rules</td>
</tr>
<tr>
<td>Claim Processing</td>
<td>Claim Processing: Determines if claims will use the static legacy user interface or the panel-based user interface</td>
</tr>
<tr>
<td>User Accounts</td>
<td>Displays details of users:</td>
</tr>
<tr>
<td></td>
<td>• Last/First Name</td>
</tr>
<tr>
<td></td>
<td>• Username</td>
</tr>
<tr>
<td></td>
<td>• Role assigned</td>
</tr>
<tr>
<td></td>
<td>• Enterprise access</td>
</tr>
<tr>
<td></td>
<td>Ability to create and edit user accounts</td>
</tr>
<tr>
<td></td>
<td>Export functionality to CSV</td>
</tr>
<tr>
<td>User Roles</td>
<td>Displays details of roles and privileges:</td>
</tr>
<tr>
<td></td>
<td>• Name of role</td>
</tr>
<tr>
<td></td>
<td>• Scope of privilege</td>
</tr>
<tr>
<td></td>
<td>Ability to create and edit user roles</td>
</tr>
<tr>
<td></td>
<td>Export to CSV functionality</td>
</tr>
</tbody>
</table>
Creating a New User

A user account is needed to authenticate a user and all logins to the system.

To create a new user:

1. On Claims Edit System’s main menu, select System Settings.
2. Select User Accounts.
3. To create a user account, select User Accounts under the system configuration panel.
5. All displayed fields must be populated to save a new user.

- Guidelines for usernames and passwords are described in detail in the User Password Security section. The same policies will be displayed in the User Accounts UI and as the username or password value is being entered. The policies that have been satisfied will be marked with a green checkmark. If a policy is not satisfied, it will be marked with a red X.
For a user to log in with this user account, the Status must be set to **Active**.

6. Selecting **New Membership** allows you to select a role in a specified enterprise. Multiple roles can be assigned to each user.

7. To add multiple roles, select **New Membership** and follow the procedure above.

---

**Important!** In a multi-tenant environment a System Administrator can create System users or, by using the Work as Tenant functionality, they can create tenant users. A Tenant Administrator is able to create tenant
Important!  

Refer to the Multi-Tenant Installations User Roles and Permissions section for more details.

Privileges Associated with User Account Modification

Modifying a User Account

Any user with a role that includes the Manage Users privilege can create and edit user accounts and memberships.

Changing the Password

All users can change their own password using the Change Password button. Users must have the Manage Users privilege to change other users' passwords.

Deleting a User

To delete a user:

1. On Claims Edit System’s main menu, select System Settings.
2. Select User Accounts.
3. Select the user that needs to be deleted.
4. In the User Account panel, select Delete User Account.
5. The panel updates with a deletion confirmation dialog as shown below.

Are you sure you want to delete this user account?  

- Delete  
- Cancel

6. Select Delete to delete the user; otherwise, select Cancel.

Deleting a User Account

Any user with a System Admin role or a user whose role contains the Manage Users privilege can delete user accounts or memberships. The setup user has access to all user roles and all modules by default. However, the setup user cannot be deleted or modified; only the password can be changed.
Accessing or Viewing User Roles

To access or view user roles:

1. On Claims Edit System’s main menu, select System Settings.
2. Select User Roles.
3. From the System Configuration panel, select User Roles.
4. Roles are now viewable.
   - Existing custom roles created prior to migration will be visible. The custom roles will have the “pencil” icon displayed and “_migrated” as the suffix.
   - Both the Name and Permissions columns are sortable.
5. Select a role by selecting on the line. This displays role details.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>System roles are non-editable; only migrated and custom roles can be changed.</td>
</tr>
</tbody>
</table>

Creating a New Role

Custom roles can be created by the user at the system configuration level only. Users cannot create roles at the enterprise level.
To create a new role:
1. On Claim Edit System’s main menu, select System Settings.
2. Select User Roles.
3. Select New User Role.
4. Type the name of the new role in the Name text box.
5. Select applicable System or Enterprise privileges for the new role.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>To create a read only or view only role, no privileges are required unless the viewing of sensitive information is also needed. In this case, assign privileges to the role such as View reports, View audit log or View claims.</td>
</tr>
</tbody>
</table>

Deleting a Role

To delete a role:
1. On Claims Edit System’s main menu, select System Settings.
2. Select User Roles.
3. Select the role that needs to be deleted.
4. In the User Role panel, select Delete User Role.
5. The panel updates with a deletion confirmation dialog as shown below.

![Are you sure you want to delete this role?
  Delete  or  Cancel]

6. Select the Delete button to delete the role; otherwise, select Cancel.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom roles cannot be deleted if the role is being used in a membership.</td>
</tr>
</tbody>
</table>
Implementing Business Policies

In Claims Edit System, business policies are unique requirements that govern how claims should be processed. They answer questions like the following:

- How should claims under one healthcare plan be analyzed differently than those under another plan?
- How should claims submitted to one payer be analyzed differently than those submitted to another payer?
- What analysis conditions should cause an automatic claim denial? What conditions should cause the same claim to be routed for manual review?
- How must the rules of claims analysis be customized to meet the changing business environment?

For Claims Edit System to work as designed, you must consider the policies behind your business as you set up the system. The more you align the system with the needs of your business, the more effective Claims Edit System can be in helping your company save money.

Four Keys to Policy Implementation

There are many tasks involved in business policy implementation, but they all fit into one of the following categories:

Data Management

To govern claims analysis, you must start by making sure the correct data is in place. Claims Edit System requires vast amounts of data to analyze claims. Some of this data remains stored in the system itself, while other packs of data must be imported and updated at regular intervals. By far, the largest source of data is the KnowledgeBase™, which is updated regularly by Optum. The KnowledgeBase contains thousands of records that verify the integrity of processed claims. However, there are other important sources of data (such as information about patients, providers, accounts, plans, etc.). All of this data must be managed effectively to keep your system in harmony with the business environment.

In Claims Edit System, there are three varieties of data to manage:

- **User-Updated Data**: Data that does not change unless you modify it.
- **System-Updated Data**: Data that changes when it is updated from an external source.
- **Claims Data**: Data that accompanies claims as they pass through the system.
Rule Management
When the data is in place, the system can analyze claims against that data. But to do this, specific rules must exist to control how various claims will be analyzed against the data. In Claims Edit System, several powerful rules come with the system to help you do this.

In Claims Edit System, rule management consists of the following tasks:

- Managing Rules
- Managing Rule sets

Claim Routing
Once you have the data and rules in place, you must then determine which rules should run against various claims. To do this, you create claim routes that lead to specific rulesets. The system comes with a pre-defined “default” route, but you can add other routes to suit your needs. For details about claim routing, refer to the Claim Routes section.

Results Management
This concerns how you want to handle the results generated by claims analysis. The system can return results to the host system as recommendations only, or as modified claims with adjustments applied. You can also customize how the results are applied - indicating when a claim should be automatically denied, approved, or routed for manual review.

For further details about results management, refer to the Claim Results section.

In Claims Edit System, results management consists of the following tasks:

- Claim Results
- Applying Edits

User-Updated Data
User-updated data remains stored in the system itself and does not change unless someone modifies it. Several forms of user-updated data must be in place for claims to process correctly:

Business Data: This is specific data that is unique to your business (e.g., information about your clients, accounts, plans, etc.). To access this data, go into the Code Repository, where you will find access to the following sets of data:
• **Provider Records:** Contain information about the providers who submit claims for healthcare services. For details about these records, refer to the Provider Management section.

• **Account Records:** Contain information about your organization’s customers. In some cases these are individual policy holders, but often they are employers who hold group plans. For details about these records, refer to the Accounts & Plans section.

• **Plan Records:** Contain information about the insurance plans available to your customers. For details about these records, refer to the Accounts & Plans section.

**New Patient History:** An “Established” patient is one that has received services from a provider within a three-year period from the current date of service. Any patient that has not received service within that period is considered a “New” patient. This distinction is important because certain E/M procedures can be billed at a higher rate when the patient is considered new. Therefore, the system needs to keep track of patient history to determine cases where new patient coding is inappropriate. For information, refer to the New Patient History section.

• **User-Defined Lists:** The Claims Edit System rules reference system lists during claims analysis to verify if values listed on claims fall within a common code grouping (such as E/M modifiers, gender codes, anesthesia codes, etc.). You cannot modify the system lists in any way. However, you can create your own additional lists, which are known as “user-defined lists.” For information about how to work with these lists, refer to the System Lists and Crosswalks section.

• **User-Defined Fields:** When a claim enters Claims Edit System from your host system, Claims Edit System can recognize only the fields of data that match items on the standard claim form. (Refer to the Claim Fields section for details about which fields are recognized.) However, suppose you have additional fields of data that you would like to include on each claim that enters Claims Edit System. When that is the case, you can create user-defined fields for each item you want to add to the claim. The system allows you to create up to twenty-five user-defined fields for these additional items. (For clients using XML file formats, an additional 25 UDFs are also available for a total of 50.) All user-defined fields are added to the end of each bill line—they become part of the transaction.

You create user-defined fields by going into the Settings module and selecting User-Defined Fields. For detailed information about how this works, refer to the User-Defined Fields section.

• **User-Defined Crosswalks:** During claims analysis, the system looks for valid data in each claim field. Within some fields, Claims Edit System only recognizes certain predefined values as valid, even though other values might be valid in the host system. Therefore, to make Claims Edit System recognize values that are unique to your organization, you must first match each of your values to one of those values recognized by Claims Edit System. This matching process is called crosswalking. After you crosswalk your custom values, the system can then recognize them as valid entries during claims analysis.
You define crosswalks by going into the Code Repository, selecting System Lists, and finding those lists that have a Type setting of Crosswalk. For detailed information about how this process works, refer to the System Lists and Crosswalks section.

- **Custom Procedure Reductions:** When a claim contains multiple procedures that occur on the same date of service, at the same place of service, and for the same patient, it is customary to reduce the payment amount on the non-primary procedures. Procedure Reduction Records allow you to define the amount (percentage) by which these reductions occur.

You define procedure reduction records by going into the Rules module and selecting Reduction Records. For detailed information about how this works, refer to the Reduction Records section.

- **Custom Codes:** The Claims Edit System KnowledgeBase contains CPT and HCPCS procedure codes for the current year and the previous two years. It also contains all of the current year’s diagnosis codes (ICD-9-CM and/or ICD-10-CM). In most cases, these industry-standard code sets are all you will need for claims analysis. However, if your company requires the use of any additional codes, you can add them individually to the system.

You add custom codes by accessing either the list of Procedures or Diagnoses inside the Code Repository. For detailed information about how this works, refer to the sections for Procedure Codes or Diagnosis Codes.

- **Custom Flags:** When the system identifies a potential error on a claim, it raises a specific flag to identify the error. If you find these flags are not enough to meet your needs, you can create additional flags by going into the Rules module and selecting Manage Flags. For detailed information about how this works, refer to the Managing Flags section.

You create custom rules by going into the Rules module and selecting Manage Rules. For detailed information about how this works, refer to the Managing Rules section.

- **Custom Rules:** As is the case with flags, Claims Edit System also contains many system rules, which make claims analysis possible. If you find these rules are not enough to meet your needs, you can add your own custom rules to supplement those provided by the system.

- **Custom Rulesets:** In Claims Edit System, claims do not automatically run against every rule in the system. Rather, claims are assigned to run against specific “sets” of rules. Claims Edit System comes with three system rulesets for claims analysis and a third system ruleset to apply edits. You cannot alter these rulesets, but you can create your own custom rulesets to tailor the system to meet the needs of your business.

You define rulesets by going into the Rules module and selecting Manage Rulesets. For detailed information about how this works, refer to the Managing Rulesets section.
• **KnowledgeBase Overrides:** The KnowledgeBase is the single largest source of data in the system. This data is secure and cannot be modified. (Refer to the KnowledgeBase Overview section.) Therefore, if you want to customize the KnowledgeBase, you must create overrides for the data. These overrides are data entries that the system will use in place of the corresponding KnowledgeBase item.

You access the KnowledgeBase by going into the Code Repository.

**System-Updated Data**

System-updated data is similar to user-updated data in that it is stored in the system and does not change unless acted upon. However, the way you modify this data is different. Unlike user-updated data (which you can modify manually), system-updated data can only be modified by running an update from an external source.

The value in this method of data management is that it keeps the data more secure and compliant. However, this also means you cannot directly customize the data. Instead, when there is a need to customize, you must create overrides for the data.

Overrides are data entries that the system recognizes as substitutes for system-updated data. These overrides are stored in the system separately from the system-updated data. Therefore, when you run an update, the system changes the data it is supposed to update, but leaves the associated overrides intact.

The following are forms of system-updated data used in Claims Edit System:

• **The KnowledgeBase:** The Claims Edit System KnowledgeBase is a repository of clinical knowledge designed to help your claims adjudication system correct costly inaccuracies. It contains thousands of records that verify the integrity of processed claims, and its depth of claims editing distinguishes it from the other, less dynamic databases. To maximize clinical accuracy, Optum updates the KnowledgeBase on a regular basis. For more information about the specific data contained in the KnowledgeBase, refer to the KnowledgeBase Overview section.

• **Local Coverage Determinations (LCD):** LCDs are “Local” policies that affect claims processing. CMS (The Centers for Medicare & Medicaid Services) uses LCDs to determine coverage for Medicare policies that are local (rather than national) in scope. For details about working with LCDs, refer to the LCD section.

• **System Lists:** Claims Edit System uses system lists to provide sub-categories for the items that can appear in a single claim field. For instance, the Modifier field on a claim line can have many valid entries, but what if you need to identify a specific kind of modifier such as Assistant to Surgery Modifiers? To find this sub-category of modifiers, the system looks at the Assistant to Surgery Modifiers list.
Many of the Claims Edit System rules need system lists to analyze claims properly. For information about how to work with these lists, refer to the System Lists and Crosswalks section. Optum updates system lists each quarter as part of the KnowledgeBase update.

- **System Crosswalks**: During claims analysis, the system looks for valid data in each field on the claim. Within some fields, the system only recognizes certain predefined values as valid. For example, in the Place of Service (POS) field, Claims Edit System only recognizes values 1 through 8 as valid. However, currently CMS defines approximately fifty valid POS values (including the eight recognized by Claims Edit System). Therefore, the system has a POS Crosswalk List, which maps each CMS POS value to one of the Claims Edit System POS values. Then, during analysis, the system checks to see if the POS value listed on each claim crosswalks to one of the Claims Edit System crosswalk values. If it doesn’t, the claim is flagged with a Missing or Invalid Place of Service flag.

You define crosswalks by going into the Code Repository, selecting List and Crosswalks, and finding those lists that have a Type setting of Crosswalk. Optum ships updates to the system crosswalks every quarter as part of the KnowledgeBase update.

- **System Procedure Reductions**: When a claim contains multiple procedures that occur a) on the same date of service, b) at the same place of service, and c) on the same patient, it is customary to reduce the payment amount for the non-primary procedures. To control the amount (percentage) by which these reductions occur, the system uses Procedure Reduction Records.

You can view procedure reductions by going into the Rules module and selecting Reduction Records. For detailed information about how reductions work, refer to the Reduction Records section. Optum does not ship separate updates for system reductions, but implements occasional changes through maintenance upgrades and new versions of Claims Edit System.

- **System Flags**: When the system identifies a potential error on a claim, it raises a specific flag to identify the error. Optum does not provide separate updates for system flags, but implements occasional changes through maintenance upgrades and new versions of Claims Edit System.

- **System Rules**: As is the case with flags, Claims Edit System also contains many system rules, which make claims analysis possible. For detailed information about each system rule, refer to the Managing Rules section.

- **System Rulesets**: In Claims Edit System, claims do not automatically run against every rule in the system. Rather, claims are assigned to run against specific “sets” of rules. Claims Edit System comes with two system rulesets for claims analysis, and a third system ruleset to apply edits. For detailed information about rulesets, refer to the Managing Rulesets section.

Optum does not create separate updates for system rulesets, but implements occasional changes through maintenance upgrades and new versions of Claims Edit System.
Claims Data

The basic process by which claims flow through the system is as follows:

1. Claims are entered into your host system.
2. The host system performs some key validations.
3. The validated claims continue through processing. At this point, the host system can pass claims to Claims Edit System. Some organizations send claims to Claims Edit System early in the adjudication process; others wait until the end. Claims Edit System is flexible enough to hook into your process wherever it is most beneficial to your situation.
4. Once Claims Edit System finishes analyzing the claims, it returns the results to the host system for billing consideration or further processing.

Managing Claims Data

In Claims Edit System, you manage the flow of claims data in the following manner:

1. Synchronize key data elements.
2. Account for historical claims data.
3. Set default values for unpopulated fields.
4. Establish connections between Claims Edit System and other systems.

5. Customize applied edits.

**Synchronizing Key Elements of Claims Data**

Three key elements of the claims data that must be synchronized when claims enter Claims Edit System from the host system:

1. For each Security ID the host system will transmit on claims, there must be a matching Routing ID in Claims Edit System.

2. For each User-Defined Field the host system will populate on claims, there must be a matching one in Claims Edit System.

3. For each item of claims data that must be validated (i.e., checked for accuracy) before claims analysis, you must create a corresponding Validation List in Claims Edit System, and also ensure the correct rules are in place to perform the validations.

**Synchronizing the Security ID/Routing ID**

When a claim enters Claims Edit System, the system looks at the Security ID on the claim. Next, it looks for a system enterprise with a matching Routing ID and then assigns the claim to the corresponding enterprise. For this reason, you must ensure Claims Edit System has a Routing ID that exactly matches each Security ID sent by the host system. Otherwise, the system will generate an error when a claim comes through containing an unrecognized Security ID.

---

**Note**

The system only generates an error when the Security ID is populated with an unknown entry. If the Security ID is blank (unpopulated), the system will not generate an error, but instead will direct the claim to the default system enterprise.

---

**To synchronize security/routing IDs:**

1. Make a list of Security IDs from the host system.

2. Make a list of “leaf-level” enterprises in your Claims Edit System. (For information about the various levels of enterprises, refer to the Parental Hierarchy in Enterprises section.)

3. Map each host Security ID (Routing ID) to its corresponding “leaf-level” enterprise (i.e., an enterprise at the end of a branch, which has no children of its own). Claims and other data will only be imported to an enterprise if the internal Security ID within the claims match the Security ID (Routing ID) of the appropriate enterprise.
4. After you map out these correlations, go into Claims Edit System and assign the correct Routing ID to each enterprise. (Refer to the Routing Claims to an Enterprise section for details about this procedure.)

Synchronizing User-Defined Fields

When a claim enters Claims Edit System, the system will recognize a set number of data fields, each corresponding to items on the standard claim form. (Refer to the Claim Fields section for details about which fields are recognized.) If you want the host system to transmit additional fields of data, you must set up user-defined fields in Claims Edit System to account for this extra data.

To synchronize user-defined fields:

1. Make a list of additional data fields you want transmitted with each claim.
2. Verify your host system is set to transmit this data using the Optum IMF (Import Messaging Format). If you are unsure about how to do this, contact Optum for assistance.
3. Create User-Defined Fields in Claims Edit System for each field of data. (Refer to the User-Defined Fields section for information about how this works.)

Defining Default Claim Field Values

When a claim enters Claims Edit System, the system checks certain fields to ensure they are populated with data. If they are not populated (i.e., they are blank), the system can insert default values into these fields on the claim.

To define default claim field values:

1. Open the Settings module from the Enterprise entry-level screen.
2. Select the Claim Field Settings icon.
3. Enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account</td>
<td>Enter the Account ID number you want Claims Edit System to assign to all claims that have left this field blank. This number should correspond to an actual account that exists in the system. (Refer to the Accounts and Plans section for detailed information.)</td>
</tr>
<tr>
<td>Plan</td>
<td>Enter the Plan ID number you want Claims Edit System to assign to all claims that have left this field blank. This number should correspond to an actual plan that exists in the system.</td>
</tr>
</tbody>
</table>
### Field Description

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider Specialty</td>
<td>Enter any provider specialty codes you want Claims Edit System to assign to all claims that have left this field blank. Specialty codes are part of the Provider Record, and they indicate the primary activity or area of expertise that a doctor practices.</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Enter any Type of Service codes (TOS) you want Claims Edit System to assign to all claims that have left this field blank. Typically, valid TOS codes are defined by the Centers for Medicare and Medicaid Services (CMS). For information about how to find a list of valid codes in the system, refer to the Working with Codes section.</td>
</tr>
<tr>
<td>Place of Service</td>
<td>Enter any Place of Service codes (POS) you want Claims Edit System to assign to all claims that have left this field blank. Typically, valid POS codes are defined by the Centers for Medicare and Medicaid Services (CMS). For information about how to find a list of valid codes in the system, refer to the Working with Codes section.</td>
</tr>
</tbody>
</table>

## Historical Claims

During claims analysis there are times when the system must look at more than just the current claim – it must also look at prior claims that have been submitted for a given patient. For this reason, the system must keep track of a certain amount of “historical” claims data.

In Claims Edit System, data from historical claims can be handled in two ways:

- Your host system can transmit history data as part of the current claim. (In this case, history data is not stored in Claims Edit System.)
- Data from historical claims can accumulate in the system database (during normal claims processing). You can also import this data directly to the database from your host system.

The method used by your system will have been determined during setup and installation. If you are unsure about which method applies to your system, contact your configuration manager or installer.

**Important!** When you store historical claims data in the system database, it is...
**Important!**

It is important to remember that this data is actually only a copy of the data that remains in your host system. This can become a problem because if someone fixes issues on a claim after it has already passed into Claims Edit System, they will usually only fix the claim in the host system and neglect the copy in Claims Edit System. Later, when another analysis occurs, the history data in Claims Edit System will fail to match the corrected claim history (which exists in the host system). To correct this discrepancy, it is recommended to re-import claims that have been modified in the host system to bring the Claims Edit System database up to date.

If you choose to accumulate historical data in the Claims Edit System database, there are two options available:

**Storing Full-Claims History**

One method is to store full claims history in the database. With this method, all of the fields on a claim are also available in history, which increases the options available when creating custom rules. This is especially true for the NPT (New Patient History) rule, which cannot be customized unless you choose to store full-claims history in the system.

However, if you want to store full-claims history your server must have adequate storage to hold this level of detail in the database - especially over an extended period (recommended up to three years). Also, you cannot purge claims for three years if you use this method. If you purge claims, the system will delete the claim history data from the database.

For information about working with full-claims history, refer to the [Claims History](#) section.

**Storing New Patient and Frequency History Only**

When storage space is limited on your server, there is another option available that will allow you to process claims against the standard “history” rules. Instead of storing full claims, the system can store only those parts of the claim that apply to the NPT (New Patient), MFX (Maximum Frequency) or Frequency History table for qualifying DDR frequency rules. If you use this method, the system extracts the relevant history data each time you perform a claim purge. (Refer to the [Claim Purge](#) section.) In addition, you can also manually import history data to the New Patient table and to the Frequency History table.

For information about storing New Patient and Frequency history, refer to the following sections:
Viewing Full-Claim History

To access the Claim History table in the database:

1. Open the **Claims** module from the *Enterprise* entry-level screen.
2. Select the **Claim History** icon.
3. On the Claim History screen, search for the record(s). You can enter information in the following fields to narrow your search or leave the fields blank to search for all records.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID</td>
<td>To search for records with specific Patient ID numbers, enter the range of ID numbers here.</td>
</tr>
<tr>
<td>Provider ID</td>
<td>To search for records with specific Provider ID numbers, enter the range of ID numbers here.</td>
</tr>
<tr>
<td>Claim Type</td>
<td>In this field, select one of the following Claim Type options:</td>
</tr>
<tr>
<td></td>
<td>• <strong>ALL</strong> - Select this option to include both Current and Non-Current types of claims.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Current</strong> - Select this option to include only current claims.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Non-Current</strong> - Select this option to include only non-current claims.</td>
</tr>
<tr>
<td>Claim ID</td>
<td>To search for records with specific Claim ID numbers, enter the range of ID numbers here.</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>To search for records with a specific procedure code, enter the code here.</td>
</tr>
<tr>
<td>Date of Service</td>
<td>To search for records with the date of service falling within a specific date range, enter the dates in the From and To fields.</td>
</tr>
<tr>
<td>Environment</td>
<td>To search for records in either the Live or Test environment, enter the selection here.</td>
</tr>
</tbody>
</table>
4. When you finish entering selection criteria, select **Find**. The system then displays a list of records containing the following information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID</td>
<td>Displays the patient identification number of the patient receiving the service recorded.</td>
</tr>
<tr>
<td>Claim ID</td>
<td>Displays the claim identification number of the patient encounter.</td>
</tr>
<tr>
<td>Current</td>
<td>Displays Y (Yes) or N (No) to indicate if the claim is current.</td>
</tr>
<tr>
<td>Line ID</td>
<td>Displays the external line identification number of the claim line recorded.</td>
</tr>
<tr>
<td>DOS (Date of Service)</td>
<td>Displays the dates of service on the claim recorded.</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Displays the CPT procedure code, Level II HCPCS code or client-specific code for the service recorded.</td>
</tr>
<tr>
<td>POS (Place of Service)</td>
<td>Displays the two-digit place of service code for the service recorded.</td>
</tr>
<tr>
<td>Units</td>
<td>Displays the total number of days of service, or total units of service for anesthesia or other procedure (e.g., 1).</td>
</tr>
<tr>
<td>Mod (Modifier)</td>
<td>Displays the two-digit CPT or HCPCS modifier code for the recorded service.</td>
</tr>
<tr>
<td>Diag (Diagnosis Code)</td>
<td>Displays the <strong>ICD-9-CM</strong>(^1) or <strong>ICD-10-CM</strong>(^2) diagnosis code that applies to the recorded service.</td>
</tr>
<tr>
<td>Provider ID</td>
<td>Displays the unique Provider Identification number of the physician performing the service recorded.</td>
</tr>
</tbody>
</table>

---

\(^1\)International Classification of Diseases (ICD), Ninth revision (-9), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval.

\(^2\)International Classification of Diseases (ICD), Tenth revision (-10), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval. These codes allow more specific reporting of diseases and patient conditions.
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Specialty</td>
<td>Displays the specialty of the physician performing the service recorded.</td>
</tr>
<tr>
<td>Environment</td>
<td>Indicates whether the record is part of the Live or Test environment.</td>
</tr>
</tbody>
</table>

**Loading Data to the Claim History table**

If your system stores historical claims data in the database (refer to the [Historical Claims](#) section), claim history data accumulates over time as each claim is processed in the system. However, you can also manually import data from your host system using a CSV (Comma Separated Values) file.

**Important!** If you want to import very large CSV files, be aware that the system might time out before the import completes. When this is the case, you should break up the CSV files into smaller chunks before importing.

**To import a data file:**

1. Select the **Import Data** button on the Claim History screen.

2. Select the **Browse** button to search for the file you want to import. This file must be located on your hard drive or on a mapped network drive.

3. Select a file in the **Choose File** dialog, and then select **Open**.

4. Select the **Begin Import** button. The system then imports the file.

For information about loading claim history data in the panel-based UI, refer to the [Data Import - Panel-based UI](#) section.

**Frequency History**

In some cases, medical procedures are not covered by the insurance policy or are only covered a certain number of times within a specified period. For this reason, the system needs to keep a running history of procedures performed for a given patient. If Claims Edit System stores historical data in the database (refer to the [Historical Claims](#) section) after a claim purge, the fields listed below will be sent to the Frequency History table.
To access the Frequency History table:

1. Open the **Claims** module from the **Enterprise** entry-level screen.
2. Select the **Frequency History** icon.
3. On the Frequency History screen, search for the record(s). You can enter information in the following fields to narrow your search or leave the fields blank to search for all records.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Code</td>
<td>To search for records with specific procedure codes, enter the range of codes here.</td>
</tr>
<tr>
<td>Patient ID</td>
<td>To search for records with specific Patient ID numbers, enter the range of ID numbers here.</td>
</tr>
<tr>
<td>Environment</td>
<td>To search for records in either the Live or Test environment, enter the selection here.</td>
</tr>
</tbody>
</table>

4. When you finish entering selection criteria, select **Find**. The system then displays a list of records containing the following information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Indicates whether the frequency history data is maintained in the Live environment or the Test environment.</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Displays the procedure code of the service on the claim.</td>
</tr>
<tr>
<td>Patient ID</td>
<td>Displays the patient identification number of the patient receiving the service on the claim.</td>
</tr>
<tr>
<td>Claim ID</td>
<td>Displays the claim identification number of the patient encounter.</td>
</tr>
<tr>
<td>Line ID</td>
<td>Displays the external line identification number of the claim line.</td>
</tr>
<tr>
<td>Service Dates</td>
<td>Displays the beginning and ending dates of service on the claim.</td>
</tr>
</tbody>
</table>
Field | Description
--- | ---
Diagnosis | Displays the diagnosis code on the claim.
Modifiers | Displays any modifiers on the claim.
Provider ID | Displays the provider identification number of the physician performing the service recorded.
Provider Specialty | Displays the specialty of the physician performing the service recorded.
Units | Displays the number of units of the procedure performed.
Imported | Displays the date on which the record was imported to the system.

**Important!** Qualifying DDR frequency rule data: DDR frequency rules that only contain fields included in the above list will qualify upon purge to be sent to the Frequency History table. DDR frequency rules that contain fields that are not currently available in the Frequency History table, such as Place of Service, will not qualify upon purge to be sent to the Frequency History table.

**Loading data to the Frequency History table**

The ability to import Frequency History data obtained from your host system using a CSV (Comma-Separated Values) file is available. The system stores this data in the Frequency History table.

**To import a data file:**

1. Select the **Import Data** button on the Frequency History screen.

2. Select the **Browse** button to search for the file you want to import.

3. Select the file in the **Choose File** dialog, and then select **Open**.

4. Select the **Begin Import** button. The system then imports the data into the Frequency History table.
To delete data from the Frequency History table:

To remove Frequency History data from your host system that is no longer needed, place a checkmark in each box that corresponds to the Frequency History data you want to delete, and then select the **Delete** button.

Prior to being deleted, a warning message states, “This will delete the selected claim history elements from the system. Do you wish to continue?” Select **OK** or **Cancel** to continue.

**New Patient History**

An “Established” patient is one that has received services from a provider within a three-year period from the current date of service. Any patient that has not received services within a three-year period is considered a “New” patient. This distinction is important because certain E/M procedures can be billed at a higher rate when the patient is considered new. Therefore, the system can keep track of patient history to determine cases where new patient coding is inappropriate.

**Note**

The system considers Provider Specialty as a part of this determination.

If your system stores historical data in the database (refer to the **Historical Claims** section), New Patient data will reside in the New Patient History table.

**To access the New Patient History table:**

1. Open the **Claims** module from the screen.
2. Select the **New Patient History** icon.
3. On the New Patient History screen, search for the record(s). You can enter information in the following fields to narrow your search or leave the fields blank to search for all records.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>To search for records with specific Patient ID numbers, enter the range of ID numbers here.</td>
</tr>
<tr>
<td>BDOS (Beginning Date of Service)</td>
<td>To search for records with the beginning date of service falling within a specific date range, enter the dates in the From and To fields.</td>
</tr>
</tbody>
</table>
The **From** field is not labeled as such on this screen, but it is implied that the first field is the date “from which” your range applies, and the second field is the date “to which” the range applies.

4. When you finish entering selection criteria, select **Find**. The system then displays a list of records containing the following information:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID</td>
<td>Displays the patient identification number of the patient receiving the service recorded.</td>
</tr>
<tr>
<td>Beginning Date of Service</td>
<td>Displays the beginning date of service on the claim recorded.</td>
</tr>
<tr>
<td>Claim ID</td>
<td>Displays the claim identification number of the patient encounter.</td>
</tr>
<tr>
<td>Line ID</td>
<td>Displays the external line identification number of the claim line recorded.</td>
</tr>
<tr>
<td>Provider Specialty</td>
<td>Displays the specialty of the physician performing the service recorded.</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Displays the CPT procedure code, Level II HCPCS code, or client-specific code for the service recorded.</td>
</tr>
<tr>
<td>(Additional Fields Selected Within Same Provider Configuration)</td>
<td>Displays the additional fields selected for Same Provider NPT within Same Provider Configuration. (Refer to the <a href="#">Same Provider Configuration</a> section for details.)</td>
</tr>
<tr>
<td>Plan</td>
<td>Displays the alphanumeric identifier for the account and the specific insurance plan that belong to the patient.</td>
</tr>
</tbody>
</table>

**To load data to the New Patient History table:**

If your Claims Edit System stores historical data in the database (refer to the [Historical Claims](#) section), New Patient History data accumulates over time as claims are processed in the system. However, you can also import data obtained from your host system by using a CSV (Comma Separated Values) file.

**To import a data file:**

1. Select the **Load New** button on the New Patient History screen.
2. Select the **Browse** button to search for the file you want to import.

3. Select a file in the **Choose File** dialog, and then select **Open**.

4. Select the **Begin Import** button. The system then imports the file.

**To delete data from the New Patient History table:**

If your Claims Edit System stores historical data in the database (refer to the [Historical Claims](#) section), New Patient History data accumulates over time as claims are processed in the system.

To remove New Patient History data that is no longer needed from your host system, select each checkbox that corresponds to the New Patient History data you want to delete, and then select the **Delete** button.

Prior to being deleted, a warning message states, “This will delete the selected claim history elements from the system. Do you wish to continue?” Select **OK** or **Cancel** to continue.

For information about loading New Patient History in the panel-based UI, refer to the [Data Import - Panel-based UI](#) section.

**Data Import – Panel-based UI**

| Note | The structure of CSV files for the different types of data that can be imported is documented separately in the CSV Import File Formats for Claims Edit System (version 5.2.1 and above) specification document. |

**Prerequisites**

<table>
<thead>
<tr>
<th>Application version</th>
<th>KnowledgeBase version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Edit System 5.4 SP2 or later</td>
<td>2019 Q3A KnowledgeBase</td>
</tr>
</tbody>
</table>

**Data Import Tab (Enterprise panel)**

The **Data Import** tab is accessed by selecting an enterprise in the ENTERPRISES section in the left-most navigation panel of the panel-based UI. It allows you to import Claim History and New Patient History data for Professional claims into the database.
Note: From the legacy UI, the Data Import tab can be accessed by navigating to an enterprise, then selecting either the Claims > Claim History or the Claims > New Patient History menu option. The Import Data or Load Data button on the respective screens will now cause the Data Import tab in the panel-based UI to be displayed.

Claim History and New Patient History data imports are required in order for rules that depend on patient claim history to produce accurate editing results. Normally, these imports occur when the software is initially installed in order to transfer claim summary data from an external system into the Claims Edit System so that the required historical data is available when new claims are processed. From that point on, CES will maintain a record of processed claims so they are available as history for future claim processing.

Importing CSV Data
The Data Import panel has three tabs that act as a “wizard” to step you through the data import process:

1. Select a file
2. Check the file
3. Results of import

Step 1
The first tab is initially the only enabled tab and the other two are disabled. Select the Browse button to open a file browser dialog where you can navigate to the directory where CSV files with data to be imported are located. After selecting a file and selecting the Open button, a progress bar is displayed while the data in the file is validated. Control then automatically jumps to the next tab (2. Check the file).

Note: Only files with a “.csv” file name extension are included in the file browser dialog

Step 2
The second tab displays a green “success” message bar if the initial validation succeeded or a red “failure” message bar if errors occurred. It also reports the type of data that is in the file based on the number of columns and other checks that were performed when the file was validated.
If any validation errors occurred during the file check, they are displayed in a table. If the number of validation failures exceeds a defined maximum (e.g., 100 failures), the *Import* button will be disabled and you must repair the errors in the file before retrying the import.

**Note**

Duplicate Record Handling:

When importing Claim History data, duplicate claims are *not* included in the list of validation errors. However, the number of duplicate records found in the file is displayed in addition to the other statistics for the file. You can still import a file with duplicates, but the duplicate claims will be stripped from the import data.

When importing New Patient History data, all existing data is first deleted and is replaced by the imported data. No checking is performed for duplicate records, so any duplicates in the file being loaded will be imported into the database. (Note that this does not cause any problems.)
In some cases, a small amount of data loss due to validation errors may be acceptable (such as a dozen invalid history claims in a batch of ten thousand). If the number of errors is not acceptable, select the Return to step 1 link that is above the table of errors to return to the previous step. Before doing so, you may also want to export the list of failures by selecting the Export Error List link so it can be referenced when correcting errors in the data file.

When you are ready to proceed with importing of the data (with or without errors), select the Import button. A progress bar is displayed to track the status of the data import. When completed, control automatically jumps to the next tab (3. Results of import).

**Step 3**

The third tab also displays a message bar reporting the success or failure of the data import along with some statistics for the expected number of rows versus the actual number of rows that were imported. The actual number of rows will be less than the expected number of rows when data was excluded due to validation failures or duplicate records.

Select the Import another file link in the message bar when ready to perform additional data imports.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only two CSV files can be loaded simultaneously. The purpose of this restriction is to avoid impacting claim processing performance due to the increased load on the database.</td>
</tr>
</tbody>
</table>

**Viewing Imported Data**

After importing Claim History or New Patient History data, it can be viewed by navigating to the Claims > Claim History or Claims > New Patient History options in the legacy UI.

**Applied Edits**

You can set up Claims Edit System to automatically apply changes to a claim during claims processing. This is known as Applied Edits.

**How the System Works with Applied Edits Off**

When Applied Edits are turned off, the system handles flags as recommendations only. The system does not make any changes to the claims during analysis, but merely raises flags to recommend changes. When analysis is complete, Claims Edit System then communicates these recommended changes back to the host system without changing the original claim data. Therefore, the host system must be able to interpret the results from Claims Edit System and then apply the recommended changes to each claim.
How the System Works with Applied Edits On

When your system has Applied Edits turned on, Claims Edit System not only generates flags (i.e., recommended changes), but it also executes special rules to create “modified” claim lines for these flags. The modified lines apply changes to the claim line that are needed due to the corresponding flag. Claims Edit System then transfers the modified claims to the host system.
About the Apply Edits Rules

The system uses the following rules to apply edits:

<table>
<thead>
<tr>
<th>Rule Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Edit - Pay</td>
<td>Applies the “Pay” status to lines as needed. This status indicates that</td>
</tr>
<tr>
<td>Set Pay Disposition</td>
<td>the line is clean and ready for payment (no edits on the line).</td>
</tr>
<tr>
<td>Applied Edit - Deny</td>
<td>Applies the “Deny” status to lines as needed. This status indicates that</td>
</tr>
<tr>
<td>Set Deny Disposition</td>
<td>you should deny payment on the line based on edit(s) received.</td>
</tr>
<tr>
<td>Applied Edit - Set</td>
<td>Applies the “Review” status to lines as needed. This status indicates</td>
</tr>
<tr>
<td>Review Disposition</td>
<td>that flag(s) have been set for the line and you need to review the line</td>
</tr>
<tr>
<td></td>
<td>and manually set the line to Pay or Deny, as appropriate.</td>
</tr>
<tr>
<td>Applied Edit - Pay</td>
<td>Applies the “Pay Add” status to lines as needed. This status indicates a</td>
</tr>
<tr>
<td>Add Disposition</td>
<td>line should be added by the host system and then be paid.</td>
</tr>
<tr>
<td>Applied Edit - Set</td>
<td>Applies the “Deny Add” status to lines as needed and ensures the line has</td>
</tr>
<tr>
<td>Deny Add Disposition</td>
<td>the most severe flag it received in normal editing. This status indicates</td>
</tr>
<tr>
<td></td>
<td>a line should be added by the host system and then be denied.</td>
</tr>
<tr>
<td>Applied Edit - Set</td>
<td>Applies the “Review Add” status to lines as needed and ensures the line</td>
</tr>
<tr>
<td>Review Add Dis-</td>
<td>has the most severe flag it received in normal editing. This status indi-</td>
</tr>
<tr>
<td>position</td>
<td>cates a line needs to be added by the host system and you need to manu-</td>
</tr>
<tr>
<td></td>
<td>ally review flag(s) on the line and set the line to Pay or Deny, as</td>
</tr>
<tr>
<td></td>
<td>appropriate.</td>
</tr>
<tr>
<td>Applied Edit -</td>
<td>Sets the amount of denied lines to “0” and removes virtual lines that</td>
</tr>
<tr>
<td>Modify Denied Lines</td>
<td>have been denied.</td>
</tr>
<tr>
<td>Applied Edit - M26</td>
<td>Changes the claim line to add the modifier 26, and then removes the M26</td>
</tr>
<tr>
<td></td>
<td>flag so the claim line goes back into the system clean.</td>
</tr>
<tr>
<td>Applied Edit - PCM</td>
<td>Changes the claim line to remove the modifier 26, and then removes the</td>
</tr>
<tr>
<td></td>
<td>PCM flag so the claim line goes back into the system clean.</td>
</tr>
<tr>
<td>Applied Edit - mPC</td>
<td>Changes the claim line to remove both the 26 and TC modifiers, and then</td>
</tr>
<tr>
<td></td>
<td>removes the mPC flag so the claim line goes back into the system clean.</td>
</tr>
</tbody>
</table>

The logic behind these rules works as follows:
1. During claims analysis, if the current line’s submitted units are not the same as its surviving units, the system splits the line into multiple lines with one unit each.

2. The system creates a copy of the current line – this will be the modified line sent back to the host system.

3. The system checks to see if there are any flags on the current line.
   a. If there are no flags, the system sets the line disposition of the modified line to “pay” and the rule stops.
   b. If there are flags, the system identifies the most severe flag on the current line (all flags having a status of “deny” or “review” which is placed on the line on the current line during its final pass). Flags TRA, M26, mPC, and PCM are excluded from this consideration. The rule then continues as with step 4 (below).

   **Important!** Profile flags are excluded from Applied Edits.

4. If a flag has been identified in step 3, the system sets the disposition of this flag (e.g., Deny or Review) on the modified line.

5. If the M26 flag has been placed on the current line, the system reacts as follows:
   - It adds modifier 26 to the modified line and removes the M26 flag from the modified line. However...
   - If the M26 flag is set to *profile* status on your system, it does not add modifier 26 to the modified line and does not remove the M26 flag from the modified line.

6. If the PCM flag has been placed on the current line, the system reacts as follows:
   - It removes modifier 26 from the modified line and removes the PCM flag from the modified line. However...
   - If the PCM flag is set to *profile* status on your system, it does not remove modifier 26 from the modified line and does not remove the PCM flag from the modified line.

7. If the mPC flag has been placed on the current line, the system reacts as follows:
   - It removes the mPC flag from the modified line. However...
   - If the mPC flag is set to *profile* status on your system, it does not remove the PCM flag from the modified line.

8. If the current line is a virtual line, the system considers the following:
   - If the modified line’s disposition is “Review” or “Pay,” it changes the disposition to “Review-Add” or “Pay-Add” respectively.
• If the modified line’s disposition is “Deny,” it removes the modified line from further consideration. (A virtual line indicates that the line has been added during rule processing. A denied virtual line adds no value to the host system, since it indicates that a line needs to be added to the claim and then denied.)

9. If the disposition of the modified line is “Deny,” the system sets the adjusted amount on the modified line to 0.

10. If the claim line has been partially denied (by the REB or MFD flag), the system sends back to the host system as many lines as there are units on the original line. Each line has a disposition similar to that of the flag that is placed on the line on that unit. In this case, the paid units are sent first. The first paid unit has a disposition of “Pay.” All other units have a “Pay-Add,” “Deny-Add,” or “Review-Add” disposition.

To receive the full benefit from the Applied Edits functionality, the interface to your host system must handle the additional “modified” claim lines from Claims Edit System (generated during analysis). Also, it must be able to handle the Pay, Deny, Deny Add, and Pay Add dispositions recommended in the results.

Additionally, if a Review or Review Add disposition is returned to your host system, it must then pend (or mark) the claim for manual review. Once you have reviewed the pended lines and determined how you want to handle them, your system must release the claim from the review queue and complete its processing according to your organization’s procedures.

The system’s rule logic sets the line disposition to Pay, Deny or Review. You can view a line’s disposition in the modified line results of the claim. You can create customizations to have the system pay, deny or mark lines for review automatically. Also, if you want to add additional flags, you can copy an existing applied edit rule, add your flag(s) to it, and then define the behavior in your rule that will result in the flag being applied.

**Activating Applied Edits**

You must take two steps to activate applied edits in your system:

a. Activate applied edits at the system level

b. Activate the Apply Edits ruleset(s)

It is important to understand how these two levels of activation work together.

**System Level Activation**

When you activate applied edits at the “system” level (i.e., going into the system settings), the system changes the way it generates results during claims processing.

• **With Applied Edits Off** - The system generates results for individual claim lines - showing the flags generated for each line.
- **With Applied Edits On** - The system generates results with the following sections of information for each claim line flagged:
  
  - Original Claim Line - This section shows each claim line as it originally existed before analysis.
  - Claims Analysis Results - This section lists any flags that were raised on the claim.
  - Modified Claim Lines - This section shows each modified claim line after the Applied Edits were applied.

Thus, activating applied edits at the system level allows the system to generate modified lines and transmit them back to the host system. If applied edits are off, the system will only generate (and transmit) flagged claim lines.

<table>
<thead>
<tr>
<th>Important!</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you turn applied edits on and process claims, the system will generate modified lines for those claims. If you then turn applied edits off, the system will not generate modified lines for any claims coming through the system after you do so, but it will retain (and transmit) modified lines for those claims processed prior to when you turned applied edits off.</td>
</tr>
</tbody>
</table>

**To turn on Applied Edits at the System level:**

1. Go to the **Main Menu** (i.e., the menu that displays after you first log in to the system).
2. Open the **System Settings** module.
3. Open the **Applied Edits** module.
4. On the **Applied Edits** screen, set the **Applied Edits** field to **ON**.
5. Select **Save**.

**Ruleset Level Activation**

The Apply Edits ruleset contains the rules used to generate modified lines. If they are disabled, the system will not generate data for the modified lines - even if (at the system level) you have turned applied edits on. Therefore, if the rules are disabled, the system leaves the modified lines section on the claim results screen blank.

Another thing you must remember is that the Apply Edits ruleset is just that - a ruleset. In addition, in Claims Edit System, all rulesets are enterprise dependent. That means if you activate (or deactivate) a ruleset within one enterprise, it does not necessarily mean the same thing will happen in other enterprises. It all depends upon the inheritance structure. (Refer to the [Defining enterprises](#) section for more information.)
By default, the Apply Edits ruleset resides at the System Enterprise level. In addition, since the System Enterprise is a parent to all other enterprises, activating the Apply Edits ruleset within that enterprise means it will be inherited in all other enterprises. However, if you do not want to have applied edits active within all enterprises, you can choose to log in at specific “lower” enterprises and activate the Professional/Facility Apply Edits ruleset there. That way, you can activate applied edits in certain enterprises while leaving it inactive in others.

To activate the Apply Edits ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Select the link to access the Professional/Facility Apply Edits ruleset. The system displays the list of rules belonging to the ruleset.
4. Look at the Status column to the right of the list of rules. If this column shows that the rules are Enabled, it means Applied Edits are already active in your system. However, if the rules are Disabled, you can activate them in the following manner:
5. Select the checkbox in the heading for the ruleset.

This causes all of the rules in the ruleset to become selected.

It is strongly recommended that you enable or disable all of the rules in the ruleset. Unless you know what you are doing, leaving some rules inactive while activating others individually may cause the applied edits to function improperly.

6. Select Change Status. The Status column changes to show that all of the rules are enabled.
7. Select the Save Changes button in the upper right portion of the screen.

Auto Fix - Overview

The Auto Fix functionality provides a way to send back a recommended change with an edit to the host system. The host system may use this functionality to automatically make changes to a claim or claim line. For the Auto Fix function to work, the host system must support it.
Auto Fix - How it Works

Each flag has the capability to send an error correction message to the host system on how to modify the claim to rectify the claim edit. On the host system side, the user receives a prompt describing how to appropriately change the line to correct the edit. Auto Fix does not automatically correct the claim edit from within Claims Edit System. This ensures that proper checks and balances are put into place to allow the claim reviewer to verify that the change is warranted.

A rule within Claims Edit System will check the claim line edits to determine if a change message is to be sent back to the host system. If a match is found, the EMF sends two additional message elements on the claim line back to the host system: Auto Fix Type and Auto Fix Value. The Auto Fix Type tells the host system what action on the claim line is to be performed on the Modifier or Procedure fields. The Auto Fix Value (if present) is sent with only a Change or Add Auto Fix Type element.

There are two ways to activate the Auto Fix function: Simple and Conditional. Each option is tied to the flag which is ultimately tied to the rule.

Simple Option

The Simple Auto Fix message can be activated by overriding the flag’s rule properties by setting the Auto Fix Type and Value.

For the Auto Fix Type, if set on the rule’s edit, a message is sent to the host system telling the user to add, change, or delete a modifier or procedure on a claim line, describing what action on the claim line is to be performed on the Modifier or Procedure fields to remove the edit. The Auto Fix Type will not affect the claim line from within Claims Edit System. An Auto Fix Type can be set for any System or Custom Rule’s edit.

When an Auto Fix Type is set in a specific rule’s properties and the rule’s edit is applied to the claim or claim line during analysis, the Auto Fix Type and Auto Fix Value will be shown statically along with the corresponding edit in the Claim Results screen.

For an Auto Fix Value (if present), a value is sent with the Auto Fix Type message to the host system telling the user to add or change the Modifier or Procedure value on a claim line to remove the edit. The system and custom rules will support Auto Fix Value.

When an Auto Fix Value and Auto Fix Type are set in a specific rule’s properties and the rule’s edit is applied to the claim line during analysis, the Auto Fix Value and Auto Fix Type will be shown, along with the corresponding edit, in the Claim Results screen. When set, an Auto Fix message will be sent back to the host system along with the flag mnemonic each time the flag is applied to the claim or claim line.

An Auto Fix Value can be set for any System or Custom Rule’s Edit.
The Simple Auto Fix option is limited to four Auto Fix Types: Add Modifier, Delete Modifier, Add Procedure, and Delete Procedure. Refer to the corresponding sections below for additional information about these Auto Fix Types.

When an Auto Fix Value is set in a specific rule’s properties and the rule’s edit is applied to the claim line during analysis, the Auto Fix Value will be shown, along with the Auto Fix Type, statically with the corresponding edit in the Claim Results screen.

The Auto Fix Value is determined from the results of the claim or claim line analysis. This behavior is similar to the way Disclosure is captured—what caused the edit to fire—the host system uses Auto Fix Value to correct the value on the claim or claim line.

If the rule logic defines the Auto Fix Type and Auto Fix Value, the rule logic supersedes the values set in the Rule properties. (Refer to the Conditional Option section for additional information.) For example, the MOD Rule property for the Flag: MOD is set to Add Modifier 25. The user adds logic to the MOD Rule and sets the MOD flag Auto Fix Type to Change Modifier and the Auto Fix Value populated with the value from the analyzed results. When the claim line is analyzed, the rule logic’s Auto Fix Type and Auto Fix Value will be sent back to the host system instead of the rule’s edit properties.

The user can set the Auto Fix Type and Auto Fix Value, such as Flag status, on the Rules properties screen. The rule will use these settings to determine if an Auto Fix element needs to be sent back through the export interface to the host system.

From the Ruleset screen, you can view the Auto Fix Type if the type has been set. If no type has been set, the term “None” is shown. If multiple flags are assigned to a rule and one or more flags have an Auto Fix Type, you will see that multiple Types have been set. In Claim Results, if multiple flags are assigned to a rule and one or more flags have an Auto Fix Type, you will see that multiple Values have been set with a comma separator.

### Important!

For each Auto Fix Type: Add Modifier, Delete Modifier, Add Procedure, and Delete Procedure, flags are not issued on history lines nor are history lines passed back to the host system. For each Auto Fix Value, the value sent back with the Auto Fix Type message can be alphanumeric.

## Add Modifier

**Auto Fix Type:** The rule sets the flag and sends back the flag mnemonic and an Add Modifier message to the Host System. The Add Modifier type is applied to the current claim line, not the history line.

**Auto Fix Value:** Sends back the value along with the Auto Fix Type Add Modifier message.
Delete Modifier

*Auto Fix Type:* The rule sets the flag and sends back the flag mnemonic and a Delete Modifier message to the host system for each modifier noted in the message. If Delete Modifier is selected, the user must set which modifier value is to be deleted. If no value is set, an error message will appear telling the user that they must include a value. (Message: “The Fix Value field must include a modifier before the Delete Modifier Fix Type can be set.”)

The Delete Modifier type is applied to the current claim line, not the history line.

*Auto Fix Value:* If the modifier indicated in the Fix Value field is on the claim line, the value assigned to the Delete Modifier message is sent back to the host system.

Add Procedure

*Auto Fix Type:* The rule sets the flag and sends back the flag mnemonic and an Add Procedure message to the host system. The Add Procedure type is applied to the current line, not the history line.

*Auto Fix Value:* Sends back the value assigned to the Add Procedure message.

Delete Procedure

*Auto Fix Type:* The rule sets the flag and sends back the flag mnemonic and a Delete Procedure message to the host system. The Delete Procedure type is applied to the current line, not the history line.

*Auto Fix Value:* If the Delete Procedure Auto Fix Type is selected, the Auto Fix Value is disabled.

Conditional Option

The Conditional option is developed along with the rule logic. This capability provides more control over how and when the Auto Fix Type and Auto Fix Value are applied to the claim or claim line. (Refer to the CPT Rule Logic Auto Fix Example for more information.)

The Conditional option provides the following:

<table>
<thead>
<tr>
<th>Auto Fix Option</th>
<th>Rule Logic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Modifier</td>
<td>Set the <em>select a claim line flag mnemonic</em> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;enter a value&gt;</code> and the recommended fix of adding the modifier <code>&lt;enter a value&gt;</code></td>
</tr>
<tr>
<td>Add Procedure</td>
<td>Set the <code>&lt;select a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;enter a value&gt;</code> and the recommended fix of adding the procedure</td>
</tr>
<tr>
<td>Auto Fix Option</td>
<td>Rule Logic</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Change Modifier</td>
<td>Set the <code>&lt;select a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;enter a value&gt;</code> and the recommended fix of changing the modifier <code>&lt;enter a value&gt;</code></td>
</tr>
<tr>
<td>Change Procedure</td>
<td>Set the <code>&lt;select a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;enter a value&gt;</code> and the recommended fix of changing the procedure code <code>&lt;enter a value&gt;</code></td>
</tr>
<tr>
<td>Delete Modifier</td>
<td>Set the <code>&lt;select a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;enter a value&gt;</code> and the recommended fix of deleting the modifier <code>&lt;enter a value&gt;</code></td>
</tr>
<tr>
<td>Delete Procedure</td>
<td>Set the <code>&lt;select a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;enter a value&gt;</code> and the recommended fix of deleting the procedure code <code>&lt;enter a value&gt;</code></td>
</tr>
</tbody>
</table>

**CPT Rule Logic Auto Fix Example**

The Auto Fix logic is highlighted in yellow below. Notice that the final *Then* condition does not contain Auto Fix logic; the reason is that if the condition is found to be true, the Auto Fix should not be sent back.

**definitions**

- set the current line to ▼ a claim line [from/in] ✗
  - where the adjusted procedure code (object) on this claim line is missing ✗
  - or the adjusted procedure code (object) on this claim line is not valid ✗
  - or the adjusted procedure code (object) on this claim line is not yet effective ✗
  - or the adjusted procedure code (object) on this claim line is disabled ✗
  - set the procedure code to the procedure code on the current line ✗
  - [where] ✗

**IF**

- the adjusted procedure code (object) on the current line is missing ✗

  **then**

  - set the ▼ CPT flag on the current line with the message: ▼ Procedure code is missing. [±] ✗
  - set the ▼ CPT flag on the current line with the message: ▼ Add Procedure Code [±] and the recommended fix of changing the procedure
Else

if the adjusted procedure code (object) on the current line is not valid  ×
or the adjusted procedure code (object) on the current line is not yet effect-ive  ×
then:

- set the ▼CPT flag on the current line with the message: ▼  “Procedure
code” + the adjusted procedure code (value) of the current line + ▼  “is
invalid.” [±] ×

- set the ▼▼ CPT flag on the current line with the message: ▼ ▼
Change Procedure Code [±] and the recommended fix of changing
the procedure code ▼ ▼99024 [±] ×

else:

- if the procedure code is disabled  ×
then:

- set the ▼CPT flag on the current line with the disclosure for the pro-
cedure code
and the message: ▼  “Procedure code” + the adjusted procedure code
(value) of
the current line + ▼  “is disabled.” [±] ×

User-Defined Fields

When the host system sends claims to Claims Edit System using one of the supported claim encapsulation
formats such as the Optum IMF (Import Messaging Format) or the Optum XMLv2 format, it contains fields of
data that match items on the standard claim form. (Refer to the Claim Fields section for details about which
fields are recognized.) However, these formats also contain several extra (empty) fields, which can be pop-
ulated by the host system with additional data. This allows you to transmit additional categories of claim data
along with the items on the standard claim form.

If you track a unique element of claim data, you can create a user-defined field for that element. All user-
defined fields are added to the end of each bill line, and therefore become part of the claim line. Up to 25 user-
defined fields can be created. When you create a user-defined field, you enable the system to recognize and
store data imported into these fields on the New Claim and Claim Edit screens.

After a user-defined field has been created for an enterprise, you can create rules based on the data in these
custom claim fields. UDFs can also be used when setting up Claim Routes and configuring Same Provider cri-
teria.
Before you create a user-defined field, be certain you are not duplicating one that already exists or creating an unnecessary one. Once you create a new field, you cannot delete it. This is because the new field immediately becomes part of the system against which claims are analyzed. Therefore, deleting such a field would invalidate any analysis that used the field.

Do not use special characters (such as _!@#$%^&?) in the name of a user-defined field. Using special characters can cause several problems, including errors with any rules designed to work with the user-defined field. However, the system will accept date formats in user-defined fields.

Inheritance of User-Defined Fields

User-defined fields in any enterprise are only inherited by immediate children of that enterprise. They are not inherited by grandchild enterprises.

To create user-defined fields:

1. Before you begin, make sure the host system has been configured to transmit the additional data as part of the claim. If you are unsure about how to do this, have your configuration manager contact Optum for assistance.
2. Navigate to the Control Panel for either a Professional or an Institutional enterprise and then select the Settings icon.
3. Select the User-Defined Fields icon.

The user interface screen for managing user-defined fields is in either the legacy UI or the panel-based UI depending on whether certain KnowledgeBase and software updates have been applied. This section applies specifically to the legacy UI. For details regarding the panel-based UI screen, refer to the User-Defined Fields – Panel-based UI section.

Prerequisites: The panel-based UI screen is enabled only after KnowledgeBase 2019 Q1A or later has been installed and the 5.4 SP2-CU01 cumulative update has been applied.
4. The system displays a list of all twenty-five user-defined fields.

5. Each UDF is assigned an index number 1-50. To define a UDF, select the "unused" link in the field “Field Name” column and a dialogue box will display.

<table>
<thead>
<tr>
<th>User-Defined Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index #</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

6. When the dialog box opens, enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Name</td>
<td>Enter a name identifying the data to be carried in this field.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter a brief description of the data to be carried in this field.</td>
</tr>
<tr>
<td>Visible?</td>
<td>Select Yes if you want the field to be visible on the claim line; otherwise, select No.</td>
</tr>
</tbody>
</table>

7. Select the **Save** button.

**User-Defined Fields - Panel-based UI**

User-Defined Fields are located under [Selected Enterprise] > Properties > User-Defined Fields in the panel-based UI.

The User-Defined Fields panel shows a tabular list of all UDFs that have been defined either in the current enterprise or in the immediate parent of the current enterprise. The following columns are included in the table:

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Number</td>
<td>This is the index number of the UDF (1 through 50). This field number is manually selected when defining a new UDF.</td>
</tr>
<tr>
<td>Field Name</td>
<td>UDF name. The name assigned should identify the function/purpose of the data that is assigned to this UDF on each incoming claim. This value will be displayed in the Add/Edit Claim screen when viewing claim data.</td>
</tr>
<tr>
<td>Column Name</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Description</td>
<td>UDF description.</td>
</tr>
<tr>
<td>Origin Enterprise</td>
<td>The enterprise where the User-Defined Field was defined/created. This may be either the current enterprise or its immediate parent (inherited UDF). Inherited UDFs are shaded gray to more easily identify them.</td>
</tr>
</tbody>
</table>

**Note**
The maximum number of UDFs is increased from 25 to 50 when 5.4 SP2-CU01 is applied; however, only the XMLv2 claim file format currently supports the additional fields.

### Adding a User-Defined Field

Select the **Add User-Defined Field** button to define a new UDF using the User-Defined Field sub-panel.

*Field Number:* Select the UDF index value from a dropdown list of all the available field numbers. Only the numbers for UDFs that are not already defined in the current enterprise are included in the list. The list includes numbers for UDFs that are inherited from the parent enterprise, which allows them to be overridden in the current enterprise as shown in the following image.
In the example above, note that index values 2, 3, and some others are not included in the choice list. This is because they have already been defined for the current enterprise and are not available for adding a new UDF with that index number.

- **Field Name:** Enter a short name that will briefly identify the data that will be held in this field.
- **Description:** Enter a more detailed description of the purpose of the UDF.

**Visibility of a UDF**

The user can disable User-Defined Fields created in the enterprise that will remove the UDF entry from the list of defined UDFs. Once a UDF is disabled, the corresponding field number will be made available when defining a new UDF.

**Important!** An inherited UDF’s visibility cannot be changed from the child enterprise. This action must be performed from the parent enterprise where it was defined.

The visibility of a UDF that is used in a claim route definition cannot be
Important! changed to "No" without first changing the route definition and removing the use of the UDF.

Overriding an Inherited UDF

User-Defined Fields that are inherited from a parent enterprise can be overridden in the child enterprise by selecting the inherited UDF, then selecting the **Override User-Defined Field** button. The Field name, Description and Visibility can be overridden in the User-Defined Field panel as shown below.

![Image of User-Defined Field panel]

Important! The **Override User-Defined Field** button is enabled only for the inherited User-Defined Field. A pencil icon is displayed for all UDFs that are editable.

User-Defined Field as a List

The user can send multiple values as a comma-delimited list to use in a single user-defined field. Note that the maximum allowed length is 255 characters for the entire list.

The following figure shows multiple comma-separated values in the UDF claim field:

![Image of User-Defined Field panel with values]

In the above example, the Billing and Servicing Provider CLIA ID is created as a user-defined field and multiple comma-delimited values have been entered such as such as CLIA ID, ZIP Code, and Specialty.
Using a UDF as a list when creating a custom DDR:

The screenshot above shows how to use UDFs as lists while creating a custom DDR rule in the panel-based UI. Go to **New Rule > Expression**. In the IF condition, select **Claim Field Statement** > **Select a claim field** > **All fields** > **Line-level fields** > **UDFs as lists**.

The UDFs will be displayed with the Field number and their corresponding field name in the brackets.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Similarly, the UDF as a list option can be used when defining the conditional expression, Route properties, and Exceptions of a DDR Ruleset.</td>
</tr>
</tbody>
</table>

Claim History Crosswalking

As mentioned in other sections of this guide, all claims that come through the system contain specific codes (i.e., procedure codes, modifiers, etc.). However, sometimes your host system will use codes that are not recognized by Claims Edit System. When this is the case, you can use crosswalks that will map any unrecognized codes to the codes recognized by Claims Edit System. (Refer to the [Crosswalks](#) section for further details.)

During claims processing, the system applies crosswalks in one of two ways:

- Crosswalks apply to the current claim only.
- Crosswalks apply to the current claim and all historical claims associated with the current claim.

**To determine if the system applies crosswalks to historical claims:**

1. From the Main Menu, open the **System Settings** screen.
2. Select the icon for **Claims History Processing**.
3. In the Claim History Crosswalking field, select one of the following options:

- **On** indicates that crosswalks apply to both current claims and associated historical claims.
- **Off** indicates that crosswalks apply only to current claims.

4. Select **Save** when finished.

## Claim Purge Panel-based UI

### Prerequisites

<table>
<thead>
<tr>
<th>Application Version</th>
<th>KnowledgeBase Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Edit System</td>
<td>2018 Q3A KnowledgeBase</td>
</tr>
<tr>
<td>5.4 SP1-CU05+</td>
<td></td>
</tr>
</tbody>
</table>

The Claim Purge panel is used to create claim purge jobs that delete claims from the database as well as display details a list of purge jobs that have already been created and executed.

### Claim Purge Filter

Claim Purge contains a list of filters that can be selected to limit which purge jobs are displayed. The filters correspond to the table columns. Select a filter option to add it to the filters bar at the top of the panel and then select options that are available for the filter. The filter pane can be hidden or shown by selecting the **+Filter** button.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <strong>Job status</strong> filter is selected by default with Schedule Pending, Scheduled, Running, and Completed options selected/checked by default. However, like other filter options, the user can remove or add this filter.</td>
</tr>
</tbody>
</table>

### Create a new purge job

You can schedule a new purge job by selecting the **New Claim Purge** button. This opens the **Purge Job** panel containing a **Properties** tab (default) and a **Log** tab.
Properties Tab

The Properties tab contains the fields needed to create and schedule a new purge job.

<table>
<thead>
<tr>
<th>Field name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Name</td>
<td>The Job Name field is a required field that allows you to provide a name for the purge job. It accepts a maximum of 30 characters. Valid characters include A-Z, a-z, 0-9, underscore (_), dollar sign ($), and pound sign (#).</td>
</tr>
<tr>
<td>Description</td>
<td>The Description field allows you to provide the job description for the purge job. It accepts a maximum of 512 characters.</td>
</tr>
<tr>
<td>Purge Frequency</td>
<td>The following options are available for purge frequency:</td>
</tr>
<tr>
<td></td>
<td><em>One-Time purge</em> – Use this option for a purge job that runs only once and does not repeat on a scheduled interval.</td>
</tr>
<tr>
<td></td>
<td><em>Recurring purge</em> – Use this option for a purge job that should be automatically repeated on a scheduled interval. There are several options for scheduling when the purge job will run: Daily, Weekly, Monthly, and Yearly.</td>
</tr>
<tr>
<td>Purge Claims From</td>
<td><em>All dates</em> – Use this option to purge claims regardless of the date they were received or last analyzed.</td>
</tr>
<tr>
<td></td>
<td><em>Claims analyzed or imported before</em> – Use this option to purge claims based on the Last Analyzed date or the System Entry date. You can enter up to a three-digit number in the days field.</td>
</tr>
<tr>
<td></td>
<td><em>Claims older than</em> – Use this option to purge claims older than a specified number of days from their Last Analyzed date or System Entry date. You can enter up to a three-digit number in the days field.</td>
</tr>
<tr>
<td></td>
<td><em>Claims within date range</em> – Use this option to purge claims within a particular date range.</td>
</tr>
<tr>
<td>Claim/Batch IDs</td>
<td><em>All Claim IDs</em> – Use this option if you want to delete all claims regardless of their Claim ID.</td>
</tr>
<tr>
<td></td>
<td><em>Batch ID</em> – Use this option to purge claims for specific batch IDs by providing a range of batch IDs or a character sequence contained in the Batch IDs.</td>
</tr>
<tr>
<td></td>
<td><em>Claim ID</em> – Use this option to purge claims for specific Claim IDs by spe-</td>
</tr>
</tbody>
</table>
cifying a range of Claim IDs or a character sequence that is contained in the Claim IDs.

| Environment | Use these radio button options to choose whether only claims that were Test or Live analyzed are included in the purge. Select the All option if all claims regardless of how they were analyzed should be included. |
| Claim State | Use these radio button options to choose whether Active claims (most recent resubmission of the claim) or Inactive claims (claims that are not the most current version) should be included in the purge. Select the All option if all claims regardless of their state should be included. |
| Facility Claims | These radio button options only apply when claims for Facility enterprises are included in the claim purge selection criteria (either All enterprises is selected or one or more Facility enterprises are explicitly selected). This allows either Inpatient or Outpatient claims to be purged separately if desired. If the All radio button is selected, both Inpatient and Outpatient claims will be purged. |
| Patient History | By default, all options are selected. The sub-checkboxes Include unanalyzed (NN) claims in NPT and Include unanalyzed (NN) claims in MFX will be available only if its parent option is selected. Starting with 5.4 SP2-CU02, the claim purge stored procedures are modified to enhance how DDR frequency claim data is saved so that DDR frequency edits flag accurately upon purging. |
| Enterprises | *All enterprises* – Use this option if you want to delete claims from all enterprises and rule sets, including professional and facility claims.  
*Select enterprises* – Use this option to select specific enterprises to delete claims from.  
Select the **Select one or more enterprises** field to open a panel displaying the enterprise list to choose from. As enterprises are selected, they are added to a list with a checkmark. |
When the **Save** button becomes enabled, either a new Recurring purge job is created or an existing recurring job is modified.

The **Run Now** button becomes enabled for One-time purge jobs. Also, if a purge job is in progress, the Run Now button will be disabled so that duplicate jobs cannot run at the same time.

### Purge by Ruleset

| Note | Parent enterprises do not contain claims. As such, they are displayed with a grayed-out checkmark. |

After one or more enterprises have been selected, options display that allow the selection of specific rulesets in order to purge only claims that were processed using those rulesets.

*All Rulesets within selected enterprises* — Select this option to delete claims for all rulesets within the selected enterprises.

*Select Rulesets within selected enterprises* — Choose this option to purge claims for specific rulesets within your selected enterprises. You also have the option to **select all** or **unselect all** rulesets within the selected enterprises. After selecting all rulesets, it is also possible to de-select unneeded rulesets.

Each Ruleset group is split into three sub-groups: Static DDR Rulesets, Dynamic DDR Rulesets, and Rulesets.

Once all the above purge criteria selections are made, the **Save** button will become enabled to finish creating the purge job.

### Log Tab

The **Log** tab displays past records of the purge operation. The **Log** tab is enabled for all saved purge jobs, and displays summary information for each purge job.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin Time</td>
<td>Server date and time when the purge job started.</td>
</tr>
<tr>
<td>Status</td>
<td>Running, Completed and Error. Purge jobs can only be edited when the job status is Completed.</td>
</tr>
</tbody>
</table>
Claim Type | Professional or Facility. This column will be left blank for migrated purge jobs from previous cumulative updates.
---|---
Total Time | Time taken for the purge job to complete (for that particular claim type).
Current Test | Shows the number of current and test claims being purged.
Current Live | Shows the number of current and live claims being purged.
Non-Current Test | Shows the number of non-current and test claims being purged.
Non-Current Live | Shows the number of non-current and live claims being purged.
Claims Purged | Total number of claims purged.

**Note**
When displaying purge job information, data for the number of both Professional and Facility claims purged is displayed regardless of whether a Professional Editing or Facility Editing license is installed for your system. When a particular license is not installed, the number of claims purged of that type is expected to be zero.

**Log Details**
Selecting a log entry opens the *Log Details* panel, which displays the details for each step of the purge.

The list of Purge sections includes:

<table>
<thead>
<tr>
<th>Section name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE Check</td>
<td>Gathering applied edits details</td>
</tr>
<tr>
<td>Claims Info</td>
<td>Collecting the purge claims information and updating SCHEDULED_PURGE_LOG counts</td>
</tr>
<tr>
<td>Exception</td>
<td>Shows in case of any errors that may occur during the purge process</td>
</tr>
<tr>
<td>Gather Claim</td>
<td>Getting the list of claims IDs to be purged and updating corresponding tables</td>
</tr>
<tr>
<td>MFX</td>
<td>Deleting data from frequency history-related tables</td>
</tr>
<tr>
<td>NPT</td>
<td>Updating data from/to new patient history-related tables</td>
</tr>
</tbody>
</table>
Purge | Purging claims from claim-related tables
Setup | Includes Variables initialization, Begin batch process

**Note**
The Log Details tab can be sorted by column. Sorting by “Begin Time” will display the latest or current step.

**Exporting to CSV**

To export the data from a purge job:
1. Select the **Tools** gear icon.
2. Select the **Export listing to spreadsheet** option.

**Deleting a Purge Job**

To delete a purge job:
1. Select the purge job to be deleted. This will open the purge job’s **Properties** panel.
2. Select **Delete Purge Job**.

To view previously deleted jobs, you can select the **Deleted** option from the dropdown menu in the **Job Status** filter criteria.

**Note**
To view previously deleted jobs, you can select the **Deleted** option from the dropdown menu in the Job Status filter criteria.

**Managing Flags**

When the system examines a claim, it identifies errors, omissions, or questionable coding relationships on the claim. Then, depending on the rules to which the claim has been routed, the system raises a flag identifying each problem it finds. Each raised flag is represented in the Claim Results screen with an abbreviated code (a mnemonic), which is often accompanied by a detailed description of the problem.

(A list of flags and their descriptions is located in the Code Repository in the Lists and Crosswalks module. Search for the CES PE Flags list.)
The Flags System List
To modify any system flag, you must use the system list for flags.

To access the Flags System List:
1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Lists and Crosswalks icon.
3. In the Selection Criteria, enter iCES PE (or FE) Flags in the Name field.
4. Select the Find button. The system displays the list you requested.
5. Select the underlined link to open the list.

The system then displays a screen you can use to find and edit specific flags.

Note If you want to display a list of all flags, select the Find button at this point. Otherwise follow the instructions below to search for specific flags.

To search for specific flags:
1. Open the system list for flags (as described above).
2. In the Selection Criteria, enter the information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>From/To</td>
<td>In this field, enter a range of abbreviated mnemonics (representing the names for the flags). The system will generate an alphabetical list of flags falling within the range you specify.</td>
</tr>
<tr>
<td>Effective (From/To)</td>
<td>In this field, select the desired effective date range (i.e., the date on which flags became active).</td>
</tr>
<tr>
<td>Expiration (From/To)</td>
<td>In this field, select the desired expiration date range (i.e., the dates between which flags will no longer be applicable).</td>
</tr>
</tbody>
</table>

3. When you finish defining Selection Criteria, select Find. The system then displays a list of all flags that meet your criteria. The system displays the following information for each flag:
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flag</td>
<td>Displays the abbreviated mnemonic for each flag.</td>
</tr>
<tr>
<td>Description</td>
<td>Displays the description for the flag.</td>
</tr>
<tr>
<td>Origin</td>
<td>Indicates the enterprise in which the flag was created. The flag will be valid in the enterprise listed here, and will be inherited by any children that belong to that enterprise. (Refer to the Parental Hierarchy in Enterprises section for more information.)</td>
</tr>
<tr>
<td>Effective</td>
<td>Displays the effective date for the flag (i.e., the date on which the flag became active).</td>
</tr>
<tr>
<td>Expiration</td>
<td>If there is an expiration date for the flag (i.e., the date on which the flag will no longer be applicable), this date displays here.</td>
</tr>
<tr>
<td>Scope</td>
<td>Indicates the ruleset scope that applies for the flag.</td>
</tr>
<tr>
<td>Disclosure</td>
<td>Indicates whether a disclosure statement is tied to the flag.</td>
</tr>
<tr>
<td>Status</td>
<td>Indicates whether this flag is currently enabled in the system.</td>
</tr>
</tbody>
</table>

**Working With Flags in the List**

After you retrieve a list of flags, you can work with them in the following ways:

- You can add a new (custom) flag to the system list.
- You can remove a custom flag or an override from the system list.
- You can import a data file containing flags from another location.

**To add a new flag:**

1. Open the system list for flags (as described above).
2. Select the **Add** button.
3. In the **Add** dialog box, enter a setting for the new flag. (Fields described above.)
4. When finished, select **Save**. The system then creates the new flag.
To remove custom flags and overrides:

1. Open the system list for flags (as described above).
2. Use the Selection Criteria to search for the desired flags and/or override flags.
3. Select the checkbox of each flag you want to remove.

| Important! | You cannot remove system flags. If you select a system flag, the Remove button will remain inactive. |

4. Select the Remove button. A message displays asking you to confirm the deletion.
5. Select OK. The system then removes the flags you selected.

To import flags:

You import flags the same way you import items to other system lists. For details about this process, refer to the Importing External Data to a List section.

Managing rules

What are rules?

Claims Edit System analyzes claims through several different means, all of which are controlled by rules. A rule is a logical set of instructions that tells the system to check for specific coding or data relationships on a claim. When a claim “breaks” a rule (i.e., fails to meet conditions), the rule also contains action statements that tell the system which flag, if any, should be raised against a claim.

When analyzing a claim, Claims Edit System applies various system rules, as well as any user-created rules, to determine if the claim agrees with your Business Policies. System rules use the coding and clinical logic of the Optum Claims Editing KnowledgeBase™. User-created rules can be created to check any aspects of the claim that meet your needs, raising flags for any special areas of concern.

Rules can be made to check any aspect of the claim, including time and dates, patient history and data, doctor and facility data, diagnosis codes, procedure codes, modifiers, insurance plans, and so forth.
Rule Planning

Rules are powerful pieces of code that can bring your business policies to life. They can help you manage costs and ensure that your claims are processed quickly and accurately.

In order to create your rules as efficiently as possible, you should first become familiar with the System Rules (i.e., those rules that come standard with Claims Edit System). In many cases, there might be an existing system rule with similar criteria that you can copy and re-use. If a rule already exists that addresses at least part of your need, Optum recommends that you copy that rule and then modify the copy to meet your needs.

For information about how to copy a rule, refer to the Working With Existing Rules section.

Standard Rules (ILOG) vs Data-Driven Rules (DDRs)

In Claims Edit System, there are two kinds of system rules:

Data-Driven Rules - These are rules (housed in a data-driven ruleset) that become installed/updated when you load the KnowledgeBase. They use the clinical data in the KnowledgeBase to identify patterns on a claim that should be flagged with clinically defined flags.

There are two versions of the DDR User Interface (UI) available:

- Static DDR UI: You cannot copy these rules or create custom versions of them, and they are heavily tied to the clinical data itself. However, you do have some control over the edits raised by these rules. (Refer to the Data-Driven Rules section.)

- Dynamic DDR UI: This allows the ability to create custom rules either by copying existing DDR rules or creating new rules. Due to this added functionality and that the dynamic UI is where new enhancements will be added, it is recommended to use this version. (Refer to the Data-Driven Rules – Panel-based UI section.)

Standard Rules - These rules are installed/updated when you install/update your version of Claims Edit System. They are the most common type of rule in the system, and you can see them listed when you open the system rulesets. (Refer to the Data-Driven Rules – Static DDR UI section and the Managing Rulesets section.) You can also create custom rules of this type.

For information about this process, refer to the Creating Rules section. After you create a new rule (from a copy or from scratch), you need to assign it to a ruleset.

The Three Parts of a Standard Rule

A standard rule is made up of three parts: definitions, conditions (if), and actions (then, else).
Rule Part | Description
--- | ---
Definition | Contains the explanation of which part of the claim or claim lines the rule will look at and what those areas are
Condition | Contains the criteria that must be met in order for the rule to apply.
Action | Specifies what will happen. For example, a flag might be applied to a claim line along with a flag message displayed on the Claim Results screen.

Each part of a rule is made up of building blocks, or functions. These functions are flexible, interchangeable pieces of code that make up the rule.

To view a list of existing functions, refer to the Rule Vocabulary section.

**History Processing**

A rule can include several types of history. Some options are:

- History on claims for the same patient for the six months prior to the current claim date
- Considering only those historical claims submitted by the same provider
- Looking at history for the same date of service
- Including one or all existing claim lines in history

Specifying the history processing of your rule is included as part of the definitions section. Once you have specified how current lines and history will be dealt with in the definitions section, you can then include the appropriate conditions and actions of the rule.

| Note | Keep in mind that a flag cannot (and will not) be applied to a history claim or claim line.

**Finding and Viewing Existing Rules**

In some cases, it is desirable to view the properties of an existing rule so that you can work with them.
To find an existing rule:

1. Open the Rules module from the Enterprise entry-level screen.

2. Open the Rules Management module. A screen of Selection Criteria displays.

3. Enter information in the following fields to filter your search (or leave the default entries if you want to view a list of all rules):

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule Name</td>
<td>Enter the name of the rule you want to open (or leave this field blank if you don’t want to search by rule name).</td>
</tr>
<tr>
<td>Description</td>
<td>Enter the description for the rule you want to open (or leave this field blank if you don’t want to search by description).</td>
</tr>
<tr>
<td>Category</td>
<td>Select the rule category for the rule you want to open (or leave this field blank if you don’t want to search by category).</td>
</tr>
<tr>
<td>Last Published</td>
<td>In this field, select to search for rules published within a specific date range:</td>
</tr>
<tr>
<td></td>
<td>- <strong>From</strong> - Enter the beginning date for the range (i.e., the date on or after which the rule was published).</td>
</tr>
<tr>
<td></td>
<td>- <strong>To</strong> - Enter the ending date for the range (i.e., the date on or before which the rule was published).</td>
</tr>
</tbody>
</table>

The system will search for all rules published between the two dates you select in these fields. If you want to search for a single date, enter the same date in both fields.

**Note**

To aid your search, remember that the wildcard character “%” indicates that you want to search for “any number of characters.”

For example, if you were to enter “A%”, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria.

4. When you finish selecting the desired criteria, select **Find**. The system then displays a list of all rules meeting the criteria.
To view the properties of an existing rule:

1. Display a list of rules using the procedure above.
2. From the list of rules, select the Rule Name of the rule you want to open.

   The system then displays the following additional properties for the rule:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version</td>
<td>Displays the version number for the rule (i.e., 1 = the first version, 2 =</td>
</tr>
<tr>
<td>Flag Information</td>
<td>Displays information about the flags associated with the rule.</td>
</tr>
<tr>
<td>Rule Disclosure</td>
<td>Displays the disclosure statement associated with the rule.</td>
</tr>
<tr>
<td>Rule Logic</td>
<td>Displays the code within the rule logic.</td>
</tr>
</tbody>
</table>

Working with Existing Rules

In Claims Edit System, once you locate an existing rule, there are three ways to work with it:

- You can copy a rule (then make revisions).
- With non-system rules - you can edit the properties to revise an existing rule.
- You can export a rule to an external file. (You can also import rules in a similar manner.)

WARNING: Any time you modify the logic of a rule, be careful that you don’t accidentally create an infinite loop within your rule. An infinite loop occurs when a rule keeps restarting itself over and over again due to the lack of conditions being met within the rule. To avoid this, make sure your rule contains instructions on what to do if the conditions are met, and also instructions on what to do when the conditions are not met.

If you have any questions about this, consult an expert rule developer for assistance.

Copying an Existing Rule

In most cases, the existing system rules should analyze in the way your organization expects (since the rules are based on nationally accepted policies and guidelines). However, there are times when a system rule may
need to be altered due to contractual agreements or organization policies. When that is the case, you may want to make a copy of that system rule, and then modify the copy to suit your needs.

To create a copy of an existing rule:
1. Find the rule you want to copy and open it. (Refer to the Finding and Viewing Existing Rules section.)
2. Select the Copy button. A screen displays, showing the settings for the new copy you are creating.
3. Enter a name for the new rule in the Enter Rule Name field.
4. Modify the other settings for the rule as desired. (Refer to the Finding and Viewing Existing Rules section for a description of each field.)
5. Select Save when finished.

| Important! | When you select Save, the system creates the new rule, but does not promote it to the live environment. Instead, the rule is placed in a test environment. This gives you time to test and refine the rule before you Publish it to the live claims processing environment. |

Editing a (Non-System) Rule

After you create a custom rule, either by copying and customizing a system rule or by creating a rule from scratch, you can make changes to that rule at any time.

To edit an existing rule:
1. Find the rule you want to edit and open it. (Refer to the Finding and Viewing Existing Rules section.)
2. Select the Edit button. A screen displays showing the settings for the rule.
3. Modify the settings for the rule as desired. (Refer to the Finding and Viewing Existing Rules section for a description of each field.)
4. Select Save when finished.

| Important! | When you select Save, the system creates the new rule, but does not promote it to the live environment. Instead, the rule is placed in a test environment. This gives you time to test and refine the rule before you Publish it to the live claims processing environment. |
Exporting and Importing Rules

In refining the way rules work for you, there may be times when you want to export rules for use in another system. For example, when testing rules in a test environment, you may want to export rules to a matched stage or a production environment. Exporting and importing rules makes this process much easier.

**Important!** Significant changes were made to the rule vocabulary (used in the rule logic) in version 4.5 or later. Therefore, if the rule comes from version 4.4.x or earlier, changes to the imported rule may require modifications to function properly.

**To export rules:**

1. Find the list of rules you want to export. (Refer to the Finding and Viewing Existing Rules section.)
2. Select the checkbox of each rule you want to export.
3. Select the Export Rules button.
4. On the Export Rules screen, indicate which version you want to export for each rule, and then select Finish.
5. On the File Download dialog box, select the Save button.
6. On the Save As dialog box, find the path to the location on your hard drive where you want to save the rules file. (The filename will contain a .zip extension.)
7. When finished, select Save. The system then saves the rules to a file you can import elsewhere.

**To import rules:**

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the Rules Management module.
3. Select the **Import Rules** button.

4. On the Import Rules screen, use the **Browse** button to find the file you want to import. (The file will contain a .zip extension.)

5. Once you find the import file, go to the **Type of Import** field and indicate whether the file contains a single rule or multiple rules.

6. Select **Begin**. The system then imports the rules.

### Installing Rule Bundles

When Optum releases a new version of Claims Edit System, the new release always updates your system rules with any changes or additions that have become necessary since the previous release. But what if important rule changes are needed in between software releases? With the Rule Import module, you can download important rule changes and install them to your system, regardless of when the next software release occurs.

You can import the following items using the Rule Import module:

- Updates to system rules created between releases
- New system rules written between releases
- Licensed rules (purchased for a fee) that do not ship with releases

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**Note**

To receive email notices, make sure you are registered as a Claims Edit System client with Optum Product Services. You can contact them at [productservices@optum.com](mailto:productservices@optum.com).

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### Installing Rule Bundles

Installing rule bundles entails loading the rule bundle to the system and then installing the updated rules in the bundle.

**Important!**

Because the data upon which claim analysis depends is being replaced, all claim processing must be stopped during the time the rules are being loaded. It may be possible to do this from the claim source (adjudication system), but if not, instructions are included below for disabling connections to the Claim Connector.
**To load a rule bundle:**

1. Open the **System Settings** module from the Main Menu.
2. Open the **Rule Install** module.
3. In the Import Rules Bundle Location field, select the **Browse** button. A dialog box displays where you can find and select the desired file.
4. Select the desired file, and then select **Open**. The system then loads the rule bundle and it displays among those listed on the Manage Rule Bundles screen.
5. Re-enable connections in the Claim Connector. From the Main Menu, navigate to **System Settings > Connection Configuration**. Enable each connection that is used for claim input via the following steps.
   a. Select the connection name to open the Edit Connection screen.
   b. Change the Status Field from disabled to **enabled**.
   c. Select the **Save** button.
6. Restart the **ICP Connector** service. This causes the configuration change to be recognized by the Claim Connector.

**To install the rules in a rule bundle:**

| Important! | Because the data upon which claim analysis depends is being replaced, all claim processing must be stopped during the time the rules are being loaded. It may be possible to do this from the claim source (adjudication system), but if not, instructions are included below for disabling connections to the Claim Connector. |

1. Disable connections in the Claim Connector. From the Main Menu, navigate to **System Settings > Connection Configuration**. Disable each connection that is used for claim input via the following steps.
   a. Select the connection name to open the Edit Connection screen.
   b. Change the Status Field from enabled to **disabled**.
   c. Select the **Save** button.
2. Restart the **ICP Connector** service. This causes the configuration change to be recognized by the Claim Connector.
3. Open the **System Settings** module from the Main Menu.
4. Open the **Rule Install** module. The Manage Rule Bundles screen displays. The lower portion of the screen shows a list of rule bundles loaded to your system.

5. On the list, find those bundle(s) you want to install and select the checkbox next to each one.

| Note | Remember to check the Status column for each item before you proceed to ensure no one else has already loaded it. |

6. When you are finished selecting items, select the **Load** button. The system then begins installing your selections. As this process can take some time, the system runs it as a background process and you can exit the screen to perform tasks elsewhere. You can return at any time to check the status of the process or you can select the **Refresh** button to show the latest status.

7. Re-enable connections in the Claim Connector that were disabled in Step 1. From the Main Menu, navigate to **System Settings > Connection Configuration**. Enable each connection that is used for claim input via the following steps.

   a. Select the connection name to open the Edit Connection screen.

   b. Change the Status Field from disabled to **enabled**.

   c. Select the **Save** button.

8. Restart the **ICP Connector** service. This causes the configuration change to be recognized by the Claim Connector.

---

**Creating Rules**

There may be times when you want to create a custom rule to supplement the system rules. However, before you create a new rule from scratch, you should check to see if copying (and then modifying) an existing rule would be a better option. (Refer to the **Working with Existing Rules** section for details.)

---

**WARNING:** Any time you create a rule, be careful that you don't accidentally create an infinite loop within the rule. An infinite loop occurs when a rule keeps restarting itself repeatedly due to the lack of conditions being met within the rule. To avoid this, make sure the rule contains instructions on what to do if the conditions are met, and also instructions on what to do when the conditions are not met.
Creating a Custom Rule

If you decide to create your rule from scratch rather than re-use any part of an existing rule, you can follow these steps:

To create a custom rule:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the Rules Management module.
3. Select the New Rule button. A screen displays on which you can enter the following properties for your new rule:

<table>
<thead>
<tr>
<th>Property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule Name</td>
<td>Enter the name for your new rule, e.g., DOS Custom Rule.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter a brief description for the rule.</td>
</tr>
<tr>
<td>Category</td>
<td>Select the desired rule category for the rule or select New&gt;&gt; if you want to create a new rule category. If you create a new category, type the name for your new category in the blank field to the right of the category selection box, e.g., Special Case Rules, as shown below.</td>
</tr>
<tr>
<td>Version [x]</td>
<td>This area displays the version number for the rule you are creating (i.e., 1 = the first version, 2 = the second version, etc.). By default, new rules are also shown as being in the TEST environment.</td>
</tr>
<tr>
<td>Flag Information</td>
<td>At first, these fields display no information. However as you work with the rule logic (below), inserting various flags into the rule, this area will display the information relative to those flags.</td>
</tr>
</tbody>
</table>

Once you have finished with the rule logic, the following information will display in this area (unless no flags have been associated with the rule logic):

Flag Name: This column shows the name for each flag associated with the rule.

Error Level: This column shows a numeric code (such as 25000, 30000, 35000, etc.) indicating a priority level for each flag. This is important because some host systems can only accept one flag passed back from Claims Edit System per claim line. Thus, if more than one flag fires on a claim line, the flag with the
<table>
<thead>
<tr>
<th>Property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>higher “error level value” is considered to have higher priority (e.g., 10 is a higher priority than 1). Therefore, the system will send that flag back to the host system.</td>
</tr>
<tr>
<td></td>
<td><em>Flag Status:</em> Flags can be set to one of four status levels: Profile, Off, Review, or Deny. These status levels determine how the system handles a claim when the corresponding flag is triggered. Typically, they also affect how the claim is handled by your host system.</td>
</tr>
<tr>
<td></td>
<td><em>Autofix Type:</em> This column shows any Autofix types associated with each flag listed. Autofix settings allow Claims Edit System to send back a recommended change with an edit to the host Adjudication system. Valid entries for this column are Add Modifier, Delete Modifier, Add Procedure, Delete Procedure or NONE.</td>
</tr>
<tr>
<td></td>
<td><em>Autofix Value:</em> This column shows the corresponding value associated with the Autofix type. (For an overview of how Auto Fix works, refer to the <em>Auto Fix Overview</em> section).</td>
</tr>
</tbody>
</table>

**Rule Disclosure**

To edit this field, select the down arrow to the right of the text reading *Rule Disclosure*.

> ![Rule Disclosure](#)

The system then displays a text box where you can enter any disclosure statement you want to associate with the rule.

**Rule Logic**

To edit this field, select the *Add/Edit Logic* button. The system displays a screen similar to the following:

```
[definitions]
if
  <select a condition> ✗
  
then
  <select an action> ✗
  
[else]
```

This screen is where you actually build the rule. Notice that this screen contains bracketed items (pointed brackets or square
brackets) which you can select. When you select any of these items, the system displays a list of corresponding Rule Elements that apply to that particular item. These rule elements are the fundamental building blocks you piece together when forming a rule. They are singular command statements that tell the system to look at a specific piece of data and/or perform some kind of action with it. Thus, there are two basic types of rule elements:

- **Condition Statements**: These command statements tell the rule to look for specific pieces of data that meet specific conditions.
- **Action Statements**: These command statements tell the rule what to do when it finds the data meeting the conditions specified above.

These two kinds of rule elements must work together for a rule to function properly. For example, consider the rule element named...

**the beginning DOS on <a claim line>**

This rule element tells the system to look for a specific piece of data (i.e., the Beginning Date of Service located on a Claim Line) rather than to act on it. Therefore, this rule element is a condition statement, which you would find **under [where]** or **if**, as described above. Once you put this element into your rule, you must also include an action statement telling the system what to do when these conditions are met.

### How Are Rule Elements Organized?

When you select either a condition statement (under [where] or if) or an action statement (under then/[else]), the system displays a list of applicable elements you can work with. This list appears in alphabetical order. Elements beginning with numeric values appear first, and these numbers are treated alphabetically (meaning...
that 090 would appear before 1 because it starts with a zero). In addition, capitalized items appear before lowercase items.

When you are looking for a specific element, you may need to look in several locations due to the use of “articles of speech” within the list of elements (i.e., the, an, etc.). For example, suppose you want an element that works with modifiers. In the alphabetical list, you would need to look in all of the following places:

- Under “a” for statements beginning with “a modifier” or “any modifier”
- Under “m” for statements beginning with “modifier”
- Under “t” for statements beginning with “the modifier”
- Under “<” for statements that open with brackets (i.e., <a modifier>)

### The Basic Structure of a Rule

As you select elements to build your rule, you will work in four main sections of the rule:

**Definitions:** This section “defines” the scope of the rule. In other words, it contains an explanation of which areas on the claim or claim lines the rule will look at, and what those areas are. To define rule definitions:

a. Select [definitions]. The system then expands this area to display options similar to the following:

```
definitions
    set variable1 to <select a choice> 
    [where] 
```

b. Select the definable rule elements within the statement you are building. As you select each of the definable elements, the system will display a list of valid options you can select for each item.

c. When you finish with one rule statement, you can add another by selecting the blue arrow ➤ below the first statement.

d. If you make a mistake, you can always delete a definition (or an entire rule statement) by selecting the red X next to the item you want to delete.

**Conditions:** Otherwise known as “IF” statements, this section contains the parameters that must be met in order for the rule to apply. To define rule conditions:

a. Select the statement you want to define below the if section.

b. Use the procedures described above to create the desired rule statements.

**Primary Actions:** Otherwise known as “THEN” statements, this section specifies what actions should be taken (i.e., raise a flag, display a message, etc.) once the “conditions” above it have been met. To define primary rule actions:
a. Select the statement you want to define below the *then* section.

b. Use the procedures described above to create the desired rule statements.

*Alternative Actions:* Otherwise known as “ELSE” statements, this section specifies what actions should be taken when the primary actions (above) do not apply. Often this section is unnecessary, and therefore left blank. To define alternative rule actions:

a. Select the statement you want to define below the *else* section.

b. Use the procedures described above to create the desired rule statements.

<table>
<thead>
<tr>
<th>Important!</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you use custom flags in your rule, ensure you do not use numbers, spaces, or an underscore in the mnemonic (abbreviation) for your flag.</td>
</tr>
</tbody>
</table>

For a list of existing rule elements, refer to the [Rule Vocabulary](#).

**Auto-Fix Elements**

When you are building a rule, you may notice some rule elements that have the word “fix” in them. Some examples are as follows:

- **Condition Statements:**
  - the *auto fix* value of *<a claim line>*
  - the *auto fix* value of *<a claim line flag>*

- **Action Statements:**
  - set the *<a claim line flag mnemonic>* flag on *<a claim line>* with *<a disclosure>* and the message: *<a string>* and the *recommended fix* of adding the modifier *<a string>*
  - set the *<a claim line flag mnemonic>* flag on *<a claim line>* with the message: *<a string>* and the *recommended fix* of adding the modifier *<a string>*
  - set the *<a claim line flag mnemonic>* flag on *<a claim line>* with the message: *<a string>* and the *recommended fix* of changing the modifier *<a string>*
  - set the *<a claim line flag mnemonic>* flag on *<a claim line>* with the message: *<a string>* and the *recommended fix* of changing the procedure code *<a string>*
  - set the *<a claim line flag mnemonic>* flag on *<a claim line>* with the message: *<a string>* and the *recommended fix* of deleting the modifier *<a string>*
  - set the *<a claim line flag mnemonic>* flag on *<a claim line>* with the message: *<a string>* and the *recommended fix* of deleting the procedure code *<a string>*

When you see elements like this, it indicates rule elements that can affect the “auto fix value” of the rule, which displays under Flag Information (see above). The Auto Fix feature gives you some helpful error-
correction options (based on a specific edit issued by the system). However, the Auto Fix settings do not actually modify the original claim data. Instead, Auto Fix provides a return field (in the export file) prompting you to modify an appropriate claim-line field in your host system. The interface must be programmed to make the change in the host system.

For an overview of how the Auto Fix functionality works, refer to the Auto-Fix Overview section.

4. When you finish, select **Save and Update Flags**.

After you create a new rule (from a copy or from scratch), you need to assign it to a ruleset. For information on this process, refer to the Managing Rulesets section.

## Testing and Publishing Rules

### Testing Rules

After you create a new rule, it is vital that you test it before analyzing live claims with it. After testing your rule, if the associated flags do not fire as expected, then you will have to modify the rule logic. You must continue alternately testing the rule and then modifying the rule until you are confident it flags as intended.

You test a new rule by analyzing test claims against it in the test environment. By default, the system keeps all new rules in the test environment until you publish them (refer to the Publishing Rules section).

### Publishing Rules

Once you are sure your rule generates the desired results, you can publish the rule to the live claims processing environment.

**To publish a rule to the live environment:**

1. Find the rule you want to publish and open it. (Refer to the Finding and Viewing Existing Rules section.)
2. Select the **Edit** button. A screen displays showing the settings for the rule.
3. Select **Publish**. A screen displays asking which ruleset you want the rule to be part of. (Refer to the Managing Rulesets section for more information.)
4. Select the desired ruleset and select **Finish**. The system then publishes the rule to the live environment as part of that ruleset.
Deleting Rules

You cannot delete system rules in Claims Edit System. However, if you have added a custom rule (whether by copying and modifying a rule or by creating a rule from scratch), there are two ways to remove that rule from the system:

- You can delete the latest customized version of a rule.
- You can delete the entire customized rule.

Deleting Custom Versions of a Rule

Each time you edit a non-system rule, the system assigns a new version number to that rule. This means that you can always go back to an earlier version of the rule (prior to the customizations you made) by deleting the later version of that rule.

To delete custom versions of a rule:

1. Find the rule you want to work with and open it. (Refer to the Finding and Viewing Existing Rules section.)
2. Select the Version number for the version you want to delete.
3. Select the Delete Version button. A message displays asking you to confirm the deletion.
4. Select OK. The system then removes this version of the rule.

Deleting An Entire Custom Rule

You can also delete an entire non-system rule from the system.

To delete custom rules:

1. Find the list of rule you want to delete. (Refer to the Finding and Viewing Existing Rules section.)
2. Select the checkbox of each rule you want to delete.
3. Select the **Delete Rule** button. A message displays asking you to confirm the deletion.

4. Select **OK**. The system then removes the rules you selected.

---

**Managing Rulesets**

Claims Edit System has a large repository of rules to control claims analysis. Some of these are system rules (those that come with the system) and others are custom rules (rules that you create or that you contract with Optum to create for your organization).

However, when a claim enters Claims Edit System, the system does not process that claim using every rule in the system. Rather, claims are assigned to process using specific “sets” of rules that work together in analyzing a specific type of claim.

Claims Edit System is installed on your system with predefined “system” rulesets. These are:

- **The Commercial Ruleset**: Rules to analyze commercial claims
- **The Medicaid Ruleset**: Rules to analyze Medicaid claims
- **The Medicare Ruleset**: Rules to analyze Medicare claims
- **The Apply Edits Ruleset**: Rules to control how the system returns analysis results to your host system

---

**Note**

The system rulesets actually have more precise names than the ones described above. If you have the Professional Editing component of Claims Edit System (which processes CMS-1500 claims), the rulesets will be named as follows:

- Medicare Professional Ruleset
- Commercial Professional Ruleset

Although the system rulesets can be used for analysis, you can also create and define your own rulesets to meet your individual requirements. You can create an unlimited number of custom rulesets. You can also modify the system rulesets to meet the needs of your organization. (Refer to the **Controlling the Content of a Ruleset** section for more information.)
To access rulesets:

1. Open the Rules module from the Enterprise entry-level screen.
2. Select Manage Rulesets.

The fields on this screen contain the following information for each ruleset:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>A name describing the ruleset.</td>
</tr>
<tr>
<td>Type</td>
<td>Indicates whether this is a standard ruleset or an applied edits ruleset. (Refer to the Applied Edits section for details.)</td>
</tr>
<tr>
<td>Environment</td>
<td>Indicates whether the ruleset has been deployed against a live or test environment.</td>
</tr>
<tr>
<td>Origin</td>
<td>Indicates the enterprise in which the ruleset was created. The ruleset will be valid in the enterprise listed here, and will be inherited by any children that belong to that enterprise. (Refer to the Parental Hierarchy in Enterprises section for more information.)</td>
</tr>
</tbody>
</table>

From within this module, you can perform the following tasks:

- Searching for a ruleset
- Create a custom ruleset
- Control the content of a ruleset
- Copy a ruleset
- Promote a ruleset to the live environment
- Retract a ruleset back to the test environment
- Delete a custom ruleset

Creating a Custom Ruleset

To create a custom ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. In the top portion of the screen, enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Enter a name describing the ruleset.</td>
</tr>
</tbody>
</table>
| Selection Date | When rules within this ruleset require a date to determine effectiveness or to get information from the KnowledgeBase, the system will use the date you define here. You can choose either of the following:  
  • **Incurred Date** - The beginning date of service on the claim line. This is the preferred option, since that is when the procedure was actually performed (and leads to results that are more accurate).  
  • **Processed Date** - The date the claim line is being processed. |
| RVU Type    | Indicate what type of Relative Value Unit (RVU) table should be used by rules in this ruleset. You can choose any of the following:  
  • **Ingenix RVU** - Unless there is an applicable override, the system will use the Optum-developed RVUs. These values are stored in the RVU table called [Ingenix RVU](#).  
  • **MPFS RVU** - Unless there is an applicable override, the system will use the Medicare Physicians Fee Schedule RVUs. These values are stored in the RVU table called [MPFS RVU](#).  
  • **CMS Gap-Filled RVU** - Unless there is an applicable override, the system will use the Medicare developed RVUs with Optum RVUs filling in the gaps (if CMS ships an RVU value equal to zero). These values are stored in the RVU table called [CMS Gap-Filled RVU](#). |
| Description | Enter a brief description showing the purpose of the ruleset.               |
| MFD         | Indicate which Maximum Frequency Per Day (MFD) values should be used by rules in this ruleset. You can choose either of the following:  
  • **Ingenix MFD Values** - Unless there is an applicable override, the system will use the “Ingenix” MFD values shipped by Optum (formerly Ingenix). These values are stored in the Procedure Code table as an attribute.  
  • **Use MFD of 1** - Unless there is an applicable override, the system uses an MFD value of 1 for every procedure code (regardless of the val- |
Field | Description
--- | ---

- ues stored in the Procedure Code table.)

Environment | This field indicates the new ruleset will be deployed originally against the test environment. Later, when you know it is working as desired, you can promote the ruleset to the live claims environment. (Refer to the Promoting/Retracting Rulesets section.)

Origin | Indicates the enterprise in which the ruleset was created. The ruleset will be valid in the enterprise listed here, and will be inherited by any children that belong to that enterprise. (Refer to the Parental Hierarchy in Enterprises section for more information.)

4. When you finish, select **Save and Create New Ruleset**.

After you create your ruleset, you must **Define the Content** of your ruleset.

### Controlling the Content of a Ruleset

Rulesets contain only rules. For this reason, it may seem like a simple matter to control the rules that belong to a ruleset. However, there are a few important issues to consider first.

### About Inherited Rules

Within a ruleset, you may see two different kinds of rules:

- **Inherited Rules** - These rules are automatically part of the ruleset because they are inherited from a parent version of the ruleset. (Refer to the Parental Hierarchy in Enterprises section for more information.)

- **Local Rules** - These rules have been added to the ruleset at the enterprise level you are working in. They do not belong to any parent version of the ruleset, but are inherited by child versions.
Within a ruleset, the system treats local rules differently that it does inherited rules. If you select a local rule, the system does not restrict the options available to you. You can remove the rule, disable/enable it, or change its priority in relation to the other rules in the set. However, if you select an inherited rule, the system only allows you to disable/enable the rule. If you want to remove the rule or change its priority, you must first consider the following questions:

a. Is the rule inherited from a parent that is a system ruleset? If so, you cannot remove the rule or change its priority. This restriction maintains the integrity of the system rules that depend on the (parent) system ruleset. However, you can disable the rule and you can indirectly adjust the rule priority by moving other local rules above or below it in the priority list.

b. If the rule is not inherited from a system ruleset, where is the rule inherited? If you can identify the parent ruleset where the rule is considered “local,” you can switch enterprises to move into that parent level. Then you can manipulate the rule.

| Note | You can only switch enterprises into a level that you have permission to access. If you do not have access rights to the level where the rule is local, you must contact an administrator of that enterprise for assistance. |

Modifying the Content of a Ruleset

To define the ruleset detail properties:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Select the Find button to generate a list of rulesets.
4. Open a ruleset from those on the list.

<table>
<thead>
<tr>
<th>Name</th>
<th>Envil</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Professional</td>
<td>Live</td>
</tr>
<tr>
<td>My Commercial Ruleset</td>
<td>Live T</td>
</tr>
<tr>
<td>Medicare Professional</td>
<td>Live</td>
</tr>
</tbody>
</table>

The system displays the settings for the ruleset, along with a list of rules belonging to the ruleset.

5. At the top of the screen you can define any of the following properties for the ruleset:

<table>
<thead>
<tr>
<th>Property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Displays the name of the ruleset. (You cannot modify this field.)</td>
</tr>
<tr>
<td>Property</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Selection Date</td>
<td>In this field, indicate whether the rules in the ruleset should use the Incurred Date or the Processed Date.</td>
</tr>
<tr>
<td>Environment</td>
<td>Indicates whether the ruleset has been deployed against a live or test environment. (You cannot modify this field.)</td>
</tr>
<tr>
<td>Origin</td>
<td>Indicates the enterprise in which the ruleset was created. (You cannot modify this field.) The ruleset will be valid in the enterprise listed here, and will be inherited by any children that belong to that enterprise. (Refer to the Parental Hierarchy in Enterprises section for more information.)</td>
</tr>
<tr>
<td>RVU Type</td>
<td>In this field, define the Relative Value Unit (RVU) type that applies to the ruleset.</td>
</tr>
<tr>
<td>MFD</td>
<td>In this field, define which Maximum Frequency per Day (MFD) values should be used by rules in this ruleset. You can choose either of the following:</td>
</tr>
<tr>
<td></td>
<td>- <strong>Ingenix MFD Values</strong> - Unless there is an applicable override, the system will use the &quot;Ingenix&quot; MFD values shipped by Optum. These values are stored in the Procedure Code table as an attribute.</td>
</tr>
<tr>
<td></td>
<td>- <strong>Use MFD of 1</strong> - Unless there is an applicable override, the system will use an MFD value of 1 for every procedure code (regardless of the values stored in the Procedure Code table).</td>
</tr>
<tr>
<td>Act on Dropped Lines</td>
<td>Selecting this checkbox indicates the rules in the ruleset should act on dropped lines (meaning that they analyze the claim as though the claim line had not been dropped).</td>
</tr>
<tr>
<td>Applied Edits Act on Profile Edits</td>
<td>Selecting this checkbox indicates the rules in the ruleset should use profile edits within the Applied Edits functionality. (Refer to the Applied Edits section for details.)</td>
</tr>
<tr>
<td>Description</td>
<td>Displays the name of the ruleset. (You cannot modify this field.)</td>
</tr>
</tbody>
</table>

6. Select the **Save Changes** button.
To add rules to a ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Select the Find button to generate a list of rulesets.
4. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
5. At the top of the list of rules, select the Add Rule button. The system displays a list of all the rules that currently exist.
6. Select the checkbox next to each rule you want to add.
7. When you finish selecting the rules, select Add to Ruleset. The system then adds the rules you selected.
8. Select the Save Changes button.

To view the properties of rules in a ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Select the Find button to generate a list of rulesets.
4. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
5. Under the Rule Name column, select the rule you want to view.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Rule Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(PAT) Missing Patient ID</td>
</tr>
<tr>
<td>2</td>
<td>(DOB) Missing Invalid DOB</td>
</tr>
</tbody>
</table>

The system displays the properties of the rule, including the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Ruleset</td>
<td>Displays the name of the ruleset where the rule resides.</td>
</tr>
<tr>
<td>Category</td>
<td>Indicates what type of rule it is (i.e., system rule, custom rule, etc.).</td>
</tr>
<tr>
<td>Enterprise Where Added</td>
<td>Indicates the enterprise in which the rule was created. The rule is valid in the enterprise listed here, and will be inherited by any children that belong to that enterprise. (Refer to the Parental Hierarchy in)</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Enterprises</td>
<td>(see the Enterprises section for more information.)</td>
</tr>
<tr>
<td>Effective Dates</td>
<td>Indicates the effective dates for the rule (i.e., the dates on which the rule begins to apply during analysis).</td>
</tr>
<tr>
<td>Status</td>
<td>Indicates whether the rule is enabled or disabled.</td>
</tr>
<tr>
<td>Version</td>
<td>Displays the version number of the rule.</td>
</tr>
<tr>
<td>Flag Name</td>
<td>This field shows the mnemonic representing an abbreviated name for each flag associated with the rule. If nothing displays in this field, it means that no flags have been associated with the rule in the rule logic.</td>
</tr>
<tr>
<td>Flag Type</td>
<td>This field indicates the following for each flag associated with the rule:</td>
</tr>
<tr>
<td></td>
<td>- <strong>Line</strong>: This means the flag applies to each line of a claim (rather than the whole claim).</td>
</tr>
<tr>
<td></td>
<td>- <strong>Claim</strong>: This means the flag applies to the whole claim (rather than to each claim line).</td>
</tr>
<tr>
<td>Error Level</td>
<td>This field displays a numeric code (such as 25000, 30000, 35000, etc.) indicating a priority level for the flag. This is important because some host systems can only accept one flag passed back from Claims Edit System per claim line. Thus, if more than one flag fires on a claim line, the flag with the higher “error level value” is considered to have higher priority (i.e., 10 is a higher priority than 1). Therefore, the system will send that flag back to the host system.</td>
</tr>
<tr>
<td>Flag Status</td>
<td>Flags can be set to one of four status levels: Profile, Off, Review, or Deny. These status levels determine how the system handles a claim when the corresponding flag is triggered. Typically, they also affect how the claim is handled by your host system. You can select any of the following options in this field:</td>
</tr>
<tr>
<td></td>
<td>- <strong>Profile</strong>: A flag with a Profile status is only used for statistical purposes—it does not prevent a claim from running through the system. When the system profiles a flag, it stores the analysis result but does not return it to your host system (unless your system is configured to return profile flags - refer to the <strong>Connection Configuration</strong> for details).</td>
</tr>
</tbody>
</table>
### Field Description

- If a flag is profiled, it will not perform actions such as dropping the line or the claim from further analysis.
- **Off:** If you don’t want a rule to trigger a flag during claims analysis, set the flag’s status to Off. A flag set to the Off status does not function during claims analysis and does not send a result back to your host system.
- **Review:** A flag with a Review status signals that a possible error needs examination. When the system raises a review flag, the system sends the flag back to the host system and the claim remains in the system until the claim is adjusted in some manner.
  
  **Important:** If a claim stays “in the system,” it means it is unresolved and can’t be billed or denied. These review flags show up on several reports.
- **Deny:** A Deny status indicates that there are errors of sufficient magnitude to justify denying the claim or the line item. Therefore, when this status is applied to a claim line, the system drops the line and no further analysis occurs on that line.

| Rule Logic | This section displays a representation of the logic used to build the rule. For information about how to edit the rule logic (or even create a new custom rule), refer to the Rules Management section. |

---

### To edit a rule in a ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
4. From the rules listed, select the checkbox next to the rule you want to edit.
5. Select the **Edit Rule in Ruleset** button.
6. Modify the rule as desired. For details, refer to the Creating Rules section.
To move rules up or down on the priority list:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
4. On the list of rules, select the checkbox next to the rule you want to move.
5. Select Move Up or Move Down until the rule reaches the desired position.
6. Select the Save Changes button.

To manually change a rule’s priority:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
4. On the list of rules, select the checkbox next to the rule you want to modify.
5. Select the Enter Priority button (1). A box displays asking you to enter a priority number.
6. Enter the priority number, then select Save.
7. When you finish changing priorities, select the Save Changes button.

To remove rules from a ruleset:

Note This does not remove the rule from the system; it only removes its association with this ruleset.

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
4. On the list of rules, select the checkbox next to each rule you want to remove.
5. When you finish marking the rules, select Remove Rule. The system then removes the rules you selected.
6. Select the Save Changes button.
To disable rules in a ruleset:
1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
4. On the list of rules, select the checkbox next to the rule you want to modify.
5. Select the Change Status button. The system changes the status to either enabled or disabled.
6. When you finish changing priorities, select the Save Changes button.

To override flags associated with a ruleset:
1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Open a ruleset from those on the list. The system displays a list of rules belonging to the ruleset.
4. Select the Flags tab.
5. From the list of flags, select the checkbox(es) next to the flag(s) you want to override.
6. Select the Override button. (Refer to the Overrides section for details on how overrides work.)
7. Make the appropriate flag status changes.
8. When finished, select the Save button to temporarily save these overrides.
9. Next, select the Save Changes button to complete saving changes and apply them to the ruleset.

Important! You must select both the Save button and the Save Changes button, or the system will not apply your overrides.

Copying a Ruleset

Sometimes the quickest (and most effective) way of creating a new ruleset is to copy the properties of an existing ruleset and then modify the properties.
To make a copy of a ruleset:
1. Open the Rules module from the Enterprise entry-level screen.
2. Select Manage Rulesets.
3. Select the checkbox next to the ruleset you want to copy.
4. Select the Copy button. A screen displays that shows the properties of the new ruleset you are creating. All of the properties appear populated with the same entries as the ruleset you are copying except for the name (which reads “Copy of Ruleset [X]”) and the environment (which is set to Test until you promote the new ruleset).
5. Enter a new name for your ruleset.
6. Modify any of the other settings.
7. When you finish, select Save Changes.

Promoting/Retracting Rulesets
When you create a new ruleset, it is not advised to run live claims against them until you have tested them thoroughly. For this reason, every new ruleset you create automatically deploys against the test claims environment first; you must later promote the ruleset to the live-claims environment after it has cleared testing. Refer to the Understanding Live and Test Claims section for more information.

To promote a test ruleset to the live environment:
1. Open the Rules module from the Enterprise entry-level screen.
2. Select Manage Rulesets.
3. Find the Test ruleset you want to promote, and then select the checkbox next to it.
4. Select the Promote/Retract button. The system displays a message letting you know the promotion has occurred.

To retract a live ruleset back to the test environment:
1. Open the Rules module from the Enterprise entry-level screen.
2. Select Manage Rulesets.
3. Find the Live ruleset you want to retract, and then select the checkbox next to it.
4. Select the Promote/Retract button. The system displays a message letting you know the ruleset has been retracted.
Deleting a Custom Ruleset

Deleting system rulesets would compromise the integrity of the system. Therefore, you cannot delete any of the system rulesets. However, you can delete any custom ruleset that you have added to your system.

To delete a custom ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Select Manage Rulesets.
3. Find the ruleset you want to delete, and then select the checkbox next to it.
4. Select the Delete button. The system displays a message letting you know the deletion has occurred.

Data-Driven Rules – Static DDR UI

Data-Driven Rules (DDRs) use the clinical data in the KnowledgeBase to identify patterns on a claim that should be flagged with clinically defined criteria. They are commonly referred to as patterns.

<table>
<thead>
<tr>
<th>Important!</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDR data does not originate in the code repository but from separate data tables. These are used only to contain the patterns to flag a claim when they match a scenario identified in a pattern.</td>
</tr>
</tbody>
</table>

DDRs have different parts that work together to produce results:

- **Patterns** - Each DDR is called a pattern.
- **Triggers** - Preconditions a claim must match before a pattern expression is evaluated.
  - **Trigger Fields** - Fields used in the current claim for matching against the trigger values.
  - **Trigger Values** - Sets of data (for each trigger field) that must match the current claim (or claim line) as it is analyzed.
- **Expressions** - Additional conditions that must be met for a flag to fire.
- **Flag Data** - Data that defines the flag that will be fired for the set of trigger values when the claim matches both the trigger values and the expression evaluates as true.
Accessing Static Data-Driven Rulesets

To access the Static Data-Driven Rulesets, select the Manage Static Data-Driven Rulesets icon from the Rules menu.

Managing Static Data-Driven Rulesets

Since Data-Driven Rules are heavily tied to the clinical data, you cannot copy these rules or create custom versions of them. However, you do have some control over the rulesets that manage these rules.

Similar to the traditional rules, Data-Driven patterns also reside in a ruleset, where you can maintain patterns and route claims to them for analysis.

To create a new Data-Driven Ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the Manage Data-Driven Rulesets module. A screen displays showing a list of Data-Driven Rulesets.
3. Select New. The Data-Driven Ruleset Details screen opens.
4. Here you can define the settings for the ruleset. (Refer to the Data-Driven Ruleset Settings section.)

To access a Static Data-Driven Ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the Manage Data-Driven Rulesets module. A screen displays showing a list of Data-Driven Rulesets. To find a specific ruleset, enter its name in the Selection Criteria search at the top of the screen.
3. In the Ruleset Name column of the list, select the ruleset you want to open. The Data-Driven Ruleset Details screen opens.
4. Here you can define or modify the settings for the ruleset. (Refer to the Data-Driven Ruleset Settings section.)

To copy a Static Data-Driven Ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the Manage Data-Driven Rulesets module. A screen displays showing a list of Data-Driven Rulesets. To find a specific ruleset, enter its name in the Selection Criteria search area at the top of the screen.
3. In the **Ruleset Name** column of the list, select the checkbox of the ruleset you want to copy.

4. Select **Copy**. The Data-Driven Ruleset Details screen displays.

5. Here you can define or modify the settings for the ruleset. (Refer to the [Data-Driven Ruleset Settings](#) section.)

**To delete an existing Static Data-Driven Ruleset:**

1. Open the **Rules** module from the *Enterprise* entry-level screen.

2. Open the **Manage Data-Driven Rulesets** module. A screen displays showing a list of Data-Driven Rulesets. To find a specific ruleset, enter its name in the **Selection Criteria** search area at the top of the screen.

3. In the **Ruleset Name** column of the list, select the checkbox of each ruleset you want to delete.

4. Select **Delete** and confirm with **OK**.

**Working with Static Data-Driven Ruleset Settings**

On the Data-Driven Ruleset Details screen, you can define or modify the settings for a Data-Driven Ruleset. There are several ways to access this screen:

- Open an existing Data-Driven Ruleset
- Create a new Data-Driven Ruleset by copying an existing one
- Create a new Data-Driven Ruleset from scratch

Performing any of these tasks will open the **Data-Driven Ruleset Details** screen, where you can work with the ruleset in the following ways:

**To define (or modify) the name of a Data-Driven Ruleset:**

1. Access the **Data-Driven Ruleset Details** screen (refer to the [Accessing Data-Driven Rulesets](#) section).

2. To the right of the Name field on the top of the screen, select **Change** to make the Name field editable.

3. Enter a name in the **Name** field.

4. Select **Save**.

**Patterns and Flags**

On the Data-Driven Ruleset Details screen, you can work with two tabs:
Patterns - This screen displays a list of patterns belonging to the ruleset. You can use this screen to add, enable, disable, or remove patterns. You can also ignore the Line of Business (LOB).

Pattern Flags - This screen displays a list of flags related to the patterns in the ruleset. You can use this screen to manage overrides to the various flags.

Working with Patterns

To add a new pattern to the ruleset:

1. Access the Data-Driven Ruleset Details screen (refer to the Accessing Data-Driven Rulesets section).
2. Make sure the Patterns tab is selected.
3. Select Add Pattern. The Add Data-Driven Patterns screen displays.
4. From among the patterns in the KnowledgeBase, search to find those you want to add. You can use the following Selection Criteria to filter:

<table>
<thead>
<tr>
<th>Selection Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern ID</td>
<td>To search for a range of pattern ID numbers, enter pattern IDs in the From and To subfields (numeric only). Note: The wildcard character “%” indicates a search for “any number of characters.” For example, “A%” indicates a search for all items starting with the letter “A” followed by any number of characters.</td>
</tr>
<tr>
<td>Pattern Name</td>
<td>Search for a specific pattern name.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Search for a specific jurisdiction, a geographical area serviced by a single Medicaid Administrator. Since Medicaid policies can vary at the regional level, the Centers for Medicare and Medicaid Services (CMS) work with independent Medicaid Administrators to develop and publish these policies within their assigned geographical jurisdictions. The size of jurisdictions can vary from an area within a single state to an area combining several states.</td>
</tr>
<tr>
<td>Line of Business</td>
<td>Search for a specific line of business (e.g., Medicaid, Medicare, Commercial, ASC, DME, etc.).</td>
</tr>
</tbody>
</table>
5. When finished, select **Find**. The system displays patterns matching the criteria.

6. Select the checkbox next to each item you want to add.

7. Select **Add** to add and remain on the screen, or select **Add Close** to add and then return to the Data-Driven Ruleset Details screen.

## Finding and Editing Patterns Already Belonging to the Ruleset

### To find patterns:

1. Access the **Data-Driven Ruleset Details** screen (refer to the Accessing Data-Driven Rulesets section).

2. Make sure the **Patterns** tab is selected.

3. In the **Selection Criteria** area at the top of the screen, enter the desired search criteria. You can make entries in any of the following fields to refine your search or leave the default entries.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act on Dropped Claim/Claim Lines</td>
<td>Search for patterns with the Act on Dropped Claim/Claim Lines option.</td>
</tr>
<tr>
<td>Pattern ID</td>
<td>Search for a range of pattern identification numbers by entering pattern IDs in the From and To subfields.</td>
</tr>
<tr>
<td>Pattern Name</td>
<td>Search for a specific pattern name. Note: The wildcard character &quot;%&quot; indicates a search for &quot;any number of characters.&quot; For example, “A%” indicates a search for all items starting with the letter “A” followed by any number of characters.</td>
</tr>
<tr>
<td>Line of Business</td>
<td>Select a specific line of business(^1).</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select a specific jurisdiction(^2).</td>
</tr>
</tbody>
</table>

\(^1\)A category assigned to data-driven rule patterns to help distinguish what kind of business is involved (e.g., Medicaid, Medicare, Commercial, ASC, DME, etc.).

\(^2\)The specific geographical area serviced by a single Medicaid Administrator. Since Medicaid policies can vary at the regional level, the Centers for Medicare and Medicaid Services (CMS) works with independent Medicaid Administrators to develop and publish these policies within their assigned geographical jurisdictions. The size of jurisdictions can vary from an area within a single state to an area combining several states.
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignore Line of Business</td>
<td>Search for patterns that ignore line of business (or vice versa).</td>
</tr>
<tr>
<td>Enabled</td>
<td>Search for patterns that are enabled or disabled.</td>
</tr>
</tbody>
</table>

4. When finished, select **Find**. This system lists all patterns that currently belong to the ruleset matching your defined criteria.

The order of these items is significant. First, the system groups all items with the same **Error Level**. Within each group sharing the same error level, the system lists items in their predetermined priority sequence (highest first).

**To edit patterns:**

**Using the Buttons**

- Select the checkbox next to each item to:
  - **Enable/Disable** - If the item is disabled, this enables it (or vice versa).
  - **Ignore LOB** - Sets the item to **Ignore Line of Business**.
  - **Remove** - Removes the selected pattern from the ruleset.

**Modifying Individual Items on the List**

- In the **ID** column, select to open the settings for individual patterns. Some settings can be modified and some cannot, depending on the pattern and ruleset you are in. For example, if you open an item from a system ruleset, you cannot edit any of the settings. However, if you open a copy made from a system ruleset, you can edit the Error Level and Status for each associated flag. If the flag contains multiple flags or flags by line of business, these will be displayed.

**Important!**

When you modify the error level number, you also change its priority (which can affect the sequence the pattern runs in relation to other patterns). Items with a higher error level value have a higher priority and will run first. Since the list of patterns displays according to priority, changing the error level may also change where the items display sequentially in the list.
Working with Pattern Flags

To find and edit flags associated with ruleset patterns:

1. Access the Data-Driven Ruleset Details screen (refer to the Accessing Data-Driven Rulesets section).
2. Make sure the Pattern Flags tab is selected.
3. In the Selection Criteria area at the top of the screen, enter the desired search criteria. You can make entries in any of the following fields to refine your search or leave the default entries.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flag</td>
<td>Search for a specific flag. Note: The wildcard character “%” indicates a search for “any number of characters.” For example, “A%” indicates a search for all items starting with the letter “A” followed by any number of characters.</td>
</tr>
<tr>
<td>Line of Business</td>
<td>Select a specific line of business¹</td>
</tr>
<tr>
<td>Error Level</td>
<td>Select a specific error level.</td>
</tr>
<tr>
<td>Pattern Name</td>
<td>Search for a specific pattern name.</td>
</tr>
<tr>
<td>Status</td>
<td>Select flags that set a specific status.</td>
</tr>
<tr>
<td>Pattern ID</td>
<td>To search for flags by associated pattern identification numbers, enter pattern IDs in the From and To subfields.</td>
</tr>
<tr>
<td>Enabled</td>
<td>Search for flags belonging to patterns that are enabled or disabled.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select a specific jurisdiction².</td>
</tr>
</tbody>
</table>

¹A category assigned to data-driven rule patterns to help distinguish what kind of business is involved (e.g., Medicaid, Medicare, Commercial, ASC, DME, etc.).
²The specific geographical area serviced by a single Medicaid Administrator. Since Medicaid policies can vary at the regional level, the Centers for Medicare and Medicaid Services (CMS) works with independent Medicaid Administrators to develop and publish these policies within their assigned geographical jurisdictions. The size of jurisdictions can vary from an area within a single state to an area combining several states.
4. When finished, select **Find**. The system lists all patterns currently belonging to the ruleset.

5. Select checkboxes of items to edit.

6. Using these buttons you can edit the corresponding items:
   
   - **Multi-Edit Override** - Active only if one or more checkboxes are selected, it activates all editable fields on each checked row. This allows you to change (override) the corresponding values.
   
   - **Remove Selected Overrides** - Active only if one or more checkboxes are selected, it removes the overrides on each selected flag. This returns the pattern and flag back to the default system settings.
   
   - **Remove All Overrides** - Active only if no checkboxes are marked, it removes the overrides on all flags, returning the pattern and flag back to the default system settings.

   **REMEMBER:** If you are working with a ruleset copied from another ruleset, removing overrides does not merely change the settings back to those of the original ruleset but to the default system settings.

7. To view details about an individual flag, select the flag link. If the flag contains multiple flags or flags by line of business, they will be displayed.

8. Select **Save** when finished.

### Claim Routes - Static UI

Because some claims must be analyzed differently than others, it is important for the system to know how to sort claims for analysis. To do this, the system needs a way to answer the following questions:

a. What should the system look for on a claim to know how that claim should be analyzed?

b. What set of rules would be appropriate to that kind of analysis?

To answer these questions, you define claim routes. Claim routes contain unique settings that tell the system which set of rules should run against certain kinds of claims. The system comes with a pre-defined “default” route, but you can add other routes to suit your needs.

**To view and access claim routes:**

1. Open the **Rules** module from the **Enterprise** entry-level screen.

2. Open the **Claim Routes** module. A screen with information about existing claim routes displays.
To create a new claim route:

1. On the Claim Routes screen, select **Add Route**. This displays the Add Route screen.

2. Enter information in the following fields, and then select **Save** when finished.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route Name</td>
<td>Enter the desired name for the route.</td>
</tr>
<tr>
<td>Current Priority</td>
<td>Enter the priority number for the route. Priorities range from 1 to 999,</td>
</tr>
<tr>
<td></td>
<td>with 1 being the highest priority, 2 the next highest, etc. The system</td>
</tr>
<tr>
<td></td>
<td>uses priorities to determine which claim route to use when more than one</td>
</tr>
<tr>
<td></td>
<td>route is valid. For example, if a claim came through that met the criteria</td>
</tr>
<tr>
<td></td>
<td>for both “Route A” and “Route B,” it would look at the priority of each</td>
</tr>
<tr>
<td></td>
<td>route and send the claim to the one with the higher priority.</td>
</tr>
<tr>
<td>ICD-10 Effective Date</td>
<td>Because the system handles both ICD-9 and ICD-10 codes, it needs to</td>
</tr>
<tr>
<td></td>
<td>determine which type of code applies for each claim that enters the system.</td>
</tr>
<tr>
<td></td>
<td>In many cases, claims will come through with a “Code Type” indicator to</td>
</tr>
<tr>
<td></td>
<td>make this distinction. However, for claims that do not have a code type,</td>
</tr>
<tr>
<td></td>
<td>the system will use an effective date instead (i.e., claims dated prior to</td>
</tr>
<tr>
<td></td>
<td>the effective date will be considered under ICD-9, while those dated on or</td>
</tr>
<tr>
<td></td>
<td>after the effective date will be considered under ICD-10).</td>
</tr>
<tr>
<td></td>
<td>The ICD-10 Effective Date setting consists of two interactive fields:</td>
</tr>
<tr>
<td></td>
<td>• <em>(Checkbox)</em> <strong>Set ICD-10 Effective Date in Claim Route</strong> - Select this</td>
</tr>
<tr>
<td></td>
<td>checkbox if you want to define an ICD-10 threshold date for this claim</td>
</tr>
<tr>
<td></td>
<td>route.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Effective Date</strong> - This screen is only active when you select the</td>
</tr>
<tr>
<td></td>
<td>checkbox described above. Here you can define the ICD-10 threshold date</td>
</tr>
<tr>
<td></td>
<td>for claims that will use this route.</td>
</tr>
<tr>
<td>Status</td>
<td>Set the status of the new route to either Enabled or Disabled. (This allows</td>
</tr>
<tr>
<td></td>
<td>you to create a new route, but temporarily disable it until you are ready</td>
</tr>
<tr>
<td></td>
<td>to use it.)</td>
</tr>
<tr>
<td>Destination Ruleset(s)</td>
<td>Select the ruleset(s) that should be used for claims entering this route.</td>
</tr>
<tr>
<td></td>
<td>To accommodate the flexibility to have one route use dynamic DDR and another</td>
</tr>
<tr>
<td></td>
<td>route use static DDR and control the</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>ruleset run order between DDR and Legacy rulesets, there are three options for Destination Rulesets:</td>
</tr>
<tr>
<td></td>
<td>• This provides the option to select if a dynamic DDR ruleset runs prior to a Legacy ruleset or to select a static DDR ruleset by name that will run prior to the Legacy ruleset. If no ruleset should run prior to Legacy, select <strong>None.</strong> Selecting <strong>Dynamic</strong> will use the ruleset and routing configurations that are set up in the dynamic DDR UI.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Legacy Ruleset Name.</strong> This provides the option to select the Legacy ruleset that should run next.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Data-Driven ruleset Option/Name (Run Last).</strong> This provides the option to select either to have a dynamic DDR ruleset run after the Legacy ruleset or to select a static DDR ruleset by name that will run after the Legacy ruleset.</td>
</tr>
<tr>
<td></td>
<td>If no ruleset should run after the Legacy ruleset, select <strong>None.</strong> Selecting <strong>Dynamic</strong> will use the ruleset and routing configurations that are set up in the dynamic DDR UI. (For information about how to set a specific ruleset in the dynamic DDR UI to run last, refer to the <strong>Rulesets &gt; Properties Tab</strong> section).</td>
</tr>
<tr>
<td></td>
<td>For information about how to define rulesets, refer to the <strong>Enterprise &gt; Rulesets Tab</strong> section.</td>
</tr>
<tr>
<td></td>
<td><strong>Data-Driven ruleset Option/Name (Run First):</strong> This provides the option to select if a dynamic DDR ruleset runs prior to a Legacy ruleset or to select a static DDR ruleset by name that will run prior to the Legacy ruleset. If no ruleset should run prior to Legacy, select <strong>None.</strong> Selecting <strong>Dynamic</strong> will use the ruleset and routing configurations that are set up in the dynamic DDR UI.</td>
</tr>
<tr>
<td></td>
<td><strong>Legacy Ruleset Name:</strong> This provides the option to select the Legacy ruleset that should run next.</td>
</tr>
<tr>
<td></td>
<td><strong>Data-Driven ruleset Option/Name (Run Last):</strong> This provides the option to select either to have a dynamic DDR ruleset run after the Legacy ruleset or to select a static DDR ruleset by name that will run after the Legacy ruleset.</td>
</tr>
<tr>
<td></td>
<td>If no ruleset should run after the Legacy ruleset, select <strong>None.</strong></td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Selecting Dynamic</td>
<td>Selecting Dynamic will use the ruleset and routing configurations that are set up in the dynamic DDR UI. (For information about how to set a specific ruleset in the dynamic DDR UI to run last, refer to the Rulesets &gt; Properties Tab section).</td>
</tr>
<tr>
<td>Medicare/Medicaid Routing Parameters, Other Routing Parameters Carrier</td>
<td>If you analyze claims using LCD (Local Coverage Determination), select the LCD Carrier or other Contractor that should apply to claims entering this route. (For information about LCD contractors, refer to the LCD Overview section.) If you do not use LCD, you can ignore this setting. However, if you do utilize LCD, you must select a carrier. Otherwise the LCD rules will cause claims analysis to fail. NCD (National Coverage Determination) data, when loaded and “In Use,” is automatically used for editing when an LCD carrier is selected in this field.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Use this dropdown menu to select a specific jurisdiction. Jurisdictions are state-specific Medicaid relationships (currently used by data-driven rulesets to select applicable patterns).</td>
</tr>
<tr>
<td>Diagnosis Comparison File</td>
<td>If you want to use this route for claims containing ICD-10 diagnosis codes and the claim history utilizes ICD-9 diagnosis codes, you should define a comparison file for the route. A comparison file helps the system determine which ICD-9 codes correlate to specific ICD-10 codes in this process. Refer to the ICD-10 to ICD-9 Diagnosis Comparison section for details.</td>
</tr>
<tr>
<td>Line of Business</td>
<td>Use this dropdown menu to select a specific line of business. A line of business is a categorization of similar business policies/patterns (i.e., Medicaid, Medicare, Commercial, etc.).</td>
</tr>
<tr>
<td>Procedure Reduction</td>
<td>Select the procedure reduction method that should apply to claims entering this route. For information about procedure reductions, refer to the Reduction Records section.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Use this dropdown menu to select a specific jurisdiction. Jurisdictions are state-specific Medicaid relationships (currently used by data-driven rulesets to select applicable patterns).</td>
</tr>
<tr>
<td>Diagnosis Comparison File</td>
<td>If you want to use this route for claims containing ICD-10 diagnosis codes and the claim history utilizes ICD-9 diagnosis codes, you should define a comparison file for the route. A comparison file helps the system determine which ICD-9 codes correlate to specific ICD-10 codes in this process. Refer to the ICD-10 to ICD-9 Diagnosis Comparison section for details.</td>
</tr>
<tr>
<td>Line of Business</td>
<td>Use this dropdown menu to select a specific line of business. A line of business is a categorization of similar business policies/patterns (i.e., Medicaid, Medicare, Commercial, etc.).</td>
</tr>
<tr>
<td>Procedure Reduction</td>
<td>Select the procedure reduction method that should apply to claims entering this route. For information about procedure reductions, refer to the Reduction Records section.</td>
</tr>
</tbody>
</table>
Field | Description
---|---
Same Provider | Select the desired “Same Provider” configuration. Refer to the [Same Provider Configuration](#) section for details.
Same Provider NPT | Select the desired “Same Provider NPT” configuration. Refer to the [Same Provider Configuration](#) section for details.
Routing Fields, Line Level | In this area, you indicate what the system should look for on the claim to determine whether it should be allowed in this route. For example, if you enter a specific Account ID in the corresponding field, then only claims with that Account ID would be allowed into the route. If you also enter a specific Plan ID, then only claims with a matching Account ID and Plan ID would be allowed into the route.

The individual fields in this area correspond to items on the claim form. For details about what can be contained in these fields, refer to the [Claim Fields](#) section.

**Important!** The Billing Provider State and Billing Provider Zip fields can be used with overpayment detection. Refer to the [Overpayment Detection](#) section for details.

**To edit a claim route:**
1. On the **Claim Routes** screen, select the checkbox next to the route you want to edit.
2. Select the **Edit Route** button. The Edit Route screen then displays, containing the fields described above.
3. Select **Manage Rulesets**.
4. Modify the settings on this screen as desired.
5. When you finish, select **Save Changes**.

**To remove a claim route:**
1. On the Claim Routes screen, select the checkbox next to the route you want to remove (other than the default route, which cannot be removed).
2. Select the **Remove Route** button. The system displays a message telling you the route was removed.

**To move routes up or down on the priority list:**
1. On the Claim Routes screen, select the checkbox next to the route you want to move.
2. Select **Move Up** or **Move Down** until the route reaches the desired position in the list.

**To change a route's priority:**
1. On the Claim Routes screen, select the checkbox next to the route you want to modify.
2. Select the **Enter Priority** button. A box displays asking you to enter the desired priority number.
3. Enter the desired priority number, then select **Save**.

**Reduction Records**

When a claim contains multiple procedures, Claims Edit System checks to determine if the procedures occurred:

a. On the same date of service
b. At the same place of service
c. For the same patient

When all three of these conditions exist, the cost of each procedure is usually much lower than it would be if the procedures were performed separately. Therefore, it is customary to reduce the payment amount on the non-primary procedures when this is the case.

---

**Important!**  There are specific clinical reasons behind the various procedure reductions. To view this rationale, refer to the *Documentation of Edit Rationale*, which ships with the KnowledgeBase.

Procedure Reduction Records allow you to define the amount (percentage) by which these reductions occur. Multiple procedures performed at the same time may be paid at a different percentage of the full base rate for the procedure, ranking the procedures by relative value (default). When procedures are ranked this way, if you have multiple procedures with the same relative value, then the procedures are put in ascending order according to their procedure codes. Claims Edit System allows procedure reductions for the following categories:

- Assistant Surgeon
- Bilateral Procedure
• Co-Surgeon
• Team Surgeon
• MPR (Multiple Procedure Reduction)

To access procedure reduction records:

1. Open the Rules module from the Enterprise entry-level screen.
2. Select Reduction Records.

When you open this module, a screen similar to the following displays:

The screen above shows a record highlighted in a medium gray color, which indicates a system record. You cannot modify or delete system records. However, you can modify and delete user-defined records, which appear highlighted in a lighter color than the gray shown above.

This screen contains the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>A name describing the reduction record.</td>
</tr>
<tr>
<td>Ranking Type</td>
<td>Indicates the method used to rank one procedure above another, i.e., the primary procedure, secondary procedure, etc. The following ranking methods are valid:</td>
</tr>
<tr>
<td></td>
<td>• Relative Value</td>
</tr>
<tr>
<td></td>
<td>• Submitted Charge: High to Low Sort</td>
</tr>
<tr>
<td></td>
<td>• Submitted Charge: Low to High Sort</td>
</tr>
<tr>
<td>Origin</td>
<td>Indicates the enterprise in which the procedure reduction was created. The reduction will be valid in the enterprise listed here, and will be inherited by any children that belong to that enterprise. Refer to the Parental Hierarchy in Enterprises section for more information.</td>
</tr>
<tr>
<td>Asst. Surgeon</td>
<td>Indicates the percentage (of the full base rate) at which assistant surgeon procedures will be paid.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bilateral Procedure</td>
<td>Indicates the percentage (of the full base rate) at which bilateral procedures will be paid.</td>
</tr>
<tr>
<td>Co-Surgeon</td>
<td>Indicates the percentage (of the full base rate) at which co-surgeon procedures will be paid.</td>
</tr>
<tr>
<td>Team Surgeon</td>
<td>Indicates the percentage (of the full base rate) at which team surgeon procedures will be paid.</td>
</tr>
</tbody>
</table>
| MPR (Multiple Procedure Reduction ) | This section established a range at which the system will pay multiple procedures. It contains three fields:  
  - From: This indicates the starting point for the range. For example, if you want to pay procedures 1 through 4 at 50%, you would enter 1 (the procedure you want to start with) in this field.  
  - To: This indicates the ending point for the range. For example, if you want to pay procedures 1 through 4 at 50%, you would enter 4 (the procedure you want to end with) in this field.  
  - Pay At: This indicates the percentage (of the full base rate) at which the range of procedures will be paid. For example, if you want to pay procedures 1 through 4 at 50%, you would enter 50 (the percentage) in this field.  

  This field can contain more than one line, allowing you to set different percentages for different ranges. For example, the following screen shows two sequential ranges. The first range pays procedures 1 through 1 at 100%, the second range pays procedures 2 through 999 at 50%. |

<table>
<thead>
<tr>
<th>from</th>
<th>to</th>
<th>pay at</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>999</td>
<td>50</td>
</tr>
</tbody>
</table>

**Working with Procedure Reductions**

From the Procedure Reduction screen you can add, copy, edit, or remove reduction records.
To add a procedure reduction record:
1. Select the **Add** button. This displays the Add window.
2. Enter the desired information in the fields described above.
3. Select **Save**.

To copy an existing procedure reduction record:
1. Select the checkbox next to the record you want to copy.
2. Select the **Copy** button.
3. Enter a name for the new record in the Name field.
4. Modify the desired information in the remaining fields.
5. Select **Save**.

To edit a procedure reduction record:
1. Select the checkbox next to the record you want to edit.
2. Select the **Edit** button.
3. Modify the desired information in the appropriate fields.
4. Select **Save**.

If you edit a non-system record, Claims Edit System updates the record with your changes. However, if you edited a system record, Claims Edit System creates an override but does not modify the system record.

To remove a procedure reduction record (non-system only):
1. Select the checkbox next to the record you want to remove.
2. Select the **Remove** button.
3. When the system asks you to confirm the action, select **OK**.

**Entering Decimal Values in the Procedure Reduction User Interface**

The Reduction Records interface allows you to enter decimal values for the “Pay At” percentage text field. You can enter values with up to two decimal places; anything more will be rounded off to the nearest value.

For example:
● 98.478 will be saved as 98.48
● 98.474 will be saved as 98.47

**Important!** Entering values with decimals is available to users who have upgraded to Claims Edit System 5.4 Cumulative Update 05+.

## Data-Driven Rules – Panel-based UI

The focus of the panel-based Data-Driven Rules (DDR) UI is to help make the set-up and management of DDR rulesets and routing easier and provide the ability to create custom DDRs.

The set-up of rulesets and routes in the panel-based UI is different from the legacy UI. For this reason, the legacy DDR rulesets and claim routes do not automatically transition to the panel-based UI. The panel-based UI fosters the creation and management of fewer rulesets and claims routes. In addition, it provides the ability to easily recognize and add new DDR rules as they are released.

### Prerequisites

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>A cumulative update (CU03+ for 5.2.1/5.3.1 SP2 or CU02+ for 5.4 SP1) is required to enable the panel-based UI. A KB from February 2016 or newer must also be loaded. Upon loading, any DDR that was used in a custom ruleset in the legacy UI will be marked as an Active Rule in the Dynamic UI (refer to the <a href="#">Enterprise &gt; Active Rules Tab</a> section).</td>
</tr>
</tbody>
</table>

### Changing Your Password

**To change your password:**

1. Select Change Password in the Main Menu. This displays the System Configuration panel, with the Change Password option selected.

2. Enter information in the following fields:

   - **Current Password:** Enter your current password.
   - **New Password:** Enter the new password (following the requirements outlined in the UI; note that passwords are case-sensitive).
   - **Confirm Password:** Enter the new password again, exactly as you entered it in the New Password field.
3. Select **Save** to save the new password.

**Accessing the Data-Driven Rules Panel-based UI**

To access the Data-Driven Rules panel-based UI, select the **Manage Dynamic data-Driven Rulesets** icon from the Rules menu in the top navigation bar of the legacy UI.

**DDR UI Navigation**

**Landing Page**

The following figure shows the landing page, which shows a selected enterprise.

![Landing Page Diagram]

**Enterprise Inheritance**

Inheritance in the panel-based UI follows the existing CES inheritance structure, which includes child enterprises inheriting properties and settings from parent enterprises.

Creating enterprises is still handled in the legacy UI. The enterprises displayed in the panel-based UI are based on what has been created in the panel-based UI. The difference is that for the panel-based UI, the system enterprise is not view-only, allowing users to change settings or data in this enterprise. It is the main parent of all other enterprises in the system. However, we recommend that you not make any changes in this enterprise.

Any property created at a parent enterprise—including new panel-based UI rulesets along with the associated claim routes, route properties and exceptions—is automatically inherited by all of its children, but not by its own parent or siblings. If a user logs into a “leaf” enterprise (one at the end of a branch that has no children), any change they make will only apply within that enterprise.
There is one exception to enterprise inheritance: Changes made to a default flag message affect the rules in all enterprises. To make changes specific to an enterprise or ruleset, use overrides.

Panel-based Navigation

In the panel-based Data-Driven Rules UI, navigation takes place in panels. This allows you to easily track where you are in the interface.

Based on options selected in a panel, additional slide-out panels may appear, if applicable. The following screen shows the Enterprise > Active Rules panel; the selected rule determines which rule panel detail appears. In this example, the Active Rules > Properties panel is displayed.

Note

The image above shows an example only and additional functionality may be added based on release.

Navigation Panel

The Navigation panel is on the far left. It automatically opens and shows System-level settings as well as enterprise tree information and ILOG Rule disabling functionality. If there are many enterprises, you may need to use the scroll bar on this panel to access the entire list of enterprises. This panel also contains any minimized panels (refer to the Minimizing Panels section).

Important!

In a multi-tenant environment, the Navigation panel options differ for system users and tenant users. Refer to the Multi-Tenant Installation section for more details.
SYSTEM

The SYSTEM > Audit Log details can be found in the Audit Log Panel-based UI section.

The SYSTEM > Configuration > About panel displays system-level information.

<table>
<thead>
<tr>
<th>Product</th>
<th>Product being accessed (CES/CM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version</td>
<td>DDR engine build loaded (may be requested by support to help resolve issues)</td>
</tr>
<tr>
<td>System Rules</td>
<td>Total number of system rules in all enterprises (PE and FE)</td>
</tr>
<tr>
<td>Custom Rules</td>
<td>Total number of custom rules in all enterprises (PE and FE)</td>
</tr>
</tbody>
</table>

The SYSTEM > Configuration > Memory tab includes a Memory Management option. The DDR PE LCD Rule makes use of cached LCD data.

To use the DDR PE LCD rule in either Static or Dynamic rulesets Memory management must be enabled; otherwise, an error message is generated, indicating that LCD Cache is disabled.

SYSTEM > Configuration > Claim processing tab: With the ability to run Dynamic Data-Driven Rulesets based on Rulesets and claim routing in the existing UI, the Claims Processing tab no longer displays based on the CU and KB version loaded.

SYSTEM > Ruleset Exceptions > Ruleset Exceptions tab: The Ruleset Exceptions panel displays a list of all exceptions in the system and provides the ability to create a new ruleset exception or copy a ruleset exception that can be shared with any other ruleset, in any enterprise. Additional rulesets can also be added to existing exceptions.

For additional information about Ruleset Exceptions, refer to the Ruleset Exceptions section.
For additional information on the Dynamic DDR routing in the existing UI, refer to the Destination Ruleset(s) section.

SYSTEM > Configuration > User Accounts and User Roles details can be found in the User Management Panel-based UI section.

ENTERPRISES

Based on the selection of an enterprise, the appropriate Enterprise panel will be displayed with enterprise-related tabs: Properties, Rulesets, Active Rules, New/Updated Rules, Deleted Rules, Inactive Rules, All Flags, Rule Categories and Members. Depending on the selections made in this panel, additional panels will open to the right, as appropriate.

ILOG RULES

The ILOG Rules section assists with the transition from ILOG to DDR rules and it includes the option to disable ILOG rules. The user can disable a single or multiple ILOG rules within custom ILOG rulesets. Refer to the Disabling ILOG Rules section for details.

Working with panels

Resizing Panels

A panel can be resized using select-and-drag functionality to make the panel smaller or larger.

Minimizing Panels

To minimize a panel, select the icon in the upper-right corner. That panel will be minimized within the Navigation panel on the left, allowing a larger view of the open panel.

Further panels can be stacked in this way.

Expanding Panels

To expand a minimized panel, select the Inner Panel Maximize icon within the Navigation panel, and that panel will open while making the active panel smaller.

The Inner Panel Maximize icon maximizes other panels.

Active Panel Expansion Icon

This icon allows an active panel (the outermost panel) to be expanded while automatically minimizing any inner panel(s).
The Active Panel Expansion icon allows an active panel (the outermost) to be expanded while automatically minimizing any inner panel(s).

Closing Panels

To close a panel, select the X in the upper-right corner of the panel.

ICP Menu Bar

To go back to the existing non-DDR ICP screens, use the menu bar located at the top of the screen. The applicable dropdown options display and, once selected, will go back to that screen.

Gear Menus

On some panels, a gear menu appears that provides additional dropdown options.

To access the gear menu, hover the cursor over it and a window will appear. Actions available at that time will appear active; grayed-out options are for future functionality.

Enterprise Panel Functionality

Enterprise > Properties Tab

The Enterprise > Properties tab ([Selected Enterprise] > Properties) provides details related to the selected enterprise.

Fields on the Enterprise > Properties tab:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>Enterprise ID created in the product.</td>
</tr>
<tr>
<td>Name</td>
<td>Enterprise name created in the product.</td>
</tr>
<tr>
<td>Routing ID</td>
<td>Routing ID created in the product.</td>
</tr>
<tr>
<td>Parent</td>
<td>Parent enterprise that was created in the product.</td>
</tr>
<tr>
<td>DDR Error Flags</td>
<td>DDRERR flag status of Review.</td>
</tr>
</tbody>
</table>

DDRERR Edit Level information

The System enterprise has the following enterprise property:
• DDRERR Edit Status with value of Review

This enterprise property can be changed in the system enterprises and/or overridden in child enterprises.

When a DDRERR edit is created, it searches the enterprise hierarchy beginning with the claim’s enterprise to find the value for the DDRERR enterprise property. The value found for this property will be applied to the edit’s Error Status.

If the DDRERR occurs before the claim has been assigned to an enterprise, the settings found in the system enterprise will be used.

The DDR Error Flags property is inherited from the parent enterprise and can be overridden using the Override Inherited Configurations button.

| Important! | A user must have the Enterprise admin role or Configure Enterprise privilege to change the DDR Error flags property. |

Modifying the DDR Error Flags property

2. Select the Override Inherited Configuration button.
3. Provide the status, as required.
4. Select Save.

Enterprise > Rulesets Tab

The Enterprise > Rulesets tab ([Selected Enterprise] > Rulesets) shows all rulesets associated with the selected enterprise. This includes rulesets inherited from parent enterprises as well as those created in the enterprise. The enterprise column on this panel shows enterprise in which the ruleset was created. If it is an inherited ruleset, the row is shaded gray.
Refer to the Destination rulesets section for information on how to set up the claim route Data-Driven ruleset Option to use Dynamic DDR rulesets.

Rulesets are displayed in priority order, but the order can be changed by dragging and dropping the rulesets.

Within a child enterprise, ruleset priority changes can only be made to rulesets created in that enterprise. The priority of a ruleset inherited from a parent cannot be changed in a child enterprise and cannot have a higher priority than a child ruleset. To change the ruleset priority of a parent ruleset, it must be accessed and updated in that enterprise.

As you hover over the ruleset number, the cursor displays as a divided two-headed arrow. Select and drag up or down to change the order.

**Note** If the priority does not appear to change right away, this is likely due to a prior ruleset priority change that has not completed saving. Wait a moment and try to prioritize the ruleset again.

**Enterprise > Active Rules Tab**

The Enterprise > Active Rules tab ([Selected Enterprise] > Active Rules) displays all Live or Test rules found in the enterprise. This is enhanced functionality from the existing DDR UI, in which you can only view rules within a specific ruleset.

**Important!** Upon loading a KB the first time, any DDR that was used in a custom ruleset in the existing UI will be marked as an active rule in the panel-based UI.
From the *Active Rules* tab there are filter options listed in the panel with a + (plus) sign. These filters provide the ability to narrow specific rules in the list. Select the filter option to add it to the filter bar at the top of the screen. One or multiple filters can be applied.

The Filter button can be selected when filters are not being used and more space is desired on the active panel. Selecting the button again will expand the filter options.

Depending on the filter selected, filtering hints are available in a dropdown box by selecting in the field, if applicable. After viewing the information, select outside the box to remove the hint.

**Fields on the Enterprise > Active Rules panel:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
<td>Enter a rule ID or multiple IDs separated by commas, a range between two IDs separated by a hyphen (-) or a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Rule name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Rule status</td>
<td>Select a status from Test or Live.</td>
</tr>
<tr>
<td>Rule type</td>
<td>Select System or Custom.</td>
</tr>
<tr>
<td>Category name</td>
<td>Enter a category name, such as “National,” etc.</td>
</tr>
<tr>
<td>Exception type</td>
<td>Select from Always Added, Conditionally Added, Always Suppressed, Conditionally Suppressed.</td>
</tr>
<tr>
<td>Dependency</td>
<td>Select Dependent or Prerequisites.</td>
</tr>
</tbody>
</table>

**By LOB**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line of business</td>
<td>Select from the available list of business options such as Medicare, Medicaid, etc.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select any state, states or state medical jurisdictions. All or none may alternately be selected.</td>
</tr>
</tbody>
</table>

**By flag**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mnemonic</td>
<td>Enter a single or multiple mnemonic(s) separated by commas or use a</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>wildcard</td>
<td>(*) to indicate any character(s).</td>
</tr>
<tr>
<td>Priority</td>
<td>(formerly Error level): Enter a priority separated by commas, a range</td>
</tr>
<tr>
<td></td>
<td>between two levels separated by a hyphen (-), or a wildcard (*) to indicate</td>
</tr>
<tr>
<td>Context</td>
<td>Select a status of Claim Level, Line Level or No Flag.</td>
</tr>
</tbody>
</table>

**Viewing the Medicaid Jurisdictions Fiscal Year**

By default, the fiscal year begins on July 1st for all jurisdictions unless otherwise specified.

**To view Medicaid Jurisdiction Fiscal Year:**

1. Navigate to the Active Rules panel under the appropriate Enterprise in the DDR UI.
2. Select a rule that contains a Fiscal Year frequency or create a new rule with a Fiscal Year Frequency.
3. Select the Expression tab and select the Condition.
4. On the Frequency panel, select Fiscal Year from the dropdown and select the arrow next to Browse Fiscal Data to view Medical Jurisdiction Fiscal Year.

**Enterprise > New/Updated Rules Tab**

The Enterprise > New/Updated Rules tab ([Selected Enterprise] > New/Updated Rules) displays rules delivered in a new KB in a status of New or Updated that require maintenance. This tab helps you easily review these rules to determine if you would like to use them.

A status of New means the rule is new. Updated means the rule is an updated DDR and that an old version is being used in the current system. The old version will continue to be used in the ruleset until the updated version is changed to the same status, thus replacing it.

It is possible to have both a Test and Live version of a rule in the ruleset (refer to the Ruleset Status section). A column called Other Statuses is included on this screen to help you identify if there is an existing version of the rule in a different status to be reviewed.

These New or Updated rules will not automatically be added to your rulesets. Once the status of a New or Updated rule is changed to Test or Live, this rule will be moved into the Active Rules tab.

In the New/Updated Rules panel there are filter options to limit a search. Select the filter option from the list to add it to the filter bar at the top of the screen. One or multiple filters can be applied.
**Fields on the Enterprise > New/Updated Rules panel:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
<td>Enter a rule ID or multiple IDs separated by commas, a range between two IDs separated by a hyphen (-), or a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Rule name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Rule status</td>
<td>Select New or Updated.</td>
</tr>
<tr>
<td>Category name</td>
<td>Enter a category name such as “National.”</td>
</tr>
<tr>
<td>Exception type</td>
<td>Select from Always Added, Conditionally Added, Always Suppressed, Conditionally Suppressed.</td>
</tr>
<tr>
<td>Dependency</td>
<td>Select Dependent or Prerequisites.</td>
</tr>
</tbody>
</table>

**By LOB**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line of business</td>
<td>Select from the available list of business options such as Medicare, Medicaid, etc.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select any state, states, or state medical jurisdictions. All or none may alternately be selected.</td>
</tr>
</tbody>
</table>

**By flag**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mnemonic</td>
<td>Enter a single or multiple mnemonic(s) separated by commas or use a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Priority</td>
<td>(formerly Error level): Enter a priority separated by commas, a range between two levels separated by a hyphen (-) or a wildcard (*) to indicate any character(s) or digit(s).</td>
</tr>
<tr>
<td>Context</td>
<td>Select a status of Claim Level, Line Level or No Flag.</td>
</tr>
</tbody>
</table>
Enterprise > Inactive Rules Tab

The Enterprise > Inactive Rules tab ([Selected Enterprise] > Inactive Rules) displays rules with a status of Ignored or Disabled. Ignored rules are those that you are not using and do not want to see updates on. Disabled rules are those you are not using but may use in the future and on which you want to see updates.

When an updated rule is delivered in the KB but the existing rule has been set to Ignored or Disabled, the rule will still be updated with the logic.

From the Inactive Rules tab, there are filter options. Select those from the list to add them to the filter bar at the top of the screen. One or multiple filters can be applied.

Filter options for the Inactive Rules tab:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
<td>Enter a rule ID or multiple IDs separated by commas, a range between two IDs separated by a hyphen (-), or a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Rule name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Rule status</td>
<td>Select New or Updated.</td>
</tr>
<tr>
<td>Category name</td>
<td>Enter a category name such as “National.”</td>
</tr>
<tr>
<td>Exception type</td>
<td>Select from Always Added, Conditionally Added, Always Suppressed, Conditionally Suppressed.</td>
</tr>
<tr>
<td>Dependency</td>
<td>Select Dependent or Prerequisites.</td>
</tr>
</tbody>
</table>

By LOB

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line of business</td>
<td>Select from the available list of business options such as Medicare, Medicaid, etc.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select any state, states, or state medical jurisdictions. All or none may alternately be selected.</td>
</tr>
</tbody>
</table>

By flag
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mnemonic</td>
<td>Enter a single or multiple mnemonic(s) separated by commas or use a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Priority</td>
<td><em>(formerly Error level): Enter a priority separated by commas, a range between two levels separated by a hyphen (-), or a wildcard (</em>) to indicate any character(s) or digit(s).*</td>
</tr>
<tr>
<td>Context</td>
<td>Select a status of Claim Level, Line Level or No Flag.</td>
</tr>
</tbody>
</table>

**Enterprise > All Flags Tab**

The **Enterprise > All Flags** tab (**Selected Enterprise** > **All Flags**) displays all flags related to rules within the selected enterprise. This is enhanced functionality from the existing user interface. It only allows viewing flags within a specific ruleset.

As with the previous **Rules** tabs, filter options will help limit a flag search. Select the filter option from the list to add it to the filter bar. One or multiple filters can be applied.

**Filter options for All Flags:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flag mnemonic</td>
<td>Enter a single or multiple mnemonic(s) separated by commas or use a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Flag status</td>
<td>Select from the dropdown list: Off, Deny, Profile, Review, All or None.</td>
</tr>
<tr>
<td>Flag priority</td>
<td>Enter a priority separated by commas, a range between two levels separated by a hyphen (-), or a wildcard (*) to indicate any character(s) or digit(s). <em>Note: Previously referred to as Error level.</em></td>
</tr>
<tr>
<td>Flag type</td>
<td>Option to choose to filter by just system flags, by overridden system flags, or overridden custom flags.</td>
</tr>
<tr>
<td>Flag LOB</td>
<td>Option to choose to filter by Line of Business.</td>
</tr>
<tr>
<td>Flag context</td>
<td>Select a status of Claim Level or Line Level. This provides the ability to override a flag message and also to insert additional flag parameters such as procedure codes, history claim IDs, line IDs, etc.</td>
</tr>
<tr>
<td>Rule ID</td>
<td>Enter a rule ID or multiple IDs separated by commas, a range between two IDs separated by a hyphen (-), or a wildcard (*) to indic-</td>
</tr>
</tbody>
</table>
### Field | Description
--- | ---
| | ate any character(s).
| Rule name | Enter a rule name or any portion of the name.
| Rule status | This displays status choices related to the associated rule, such as New, Updated, Test, Live, etc.
| Line of business | Select from the available list of business options such as Medicare, Medicaid, etc.
| Jurisdiction | Select any state, states or state medical jurisdictions. All or none may alternately be selected.

**Enterprise > Deleted Rules Tab**

The Enterprise > Deleted Rules tab ([Selected Enterprise] > Deleted Rules) displays the rules that should not be used, based on clinical recommendations, which have been removed from the KB.

When a KB has deleted rules currently in a Test or Live status in your system, the rules will be removed from that ruleset and placed in the Deleted Rules tab for review. The Deleted Rules tab will only display if deleted rules are in the KB. You should review these rules and either confirm the delete recommendation (thus removing the rules from the system) or use the rule against clinical recommendations and change the status back to Live or Test. In that case, each time a new KB is loaded, any deleted rule(s) will be returned to the Deleted Rules tab for review.

![Enterprise Professional Main](image-url)
Important! The image above shows sample deleted rules only. The Deleted Rules tab will only display in the list if deleted rules exist in the KB.

From the Deleted Rules tab there are filter options. Select those from the list to add them to the filter bar at the top of the screen. One or multiple filters can be applied.

<table>
<thead>
<tr>
<th>Filter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
<td>Enter a rule ID or multiple IDs separated by commas, a range between two IDs separated by a hyphen (-), or a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Rule name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Rule type</td>
<td>Enter System or Custom.</td>
</tr>
<tr>
<td>Category name</td>
<td>Enter a category name such as “National.”</td>
</tr>
<tr>
<td>Line of business</td>
<td>Select from the available list of business options such as Medicare, Medicaid, etc.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select any state, states, or state medical jurisdictions. All or none may alternately be selected.</td>
</tr>
</tbody>
</table>

*By flag*

<table>
<thead>
<tr>
<th>Filter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mnemonic</td>
<td>Enter a single or multiple mnemonic(s) separated by commas or use a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Priority</td>
<td><em>(formerly Error level): Enter a priority separated by commas, a range between two levels separated by a hyphen (-), or a wildcard (</em>) to indicate any character(s) or digit(s).*</td>
</tr>
</tbody>
</table>

From the Deleted Rules > Properties tab, the status will be reflected as Deleted (from Test) or Deleted (from Live). To confirm, select Confirm Delete. To change the status to Test or Live (against clinical recommendations), select the appropriate option from the Status dropdown.

Once the status has been manually changed to Test or Live, it cannot be reverted to Deleted (from Test) or Deleted (from Live). As mentioned previously, in the case where the deleted rule is changed to Live or Test, each time a new KB is loaded any of these deleted rules will be returned to the Deleted Rules tab for review.
If a rule status has been manually updated but does not appear to display on the correct tab, refresh the screen by pressing F5.

Enterprise > Rule Categories Tab

Categories allow further defining and filtering of rules. You can use the system categories delivered for existing Data-Driven Rules or you can create your own.

System categories are identified by a small circled “S” at the end.

User-created categories have a pencil icon next to them.

To create a user-defined category:

1. Select New category. A new panel opens
2. Name the category and select Save. Once saved, it will be available in the Category dropdown of a copied or custom DDR.

System categories assigned to system rules cannot be removed. However, you can add a system category to a copied or custom Data-Driven Rule. You also can add a custom category to a system Data-Driven Rule.

Flags Panel Functionality

The Flags panel is displayed once a flag is selected from either the Enterprise > All Flags tab or the Ruleset Flags tab.

All Flags > Status, Priority and Message

The All Flags > Status, Priority and Message tab shows the default flag information for a system rule and provides the ability to override any system rule flag options. Default flag information appears at the top of the page if no override has been applied.
Flag Overrides

A system rule’s flag status, priority and/or message can be overridden at the enterprise level.

Select Add enterprise override. A new box appears that allows overrides to the flag status, priority and/or flag message. When selecting an override, applicable options will display.

**Important!** If the Add enterprise override option is not enabled, confirm that the rule is an active rule (Live/Test). Flag overrides are only allowed with active rules.

Filter options for Add enterprise override.

- **Add Status Override**
  A dropdown box for the status will appear, allowing you to choose the appropriate selection: Off, Deny, Profile or Review.

- **Add Priority Override**
  Provides a text box allowing you to enter the appropriate numbers (previously...
**Error Level). This will determine the priority that the flag/rule will run.**

**Add Message Override**

Provides an editable copy of the default message, where text can be added, edited, or deleted. Any existing parameter (value pulled into the message) can be inserted into a different part of or removed from the message.

To edit text in a message, place the cursor inside and make the desired changes. Select **Save**. In this example, the text “Please review for accuracy” has been inserted.

To insert an existing parameter elsewhere in the message, place the cursor at the insertion point.

Select the **Insert a parameter** dropdown and choose the correct option.

The parameter is added to the message.

To remove an override, hover to the left of the override box until a red X appears. Select it to remove the entire enterprise override.

**Flag Override(s) assigned to multiple enterprises**

The option is available to override a flag and apply it to other enterprises besides the one in which you have completed the override. To do this, select the slide-out drawer next to the Enterprise name.
A new panel will display to the right that shows all the available enterprises that this override could be assigned to. Place a check next to the enterprise(s) that should receive the override and select the **Save** button.

You can also choose multiple flags to have an override. Select the slide-out drawer next to the Enterprises field; the same panel will open to the right, allowing you to choose the enterprises to assign these flag overrides to.
The flag symbol next to an enterprise indicates that an enterprise contains an override for one or more of the selected flags. By saving a new override to one of these enterprises, the previously existing override value will be changed.

All Flags > Source

The All Flags > Source tab shows the Source and Source info related to this flag. An enterprise-level flag source on a system rule cannot be overridden.

Fields on the All Flags > Source panel:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>The entity providing information regarding this flag edit.</td>
</tr>
<tr>
<td>Source info</td>
<td>Information provided by the source entity.</td>
</tr>
</tbody>
</table>

All Flags > Disclosure

The All Flags > Disclosure tab shows the edit rationale related to this flag. A flag disclosure on a system rule cannot be overridden at an enterprise level.

Disabling ILOG rules

To assist with the transition from ILOG to DDR rules, a Disable ILOG rules option appears on the navigation panel below the Enterprises section. The Disable ILOG rules tab allows the user to disable a single or multiple ILOG rules within custom ILOG rulesets.
Note that both Facility and Professional rules can be accessed regardless of the enterprise selected for accessing the Dynamic DDR module.

**Important!** Claim processing must be stopped prior to disabling ILOG rules. Once a rule is disabled, it can only be enabled within each individual ruleset. Only users with the *Manage rules and rulesets* privilege can disable ILOG rules.

**Prerequisites**

<table>
<thead>
<tr>
<th>KnowledgeBase</th>
<th>Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES_KB_2018_Q3A_5.0-5.4</td>
<td>Manage rules and rulesets</td>
</tr>
</tbody>
</table>

**Important!** A rules install must be performed after every CU install. If a rules install is not completed, the Save button will not display for the Disable ILOG Rules option.

**Accessing Disable ILOG Rules**

*Disable ILOG rules* can be accessed by navigating to the *panel-based UI navigation panel > ILOG RULES* section.

**Filtering and searching Disable ILOG Rules**

The Disable ILOG rules UI has the following search criteria to filter the rules:

<table>
<thead>
<tr>
<th>Search Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Status</td>
<td>Enabled, Disabled, Mixed, All or None.</td>
</tr>
<tr>
<td>Rule type</td>
<td>System, Custom, All or None.</td>
</tr>
<tr>
<td>Claim type</td>
<td>Professional, Facility, All or None.</td>
</tr>
<tr>
<td>Ruleset</td>
<td>The ruleset(s) the rule is used in.</td>
</tr>
</tbody>
</table>

*Rule type* is not available in a multi-tenant installation.
Disabling a single ILOG rule in multiple rulesets

To disable an ILOG rule in multiple rulesets:

1. Navigate to the Disable ILOG Rules option.
2. Select the ILOG rule that needs to be disabled. The Rulesets tab displays with the enterprises to which the user has access and includes the rulesets that contain the selected rule.
3. Select the rulesets in which the ILOG rule needs to be disabled, or select Disable All to select all of the rulesets. If the ruleset has a checkbox selected, this indicates the rule is already disabled in that ruleset.
4. Select the Save button.

| Note | It may take some time for the rules to be disabled, depending on the number of rulesets. It is recommended not to make any changes to rulesets in the system from this screen or from other screens until the current process of updating the rulesets has been completed. |

Disabling multiple ILOG rules in multiple rulesets

The ability to select multiple rules and disable them at the same time across different rulesets is available. To select multiple rules, hold SHIFT or CTRL and then select the rules.

When selecting multiple rules, rulesets containing the selected rules will be displayed. For information about the selected rules that are tied to each ruleset, expand the Used By: section. Select the checkbox to disable the selected rules in that ruleset.

Viewing the progress of disabling and updating rulesets

When rules are being disabled across rulesets, the “Estimated update time” to complete the process will display in the UI. The current progress can be viewed even after navigating to other screens and returning to this screen.

| Note | The disabling of rules will be captured as an Audit Log entry. |

Rulesets Panel Functionality

The Rulesets tab ([Selected Enterprise] > Rulesets) provides the ability to manage rulesets within an enterprise. As in the existing static user interface, rulesets consist of rules grouped together to be run against claims as a group. The difference is that in the panel-based user interface, rulesets are dynamic, meaning
they can be auto-generated based on specific claim type and line of business attributes that are assigned to each rule (refer to the Rulesets > Properties Tab section).

![Ruleset Management Panel](image)

### Priority of Rulesets

The priority of a ruleset will determine which ruleset is evaluated first for a claim. Rulesets are displayed in priority order, and the order can be changed by dragging and dropping the rulesets.

Within a child enterprise, ruleset priority changes can only be made to rulesets created in that enterprise. A ruleset inherited from a parent cannot be changed in a child enterprise and cannot have a higher priority than a child ruleset. To change the ruleset priority of parent rulesets, the parent enterprise ruleset must be accessed and the priority updated in that enterprise.

As you hover the cursor over the ruleset number, the cursor displays as a divided two-headed arrow. Select and drag up or down to change the order.

### Adding a Ruleset

A new ruleset can be created by selecting Add a Ruleset. The Rulesets > Properties tab will appear, allowing the ruleset to be created. A key feature of ruleset management in the panel-based UI is the ability to auto-create a ruleset based on assigning attributes to that ruleset; this is covered in the Rulesets > Properties Tab section.

---

**Important!** Before a ruleset can be saved, claim routing must be created. Once created, the Save button will be enabled (refer to the Rulesets > Claim Routing Tab section).

### Copying a Ruleset

A copy of a ruleset can be created by highlighting the ruleset and selecting Copy Ruleset. The Rulesets > Properties tab will appear, allowing the ruleset to be edited. The name will display as “Copy of <Ruleset
Name>“ and can be edited to display a new name. The remaining functionality is the same as in the Adding a Ruleset section.

Deleting a Ruleset

To delete a ruleset, select the Delete button located on the bottom left of the Rulesets panel. Respond with Delete or Cancel.

Note If the ruleset does not immediately show as deleted, refresh the screen by pressing F5.

Rulesets > Properties Tab

The Rulesets > Properties tab ([Selected Enterprise] > Rulesets > Properties) displays details specific to this ruleset, including the ID, Name, Processing Order, Environment, Enterprise where it was created, and Default Rules.

List of fields on the Rulesets > Properties panel:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID</td>
<td>Auto-generated ruleset ID.</td>
</tr>
<tr>
<td>Name</td>
<td>Displays the name given to the ruleset.</td>
</tr>
<tr>
<td>Processing Order</td>
<td>Normal: Normal (default setting) means running DDR rulesets and then Legacy rulesets.</td>
</tr>
<tr>
<td></td>
<td>Post-processing ruleset: Provides an option to specify if any post-processing is required for the ruleset, meaning it would run last.</td>
</tr>
<tr>
<td></td>
<td>Important: If there is a need to have a ruleset process after all other</td>
</tr>
</tbody>
</table>
rulesets, it is a two-part configuration. In the Legacy Claim Routing screen, the Data-Driven ruleset Option/Name (Run Last) setting should be set to Dynamic and in the panel-based UI this ruleset should be set to Post-processing. The 2018 Q1A or newer KB must be loaded to enable this functionality.

Environment
Status of Test, Live, or Disabled, which helps determine when rules are run against claims (refer to the Ruleset Environment section).

Enterprise
Displays the enterprise in which the ruleset was created.

Default Rules
Shows a list of rule attribute groups and the number of rules assigned. Provides options to define what rules are automatically used to create the ruleset dynamically (refer to the Default Rules section).

Notes
Enter ruleset-level notes.

Ruleset Environment
A ruleset environment helps determine if or when the ruleset’s rules are run against claims. The following table explains how the ruleset will process rules based on the type of claim analysis performed.

<table>
<thead>
<tr>
<th>If claim analysis type is</th>
<th>And ruleset environment is</th>
<th>What rule environment will process?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Analyze</td>
<td>Test</td>
<td>Test and Live</td>
<td>If there is a test and live version of a rule, only the test version will run; otherwise, the live version will run.</td>
</tr>
<tr>
<td>Test Analyze</td>
<td>Live</td>
<td>Test and Live</td>
<td>If there is a test and live version of a rule, only the test version will run; otherwise, the live version will run.</td>
</tr>
<tr>
<td>Test Analyze</td>
<td>Disabled</td>
<td>N/A</td>
<td>Claims will not process against disabled rulesets.</td>
</tr>
<tr>
<td>Live Analyze</td>
<td>Test</td>
<td>N/A</td>
<td>Live claims analysis will not route to a test ruleset.</td>
</tr>
<tr>
<td>Live Analyze</td>
<td>Live</td>
<td>Live</td>
<td>Only live rules will process with a live claim analysis.</td>
</tr>
</tbody>
</table>
### Default Rules

There is a concept change in the panel-based UI for default rules. Rules have been assigned attributes such as **Claim type**, **LOB**, and/or **Jurisdiction**. When a ruleset is created, a default rule attribute group is chosen. This attribute group defines what rules are automatically used to create the ruleset dynamically. The number of rules listed after a default rule group depends on the license installed and includes rules in a status of **Live**, **Test**, or **Disabled**.

**Note**

For testing or troubleshooting purposes, a test ruleset can be created with no default rules by selecting “None (empty by default).” Rules can be manually added to the ruleset via the exceptions process (refer to the Rulesets > Exceptions Tab section.

### Rulesets > Claim Routing Tab

On the Rulesets > Claim Routing tab ([Selected Enterprise] > Rulesets > Claim Routing), a ruleset is automatically generated based on the Default Rules attribute group selected, and the claim route is now a sub-component of that ruleset.

When a claim reaches an enterprise, it is routed to the appropriate ruleset based on a routing expression assigned to the ruleset. Using a mini rule editor, an expression is created to define where the ruleset is routed.

### Adding a Claim Route

**To add a claim route:**

1. Select the **Claim Routing** tab, which provides options for a conditional (If-Then) or unconditional statement (Always).

2. If the ruleset should only run with certain conditions met on the claim, then from the **Condition type** dropdown select **If-Then**. If this ruleset should always run, select **Always**.
Adding an If-Then Condition Type

To add an If-Then Condition type:

1. With a condition type of **If-Then** selected, to define the *If “New Statement”* section, a panel asking “What type of statement do you want?” will be displayed. Select **+ a claim field**.

2. From the prompt “What claim field do you want to add to this statement?” a list of Common Claim Level and Line Level field groupings used for routing will be displayed.

3. Type a key word in the search box or select a field from the list. An **All Fields** option is also listed that includes all possible fields that can be selected.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
</table>
| In the legacy UI, you can only route based on AND parameters; however, in the panel-based UI, you can route based on both **AND** and **OR** routing options. This can help reduce the number of claim routes that need to be created.  
**AND routing**: If Place of Service is 11 and Provider ID is 64, then route to this ruleset.  
**OR routing**: If Procedure Code is 99211 and Provider ID is 10, plus **OR** Procedure Code is 99024 and Provider ID is 11, then route to this ruleset. |

Example Claim Route

This section shows how to create a claim route scenario. If the Procedure Code is 99211 and the Provider ID is 64, then route to this ruleset.

1. With a Condition type of **If-Then** selected, a panel asking “What type of statement do you want?” will be displayed. Select **+ a claim field**.

   Refer to the [Calculated Value Statements](#) section for more information on the statement options.

2. Choose the claim’s line-level Adjusted Procedure Code by typing a portion of the option in the search box (such as Adjusted) and then clicking on the correct option.

3. Choose **= equal to** from the list of operators.

   Refer to the [Operators](#) section for more information on the statement options.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
</table>
| If adding a list of values or a system list to the expression, select **+ included in.**  
In the next panel select **+ a list of values** where you can add a list of comma-separated values in the statement or choose the **+ a system list** option to see a list of system lists. |
4. Define “…What type of field or value do you want to add to this statement?” by selecting a particular value and enter 99211 in the provided field.

5. The first part of the If statement is complete. Click the New icon from the bottom of the panel to add another condition statement.

6. Boxes will appear showing where a new statement can be inserted. Click the box following the adjusted procedure code previously entered.

7. Select + a claim field and choose + Billing Provider ID.

8. Select = equal to.

9. Select + a particular value. Enter “64” and click Save.

10. When the second condition was added, note that the If statement changed to “all of the following” with a bulleted list. This indicates an AND condition was defined, so all of the bulleted statements must apply in this scenario.

The claim routing for this scenario is complete.

If you wanted the expression to handle an option other than “all of the following”:

Select all of the following and a drop-down box will display with following selection choices-

- both of the conditions is an AND statement: used in above scenario
- either condition is an OR statement: if the claim’s procedure code is equal to 99211 or the Provider ID is equal to 64, then use this ruleset.
• **neither condition** if the claim’s procedure code is not equal to 99211 and the Provider ID is not equal to 64, then use this ruleset.

• **not all conditions** if the claim’s procedure code is either not equal to 99211 or the Provider ID is not equal to 64, then use this ruleset.

| Note | When adding dates in claim routing or route properties, the date format for BDOS/EDOS is MM/DD/YYYY (e.g., November 12, 2019, would be entered as 11/12/2019). When using the “is in” parameter, multiple values need to be comma separated. |

**Rulesets > Route Properties Tab**

*Rulesets > Route Properties ([Selected Enterprise] > Rulesets > Route Properties) enables customizing properties related to the route, such as setting an **LCD carrier,** **Same Provider,** or **Diagnosis Comparison** file. This is also where the **Act on Dropped Lines** functionality can be set for the ruleset. The condition expression is created using the mini-rule editor.*

**Add a Route Property**

**To add a route property:**

Select **Add a Property.** A new panel will appear where you can add a **Condition Expression** using the mini-rule editor to designate a conditional (If-Then) or unconditional statement (Always).

**Condition Expression**

A condition expression is created using the mini-rule editor. The difference is that **Route Property** options are presented for the selection, such as **Set LCD carrier,** **Set jurisdiction,** **Same provider,** etc.

**Example Route Property**

If the claim’s Plan ID is equal to 123, then set the LCD carrier to 09101.

1. With a Condition type of If-Then selected, a panel asking “What type of statement do you want?” will be displayed. Select **+ a claim field.**

2. Select **Plan ID.**

3. Select **= equal to.**

4. Select **+ a particular value** and enter "123" in the provided field.
5. In the *Then* statement choose *+ Set LCD and NCD carrier*. In the Action panel that is opened, choose the LCD and NCD carrier that are to be used for this route. The choice list for these fields will include the LCD and NCD carriers that have been loaded on your system.

6. When finished, select the **Save** button. The property description in the Route Properties tab will then be updated.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>When creating a new route property using the <em>+ Set LCD and NCD carrier</em> option, “— select —” is initially displayed as the choice for both the LCD and NCD carrier. At least one of these must be changed to a valid carrier for the <strong>Save</strong> button to be enabled.</td>
</tr>
</tbody>
</table>

## Copying a Route Property

### Prerequisite

- 2019 Q4A KnowledgeBase

A copy of a route property within the same ruleset can be created by highlighting the route property and selecting **Copy Property**. A new panel will appear where you can edit a Condition Expression using the rule editor to designate a conditional (If-Then) or unconditional statement (Always).

## Deleting a Route Property

### To delete a route property:

1. Select the property. The *Route Properties > Condition Expression* panel will appear.
2. Select **Delete**.

## Route Property Descriptions

### Note

The *Same Provider for a rule, rule category and ruleset route property* options were added in the 2019 Q4A KnowledgeBase. This functionality allows users to specify different Same Provider configurations based on the rule, category or ruleset within a given ruleset.

<table>
<thead>
<tr>
<th>Property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set LCD and NCD Carrier</td>
<td>Define an LCD and NCD carrier for routing. The available carriers are based on current LCD/NCD data loaded into the system.</td>
</tr>
<tr>
<td><strong>Set Jurisdiction</strong></td>
<td>Define a Medicaid jurisdiction to be used for routing. Jurisdictions that display are based on your current Medicaid license key.</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Same Provider for a ruleset</strong></td>
<td>Determines the Same Provider configuration for the ruleset you should use during editing.</td>
</tr>
<tr>
<td><strong>Same provider for a rule category</strong></td>
<td>Determines the Same Provider configuration for a rule category you should use during editing.</td>
</tr>
<tr>
<td><strong>Same provider for a rule</strong></td>
<td>Determines the Same Provider configuration for a rule you should use during editing.</td>
</tr>
<tr>
<td><strong>Same Provider, new patient</strong></td>
<td>Determines which same provider configuration should be used for NPT and EST editing.</td>
</tr>
<tr>
<td><strong>Diagnosis Comparison</strong></td>
<td>Defines which diagnosis comparison file to use.</td>
</tr>
<tr>
<td><strong>Dropped Lines</strong></td>
<td>Determines whether a rule should act on dropped lines.</td>
</tr>
<tr>
<td><strong>LCD Implementation Date</strong></td>
<td>Determines whether the LCD rule should use the implementation date instead of the effective date.</td>
</tr>
<tr>
<td><strong>Procedure Reduction</strong></td>
<td>This is future functionality, when reduction capabilities are included.</td>
</tr>
</tbody>
</table>

**Note**

Same Provider hierarchy:

The order of precedence follows this pattern: **Same Provider for a rule** – **Same Provider for a rule category** - **Same Provider for a ruleset**.

When a rule is removed from a ruleset that was added via an exception that is also used in the ruleset route property action “Same Provider for a rule,” then the rule will be removed from the route property.

**Note**

When entering dates in claim routing or route properties, the format for BDOS/EDOS is MM/DD/YYYY.

When using the “is in” parameter, multiple values need to be comma separated.
Rulesets > Exceptions Tab

*Exceptions ([Selected Enterprise] > Rulesets > Exceptions) provides the ability to add or suppress one or more rules in an auto-created ruleset.*

**Add a New Exception**: Add a rule or group of rules to an existing ruleset either unconditionally (always) or conditionally (under specific definable conditions).

**Suppress Exception**: Suppress a rule or group of rules from an existing ruleset unconditionally or conditionally.

Rules that are added to or suppressed from a ruleset will display with an indicator on the *Rules* panel to show that they are not part of the original ruleset.

From the *Exceptions* tab there are two options:

**Option 1**: Use the default *Add/Suppress Rules* (unconditional) selection. This enables easy adding or suppressing of rule(s) unconditionally so that they will always be added and/or suppressed when this ruleset is used. This is a quick method that precludes the necessity to name the exception, as you would in Option 2.

**Note**: The default Add/Suppress Rules (unconditional) selection on a new ruleset is no longer created as of the 2018 Q4A KB.

**Option 2**: Use *Add a New Exception* and name it. This allows you to create an exception conditionally. You can apply conditions to this rule exception, such as when a Provider ID is equal to 99 on the claim. With this option the exception can be named to easily identify it.

**Note**: Rules added by exceptions run before rules suppressed by exceptions run so that all exceptions process in order.

Rulesets > Exceptions > Properties

This selection ([Selected Enterprise] > Rulesets > Exceptions > [Selected Exception] > Properties) shows the properties related to the exception.

List of fields on the Exceptions > Properties panel.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>If using a conditional exception, enter an exception name to be displayed here.</td>
</tr>
</tbody>
</table>
### Field Description

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabled</td>
<td>Ability to enable or disable an exception. <strong>Default</strong>.</td>
</tr>
<tr>
<td>Enterprise</td>
<td>The enterprise where the exception was created.</td>
</tr>
<tr>
<td>Claim type</td>
<td>Professional or Facility. Defaults based on the Professional or Facility Module it was created in.</td>
</tr>
<tr>
<td>Notes</td>
<td>Enter ruleset exception notes.</td>
</tr>
</tbody>
</table>

### Rulesets > Exceptions > Condition Expression Tab

The *Condition Expression* tab provides the ability to create an expression via the rule editor to define the unconditional or conditional criteria for a rule to be added or suppressed from this ruleset. There are multiple options for actions to add or suppress a rule displayed below.

![Condition Expression Tab](image)

### Example Exception

The scenario: In a Commercial ruleset, if the Billing Provider ID is 6570, add rule 27 and suppress rule 20065 from this ruleset.

1. Select **Add a New Exception** and give a new name to the Exception.
2. On the Condition Expression tab, with the condition type of “If-Then” selected. A panel asking “What type of statement do you want” will be displayed. Select + a **claim field**.
3. A panel asking “What claim field do you want to add to this statement?” will be displayed. Select Billing Provider ID.
4. Select *equal to* from the list of operators.
5. Select + a particular value and enter “6570.”
6. In the Then statement, select New Action and select + Add Rule.
8. The Action panel will show that rule 27 has been added to the ruleset and flag details and default LOB are described.
9. The Show rule expression button allows the option to view rule logic for the rule that was just added.
10. Select the New icon to add another action and click in the box following where you added rule 27.
11. Select + Suppress Rule and choose “Rule 20065” from the rules provided. Only rules available in the ruleset will be displayed.
12. Select the Save button.

The exception for this ruleset has successfully been added.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple rules can be selected, but only one is used in this example. Also note that if a rule has both Test and Live versions, they will both appear in the list of rules to choose from. Be sure to select the right one (based on what is shown in the Status column).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>As of the 2019 Q3A KnowledgeBase, a capability has been added with regard to rules that have multiple flags that are specific to different lines of business. It is possible to specify which flag should be used for rules added by exception.</td>
</tr>
</tbody>
</table>

**Example Exception Using the NPT Table**

**Scenario:** If the Provider ID on the current line matches the Provider ID for an entry in the NPT table, then suppress rule ID 1234, EST flag, from this ruleset.

1. From the Exceptions tab in your ruleset, select Add a New Exception.
2. Name your exception and select the Condition Expression tab.
3. Select + whether any history claim or claim line matches certain condition.
4. The statement shows options for creating a history group. Keep the options for any history line of the same claim type from any provider meets all conditions in this group.
   - The selections for same provider are based on the fields selected in the Same Provider Configuration screen.
<table>
<thead>
<tr>
<th>the same provider</th>
<th>Uses the <em>same provider</em> configuration settings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a different provider</td>
<td>Uses the <em>same provider</em> configuration settings.</td>
</tr>
<tr>
<td>same provider NPT</td>
<td>Uses the <em>same provider NPT</em> configuration settings.</td>
</tr>
<tr>
<td>any provider</td>
<td>Uses the <em>same provider NPT</em> configuration settings.</td>
</tr>
<tr>
<td>include NPT history checkbox</td>
<td>A checked box will include the NPT history table data.</td>
</tr>
</tbody>
</table>

5. In the scenario for this exception, we want to look at any provider in the NPT table. Check the **Include NPT history** box. The exception will now use data stored in the NPT history table.

6. Select **New** icon and click on the box directly below the "any history line" statement just added. Select **+ a claim field**.

7. Choose **Billing Provider ID**. The statement will automatically default to “the history claim line’s” billing provider ID.

8. Choose **= is equal to**.

9. Select **+ A value from another claim field**.

10. Choose **Billing Provider ID**. The statement will automatically default to “the current claim line’s” billing provider ID.

11. Under the Then statement, click on **New Action**, and select **+Suppress Rule**.

12. Click on the arrow next to “Choose a rule...” and choose Rule ID “1234”.

13. Save the exception.

The exception is complete. If any Provider ID in the NPT table matches the current claim Provider ID, the EST flag will be suppressed.

**Shared Exceptions**

Exceptions can be shared across multiple rulesets and enterprises. This functionality alleviates the need to create the same exception within each ruleset and enterprise where it is used.

**Prerequisites**

- 2018 Q4A KnowledgeBase or newer
SYSTEM > Ruleset Exceptions Tab

The Ruleset Exceptions panel in the SYSTEM navigation menu displays a list of all exceptions in the system and provides functionality to create a new ruleset exception or copy a ruleset exception that can be shared with any other ruleset, in any enterprise. Additional rulesets can also be added to existing exceptions.

Filter options for Ruleset Exceptions

Select the filter option from the list to add it to the filter bar. One or multiple filters can be applied.

<table>
<thead>
<tr>
<th>Filter option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Enter an exception name or any portion of the name</td>
</tr>
<tr>
<td>Claim type</td>
<td>Select from the dropdown list:</td>
</tr>
<tr>
<td></td>
<td>• Professional</td>
</tr>
<tr>
<td></td>
<td>• Facility</td>
</tr>
<tr>
<td></td>
<td>• All</td>
</tr>
<tr>
<td></td>
<td>• None</td>
</tr>
<tr>
<td>Used in</td>
<td>Select from dropdown list:</td>
</tr>
<tr>
<td></td>
<td>• Multiple Rulesets: Displays the list of exceptions used in multiple rulesets</td>
</tr>
<tr>
<td></td>
<td>• Single Ruleset: Displays the list of exceptions used in single ruleset</td>
</tr>
<tr>
<td></td>
<td>• Not used: Displays the list of exceptions which are not used in any of the rulesets</td>
</tr>
<tr>
<td></td>
<td>• All</td>
</tr>
<tr>
<td></td>
<td>• None</td>
</tr>
</tbody>
</table>

SYSTEM > Ruleset Exceptions functionality

Add a New Exception: Add a rule or group of rules to an exception either unconditionally (always) or conditionally (under specific definable conditions).

SYSTEM > Ruleset Exceptions > Properties

This selection shows the properties related to the exception.
List of fields on the Ruleset Exceptions > Properties panel:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Enter an exception name to be displayed here.</td>
</tr>
<tr>
<td>Claim type</td>
<td>Select a type (Professional or Facility).</td>
</tr>
<tr>
<td></td>
<td><strong>Important!</strong> The claim type, once selected, cannot be changed for the exception. The list of rules available to add or suppress for an exception depends on the claim type selected.</td>
</tr>
<tr>
<td>Notes</td>
<td>Enter system-level ruleset exception notes. These notes will also display as view-only within the rulesets where this exception has been shared.</td>
</tr>
</tbody>
</table>

SYSTEM > Ruleset Exceptions > Condition Expression

The Condition Expression tab provides functionality to create an expression to define the unconditional or conditional criteria for a rule to be added or suppressed from this ruleset. There are multiple options for actions to add or suppress a rule.

SYSTEM > Ruleset Exceptions > In Rulesets

The In Rulesets tab provides the ability to select multiple enterprises and rulesets in which the exception applies.

**Important!** The Manage Custom DDR privilege is required to share an exception to multiple enterprises and rulesets from SYSTEM > Ruleset Exceptions.

SYSTEM > Ruleset Exceptions > Delete Exception

The Delete Exception button provides the ability to delete an exception that is shared among multiple rulesets. A confirmation message displays with the details of rulesets and enterprises where this exception is being shared.
The Delete Exception button will be enabled only if the user has access to all enterprises where this exception is used.

Example: Create an exception and share it with multiple rulesets across enterprises.

The scenario: Create a Shared Exception with all National Medicaid category rules and share it with multiple rulesets across enterprises.

1. From the System > Ruleset Exceptions tab, select Add a New Exception.
2. Provide the name of an exception in the Properties tab and select Professional.
3. On the Condition Expression tab, select the Condition type Always.
5. Select + Add rules from category.
7. Select the Save button.

Rules with the National Medicaid category will be added to the ruleset wherever this exception is shared.

8. Navigate to the In Rulesets tab and choose Select one or more enterprises.
9. Select the appropriate enterprises. Once the enterprises are selected, the rulesets are displayed under the enterprise.
10. Select the rulesets where this exception applies.

Selecting parent enterprise rulesets will automatically select child enterprise inherited rulesets.

11. Select the Save button to share the exception to multiple rulesets across enterprises.

Copy Exceptions

Exceptions can be copied across multiple rulesets and enterprises and can be modified. This functionality provides the ability to copy and easily modify an exception.
**Prerequisites**

- 2019 Q1A KnowledgeBase or newer

**SYSTEM > Ruleset Exceptions > Copy Exception**

The Copy Exception button provides the ability to copy an exception to multiple rulesets and enterprises.

**List of fields on the Ruleset Exceptions > Copy Exception panel**

*Name:* This is the name of the exception copied; it can be modified.

When an exception is copied to a ruleset where an exception with the same name already exists, the word “copy” is appended to the exception name.

Example: “ABC” exception is copied to ruleset1 where ABC exception is already present in ruleset1. The exception name would be ABC copy and consecutive copies would be named ABC Copy 2, ABC Copy 3 and so on.

*Enterprises:* Select one or more enterprises to which you want to copy an exception.

| Note | The Manage Custom DDR and Manage rules and rulesets privileges are required to copy an exception to multiple enterprises and rulesets from SYSTEM > Ruleset Exceptions. |

**Example: Copy an exception to multiple rulesets across enterprises.**

1. From the System > Ruleset Exceptions tab, select an exception to copy.
2. Select the Copy Exception button.
3. In the Copy Exception panel, provide the exception name in the Name field.
4. Select the “Select one or more enterprises” option.
5. Select the appropriate enterprises. Once the enterprises are selected, the rulesets are displayed under the enterprise.
6. Select the rulesets where this exception should be copied to as an individual exception. Selecting multiple rulesets creates individual copies of the exception – one for each ruleset.

| Note | Selecting parent enterprise rulesets automatically selects child enterprise inherited rulesets. |
7. Select the **Save** button to copy an individual exception to single or multiple rulesets across enterprises.

8. The copied exception’s condition expression can now be modified within each ruleset.

**Note**

To copy an existing exception that will be modified and shared to additional rulesets:
Copy an exception and save it to a single ruleset. Modify the exception and then share it within the appropriate rulesets. Refer to the [Shared Exceptions](#) section for information about sharing exceptions.

**Rulesets > Rules Tab**

This tab displays all rules associated with this specific ruleset. The following key indicates that a rule has been added as an exception.

**KEY**

➕ When a rule is added to a ruleset via an exception with no condition, this icon will appear next to the rule.

➕ When a rule is added to a ruleset via a conditional exception, this icon will appear next to the rule.

🚫 When a rule is suppressed from a ruleset via an exception with no condition, this icon will appear next to the rule.

🚫 When a rule is suppressed from a ruleset via a conditional exception, this icon will appear next to the rule.

**Rules Filtering Options**

The rules filtering functionality is the same process as outlined in the *Enterprise Rules* tab. From the *Rules* tab there are filter options listed in the panel with a + sign. Select an option to add it to the filter bar at the top of the screen. One or multiple filters can be applied.

**Filter options for Rulesets > Rules:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
<td>Enter a rule ID or multiple IDs separated by commas, a range between two IDs separated by a hyphen (-) or a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Rule name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rule status</td>
<td>Select a status from New, Used, All or None.</td>
</tr>
<tr>
<td>Claim type</td>
<td>Select a type from Professional, Inpatient Facility, Outpatient Facility, All or None.</td>
</tr>
<tr>
<td>Rule type</td>
<td>Select System or Custom.</td>
</tr>
<tr>
<td>Category name</td>
<td>Select a category name.</td>
</tr>
<tr>
<td>Execution type</td>
<td>Select from Claim Level or Line Level. All or None may alternately be selected.</td>
</tr>
<tr>
<td>Exception type</td>
<td>Select from Always Added, Conditionally Added, Always Suppressed, Conditionally Suppressed.</td>
</tr>
<tr>
<td>Dependency</td>
<td>Select Dependent or Prerequisite rules. All or None may alternately be selected.</td>
</tr>
</tbody>
</table>

**By LOB**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line of business</td>
<td>Select from Commercial, Medicare, Medicaid, Ambulatory Surgical Center (ASC), Durable Medical Equipment (DME), QA, All or None.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Select any state, states or state medical jurisdictions. All or None may alternately be selected.</td>
</tr>
</tbody>
</table>

**By flag**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mnemonic</td>
<td>Enter a single or multiple mnemonic(s) separated by commas, or use a wildcard (*) to indicate any character(s).</td>
</tr>
<tr>
<td>Priority</td>
<td>Enter a single or multiple numeric error level(s) separated by commas, a range between two levels separated by a hyphen (-), or use a wildcard (*) to indicate any character(s) or digit(s).</td>
</tr>
<tr>
<td>Context</td>
<td>Select a status of Claim Level, Line Level or No Flag.</td>
</tr>
</tbody>
</table>
Rulesets > Flags Tab
This tab displays all flags related to rules within the selected ruleset. As in the Rulesets > Rules tab, there are filter options which are listed in the panel with a + sign. These filters provide the ability to narrow the list of rules in the list. Select the filter option from the list and it will be added to the filter bar at the top of the screen. One or multiple filters can be applied to the list.

Flags Panel Functionality
From the Rulesets > Flags tab ([Selected Enterprise] > Rulesets > Flags), a list of all flags related to rules in this ruleset are displayed.

Rule sets > Flags > Status, Priority and Message
This tab shows the default inherited flag information and provides the ability to override any of these options in this ruleset. With no overrides, it displays as follows.
Flag Overrides

A flag status, error level, and/or message can be overridden at a ruleset level.

Selecting the **Add ruleset override** button provides an option to add an override to the flag status, priority and/or flag message. Select the + on any overrides for the appropriate options to display.

Override options in Rulesets > Flags > Status, Priority and Message.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Displays the name of the report. It is set to “Claim Edit Summary” by default and is a non-editable field.</td>
</tr>
<tr>
<td>Add Status Override</td>
<td>A dropdown box with Off, Deny, Profile or Review.</td>
</tr>
<tr>
<td>Add Priority Override</td>
<td>Enter the appropriate numbers (previously known as Error Level). This will determine the priority that the flag/rule will run. <strong>Note:</strong> Remove the “e.g.,” in the priority box; if you do not, <strong>Save</strong> will not enable.</td>
</tr>
<tr>
<td>Add Message Override</td>
<td>Provides an editable copy of the default message. Text can be added, edited or removed, including inserting of the parameter value part of the default message (which can be removed or added to another part of the message).</td>
</tr>
</tbody>
</table>

To remove an override, hover to the left of it until a red X icon appears. Select it to remove the entire ruleset override.
Flag Overrides for Multiple Rulesets

A flag override can be applied to multiple rulesets. When creating a ruleset-level override, select the slide-out drawer next to the Ruleset name.

A panel listing all of the available rulesets that this flag override can be applied to displays. Select the checkboxes next to the rulesets that you would like the flag override to apply to and select the Save button.

Note
As new rulesets are selected to receive a flag override, the text will update to say the number of rulesets these will apply to. If adding them to other rulesets in other enterprises it will also show the number of enterprises being impacted.

Rulesets > Flags > Source

This tab shows the Source and Source info related to the flag. There are no source overrides at the ruleset level on system rules.

<table>
<thead>
<tr>
<th>Source property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>The entity providing information regarding this flag edit.</td>
</tr>
<tr>
<td>Source info</td>
<td>Information provided by the source entity.</td>
</tr>
<tr>
<td>Source URL</td>
<td>Link to source information for system rules.</td>
</tr>
</tbody>
</table>

Rulesets > Flags > Disclosure

This tab shows the edit rationale related to the flag. There are no disclosure overrides at the ruleset level for system flags.

Multiple Flags by Line of Business

Data-driven rules can have separate flag and flag details for different Lines of Business (LOB). For example, if a rule applies to both Medicare and Medicaid LOBs, the rule can have one edit mnemonic and message for Medicare and a different edit mnemonic and message for Medicaid.

When a rule has multiple flags based on the LOB, the flags are displayed within the expression of the rule.

Each rule has a default flag and message that will display first in the rule expression. The default flag is not tied to a specific LOB and will fire when the default rules from the Properties tab of a ruleset do not match an LOB in the expression for a flag. For instance, for a rule that has two flags, a default flag and a Medicaid flag, if
the Ruleset Properties tab contains default rules of Medicare, the default message will appear on a claim. If the Ruleset Properties tab contains Medicaid, the Medicaid message will appear on a claim.

However, when rules are added to a ruleset by exception, you can specify which flag is to be used for the rule. For example, if a rule has two flags (a default flag and a Medicare flag), you can specify that the Medicare flag be used when it is added by exception to a Commercial ruleset.

Any subsequent flags after the default flag that are displayed in the rule are tied to an LOB. A flag can only be tied to an LOB that is on the Properties tab of the rule and each LOB can have only one flag tied to it.

When viewing the rule expression, the default flag details will end with the statement “for all lines of business” or “for all other lines of business” if additional flags by LOB have been added. Flags specific to an LOB will end with the statement specific to the LOB, such as “for Medicaid” or “for Medicare.”

When viewing the Flags tab of a ruleset, the flag that is displayed is based on the default rules selected in the Properties tab of the ruleset. If none is selected in the default rules, the default flag is displayed.

Flags by Line of Business can be added to custom rules. Refer to the sections for Creating Custom Data-Driven Rules and Copying System Data-Driven Rules for more details.

**Copying System Data-Driven Rules**

A system DDR can be copied and modified to meet specific business needs. Only Active (Test/Live) and Disabled rules can be copied, so only those tabs will have an activated Copy rule button.

New and Updated rules need to be reviewed and made Active or Disabled before being copied or modified. Ignored rules are those you have determined to not use and do not want to view updates on.

The Copy rule button activates when any rule is selected from the Active Rules tab or a Disabled rule on the Inactive Rules tab.

| Note | The New rule button is for creating new rules. Refer to the Creating Custom DDRs section. |

Selecting the Copy rule button opens a new panel where you can specify changes to the rule.

**Properties Tab**: When a rule is copied, the rule ID is appended with the word “Copy” on the end. Keeping the original rule ID is recommended, as it allows you to reference it. The name of the copied rule is appended with the word “Copy of” in front of it.

*List of fields on the Active Rules > Properties tab that can be modified.*

| ID | The default ID is the original rule ID with “copy” appended to the end. - A copy of rule 9 |
above displays as “9 copy”.

- If a system rule is copied more than once, a sequential number is added to the end each time, i.e., “9 copy”, “9 copy 2”, “9 copy 3”, etc.
- If a copied rule is copied more than once, “copy” is added to the end of the ID each time it has been copied, i.e., “9 copy”, “9 copy copy”, etc.
- The original ID is kept to easily identify which system rule was copied. - The original ID can be modified; however, removal makes it difficult to determine which rule was copied.
- The ID is limited to 50 characters.

### Status
Valid statuses for a custom DDR rule are Test, Live, or Disabled.

### Name
The original rule name is appended with “Copy of” in front to identify a copied rule.

- A copy of rule 9 displays as “Copy of Medicare Modifier 53”.
- If a system rule is copied more than once, a sequential number is added after the word copy, i.e., “Copy of”, “Copy 2 of”, “Copy 3 of”, etc.
- If a copied rule is copied more than once, “Copy of” is appended in front of the rule name each time it has been copied, i.e., “Copy of Medicare…,” “Copy of Copy of Medicare…”, etc.
- The rule name is limited to 2000 characters.

### Effective
Effective date of the copied rule.

### Expiration
Expiration date of the copied rule.

### Categories
Select the appropriate categories.

### Lines of business
Displays Line of business options that were copied from original rule with an option to select others.

### Notes
Enter Notes related to this copied rule.

After modifying the Properties tab, you can select the **Save** button or the **Expression** tab to make further changes.

### Note
When the rule is saved, the rule expression was changed from “53 is in list” to “53, 52’ is a subset of”. This is because we used “Any Adjusted Modifiers” (or Any Diagnosis)
and a single value vs. multiple values. When using the field “Any,” multiple values display is a subset of, where single values display is in list.

Expression tab: After modifying the expression logic for the rule to meet your needs, select the Save button. The copied rule now displays in Active Rules.

A new filter has been added called Rule type, which allows filtering based on system versus custom rules.

To view which rulesets a copied rule is used in, select the Rulesets tab.

Deleting Copied Rules

To delete a copied rule, open the rule or select multiple copied rules at a time. Select the Delete button on the Properties tab. If more than one rule is selected, the number of rules will display. If only one rule is selected, only the name of the rule displays.
A new panel displays for deletion confirmation, while also displaying the ruleset(s) the rule is used in.

**Editing Default Flag Details on Copied Rules**

When a rule is copied, users have the option to edit default flag details on the *Expression* tab as a *Then* condition.

The *Flag mnemonic* is updated by selecting in the box and editing the text.

The *Default status and priority* is overridden by selecting the appropriate boxes and selecting from the drop-down option or adding text, depending on the field.

**Note**

Changes to the flag defaults will affect this rule in all enterprises. To make changes in a single enterprise, refer to the *Overriding Flag Details on Copied Rules* section. The flag mnemonic field is limited to 50 characters. The flag message field is limited to 2000 characters.

To update the default flag message, select in the message box and edit the appropriate text.
To insert parameters from the claim into the message, place the cursor in the appropriate location to add the parameter and select the **Insert a parameter** dropdown box. A list of available options appears. These include any value already part of the rule expression and the option to `<Add another claim field>`, which allows a search for additional fields.

![Image of rule editor](image)

In the following example, the **Current Adjusted Procedure Code** and **Current Age in Years** parameters have been included in the flag message.

![Image of rule editor with parameters](image)

The **Source** and **Source info** fields are edited by selecting the **Flag source** section.
The Flag disclosure section can be edited.

Select Save, and the screen displays all default flag settings.

**Editing History Default Flag Details on Copied Rules**

If editing a flag with one or multiple history statements, the history options appear in the Insert a parameter dropdown options. Choose the appropriate history fields to pull into the message and select Save.

In the example below, the Adjusted Procedure Code, History Claim ID and History Claim Line ID were pulled in from the History 1 claim.
Adding a calculation to the Flag message

When a calculation is defined in an expression, it can be added to the flag message.

Overriding Flag Details on Copied Rules

To override the flag message for an enterprise, select Add enterprise override.
An enterprise override box appears with options to override the status, priority, and/or message for the rule.

Flag override options.

<table>
<thead>
<tr>
<th>Add Status Override</th>
<th>Add Priority Override</th>
<th>Add Message Override</th>
</tr>
</thead>
<tbody>
<tr>
<td>A status dropdown appears, allowing these selections: Off, Deny, Profile, or Review.</td>
<td>Provides a text box to designate numbers to determine the priority that the flag/rule will run (previously known as Error Level).</td>
<td>Provides an editable copy of the default message. Text can be added, edited, or deleted. Any existing parameter (value pulled into the message) can be inserted into or removed from the message.</td>
</tr>
</tbody>
</table>

In this example, the enterprise override in CQATEST was updated from “Profile” to “Review,” and the priority was overridden from “25001” to “30000.”
Select + Add Message Override, and a copy of the default message appears in an editable box. Both textual changes and parameters can be added. To insert a parameter, place the cursor at the location the change takes place.

**Note**  
When overriding flag details on a copied rule, both current and history claim fields can be included in the flag message. Refer to the Editing History Default Flag Details on Copied Rules section.

Choose the Insert a parameter dropdown and select the <Add another claim field> to view a slide-out panel with claim field options to choose.

In the example, the Primary Diagnosis is selected, and it appears as a parameter where the cursor was located.
Upon completing details on overrides, select **Save**. The override is applied to this enterprise.

When custom flags are created in the system, a custom flag indicator displays after the flag as a pencil, the same indicator on a panel displaying custom rules. When a flag’s default status, priority, or message has been overridden, the flag is displayed in light gray.

### Flag Types

There are four types of flags in the panel-based DDR UI.

<table>
<thead>
<tr>
<th>System flags</th>
<th>Overridden system flags</th>
<th>Custom flags</th>
<th>Overridden custom flags</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flags created as part of the system rule.</td>
<td>System flags that have been overridden.</td>
<td>A flag created by copying a rule or creating a custom DDR.</td>
<td>A custom flag that has been overridden.</td>
</tr>
</tbody>
</table>

To search for different types of flags, a **Flag type** filter has been created.
Select Flag type to add it to the Filter bar. The dropdown allows filtering among flag types.

**Deleting Overrides on Custom Flags**

To delete custom flag overrides, hover over the overridden flag until a red X icon appears. Select the red X to delete the overridden flag.

**Adding New Flags to Copied Rules (original flag deleted)**

Another option to create a custom flag on a copied rule is to delete the existing flag and add a new flag. To delete an existing flag, hover over the flag until a red X icon appears, then select it.

Once the flag has been deleted, an "+ Add Action" selection will display. Select it to display a new panel with a choice to "+ Apply a new flag".

A flag details box will display where you can create the flag details.

### Note

The rule ID "[DDR 9 copy]" will display in the box. Although this can be removed, we recommend leaving it to help distinguish DDR flags from ILOG flags in the claim results.

Enter a Flag mnemonic, Default status, priority, and/or message.

Select the Flag source section to add additional Source and Source info, if desired.

Select Flag disclosure to add disclosure information, if desired.

When you are finished creating your custom flag, select Save.

**Adding multiple flags by Line of Business**

Additional flags by LOB can be added after the default flag.

**To add additional flags by LOB (after the default flag):**

1. Select the New icon and select in the box below the previous flag. Then select + Apply a new flag. A flag details box will display where you can create the flag details.
2. Select the Line of business from the dropdown list.
3. Enter a Flag mnemonic, Default Status, Priority and message.
4. Details can be added in the Flag source section and Flag disclosure section, if desired.
5. Select Save when you finish adding the flag details.
Additional flags can be added to the expression for each LOB associated to the rule. The default flag in a rule can only be deleted when all other flags by LOB in that rule have been deleted.

**Additional Rule Functionality**

**Viewing System Lists in Custom Rules**

System list data is only visible within copied or custom rules. The following example rule is a copy of rule 9. It looks at a system list called *DDR Medicare Colonoscopy Modifier 53 Codes*.

Select the statement that contains the list within the rule expression to open a slideout panel with the rule logic.

Choose the arrow next to **system list** to open all available system lists.

Select the arrow next to **view contents**… to open the data within the system list.

A slide-out panel opens showing the system list’s contents.

The number of items found will be displayed.

When a list contains a large amount of data, 100 items are initially displayed. To view the next 100, select the **Load more** button at the bottom right. **Load more** is only visible within lists with large amounts of data.

Filtering by the **value** and **effective date** is also available.

The **Refresh** button updates the data if the list has been updated while you have the rule open.

To close the panel, select the upper right **X**.

**Creating Custom Data-Driven Rules**

Custom Data-Driven rules can be created from the **Active Rules or Inactive Rules** tabs.

To create a new rule, select the **New rule** button.
A panel opens to the right with rule properties. Enter applicable information in the fields.

Following is a list of fields on the Active (or Inactive) Rules > New rule > Properties tab.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
</table>
Once fields are entered in the Properties tab, the rule ID and name in the Active Rules tab are grayed out because they have not been saved. When the Properties tab is completed, a rule expression must be added before the rule can be saved.

If a rule has been started but you do not want to continue with it, select the Cancel button.

**Example rule scenario:** When Therapy Services 92507, 92508, or 92597 are submitted by provider ID 11111, and modifier GO is not present in any position on the claim, set the u1 flag status to "Review," priority “25000”, and message “Therapy Services require a modifier GO when submitted by provider ID 11111.”

In this example the rule is always effective, belongs to the category of CUSTOM COMM RULES, and is assigned to the Commercial LOB.

1. Select the Expression tab.
2. With a Condition Type of If-Then selected, a panel asking “What type of statement do you want?” will be displayed. Select + a claim field.
3. Choose + adjusted procedure code.
4. Select included in from the list of operators and select + a list of values. Enter values "92507, 92508, 92597" as list of values.
5. Select the New icon to add a new statement. Select in the box directly after the adjusted procedure code statement you just added.
6. Select + a claim field.
7. Choose Billing Provider ID and then select is equal to.
8. Select + a particular value and enter "11111".
9. Select the New icon to add a new statement. Select in the box directly after the billing provider statement you just added.
10. Select + a claim field.
11. Choose ”Adjusted Modifiers.”
12. Select **Do Not Include** from the drop down and enter value "GO". The *IF* portion of the expression is complete.

13. In the *Then* section, select **New action** and select + **Apply a new flag**.

14. In the Flag mnemonic field, enter "U1".

15. The Default status is Review and the priority is 25000. In the message box, type “Therapy Services require a modifier GO when submitted by provider 11111.”

16. Select the **Save** button and the rule is complete.

---

### Note

*Priority* was previously known as **Error Level**. The value entered will determine the order in which the DDR flags will run and fire. Enter any numerical value in this field.

---

### Note

The rule name, in this scenario “[DDR u1]”, is automatically appended. It is recommended to keep this as part of the flag message to distinguish DDR flags from ILOG flags.

When writing custom rules there are 4 icons that can be used. In the above scenarios we covered the "New" icon.

<table>
<thead>
<tr>
<th>Icon Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Add a new statement in an expression.</td>
</tr>
<tr>
<td>Copy</td>
<td>Copy a statement or group of statements in the expression</td>
</tr>
<tr>
<td>Move</td>
<td>Move a statement or multiple statements to a different position within the expression.</td>
</tr>
<tr>
<td></td>
<td>If a frequency statement or statement group contains a history group, then the statement</td>
</tr>
<tr>
<td>Icon Name</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>should not be moved inside of a history group.</td>
</tr>
<tr>
<td></td>
<td>If a history group is selected, then it will not move inside another history group.</td>
</tr>
<tr>
<td></td>
<td>If a statement or statement group contains a reference to the history context, then the statement cannot be moved outside of a history group. However, the statement can be moved from one history group to another.</td>
</tr>
<tr>
<td>Delete</td>
<td>Delete a statement or multiple statements from the expression.</td>
</tr>
</tbody>
</table>

When + a claim field is selected within a rule, Calculated Fields are available as a selection option. Refer to the [Calculated Field Options](#) section for more information.

When + a calculated value is selected, calculated value statements are available as a selection option. Refer to the [Calculated Value Statements](#) section for more information.

**Adding an additional flag by Line of Business**

Additional flags by LOB can be added after the default flag.

**To add an additional flag by LOB:**

1. After the default flag, select the +Add Action to display a new panel with a choice to +Apply a new flag. A flag details box will display where you can create the flag details.
2. Select the Line of business from the dropdown list.
3. Enter a Flag mnemonic, Default Status, Priority and message. Details can be added in the Flag source section and Flag disclosure section, if desired.
4. Select Save when you finish adding the flag details.

**Important!** Additional flags can be added to the expression for each LOB associated to the rule. The default flag in a rule can only be deleted when all the other flags by LOB in that rule have been deleted.

**Adding Source and Disclosure to Custom DDR Flags**

There is an option to add a Source, Source info, and Disclosure to the flag. To add the Source and Source info, select the Flag source tab located below the flag details.
1. Add the title of your source in the **Source** field and any related information in the **Source info** field.

2. To add disclosure information, select the **Flag disclosure** tab.

3. In the text box add disclosure information, if desired.

4. When finished, select **Save**. Flag source and disclosure information will be saved to the custom flag.

Now your custom rule and flag are complete.

Once the custom rule is saved, you can view the **Rulesets** tab to see what ruleset(s) the rule is in.

From the **Active Rules** tab, the custom rule now displays with the pencil icon next to it. The rule is also displayed when filtering by **Rule type, Custom**.

**Adding Additional Actions to a Custom Rule**

The most common action used for custom rules is **Apply a new flag**. Other actions may be added to a rule either in addition to or in the place of the Apply a new flag action. These are described in the table below.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply a new flag</td>
<td>Applies a flag to the current claim line with a given status and priority. This action cannot be used in the same rule with the Flag all lines action.</td>
</tr>
<tr>
<td>Flag all lines</td>
<td>Applies a flag to all lines of a claim with a given status and priority. This action cannot be used in the same rule with the <strong>Apply a new flag</strong> action.</td>
</tr>
<tr>
<td>Drop specific flag(s)</td>
<td>Removes any of the flags in a specified list of flags from the current claim line if they were applied by a rule that executed prior to the rule with this action. This action cannot be used in the same rule with the <strong>Drop all flags</strong> action.</td>
</tr>
<tr>
<td>Drop All Flags</td>
<td>Removes all flags from the claim that were applied by rules that executed prior to the rule with this action. This action cannot be used in the same rule with the <strong>Drop specific flag(s)</strong> action.</td>
</tr>
<tr>
<td>Add Priority</td>
<td>Determines the order the rule will run in the ruleset for scenarios where the rule does not have a flag.</td>
</tr>
<tr>
<td>Stop processing for line</td>
<td>Stops all further execution of rules on the current line. This action can be added after an action for a flag on the line or applied independently for scenarios where the line should stop processing without a flag firing.</td>
</tr>
</tbody>
</table>
Stop processing for claim

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop processing for claim</td>
<td>Stops all further execution of rules in the current ruleset for the current line and all additional lines of the claim. This action can be added after an action that applies a flag on the claim or can be the only action of the rule.</td>
</tr>
<tr>
<td>Change a Claim field</td>
<td>Action is performed to change the value of a claim field. This action can only be used with adjusted values and user defined fields.</td>
</tr>
</tbody>
</table>

Important! Stop processing actions take place when the rule executes, so you should evaluate the priority of the rules in your rulesets to ensure the stop processing rules fire in the appropriate sequence.

Importing and Exporting Custom DDR Rules

Beginning with the 2018 Q1A KnowledgeBase, users have the ability to import and export custom DDR rules. This functionality facilitates the sharing of custom DDR rules between systems, e.g., between Test and Production environments.

Importing Custom DDR Rules

Importing custom rules is performed from the Active Rules panel in DDR.

To import custom rules:

1. Navigate to the **Active Rules** panel under the appropriate Enterprise in the DDR UI.
2. Select the **Tools** menu in the Active Rules panel and select **Import rules**.
3. Navigate to the folder where the *.json file was saved and select it for import.

   The UI will display the imported rules in the Import data panel. In addition to the rules imported, this panel will display information regarding the source export system. *Note: The rules will appear light gray in color until they are saved.*

4. To save an imported rule, select the rule and then select the **Save** button. Multiple rules can be saved by using Ctrl or Shift to select them, then selecting the **Save** button.

If you import a rule that already exists, a warning will indicate there is a rule that already exists that you may want to review before saving. Warnings can be reviewed by selecting the rule listed in red. Note that saving an imported version of a custom rule that already exists in the target system will replace the original rule with the imported rule.
If you import a rule that references a System List that is not present in the target system, the following logic determines how the proper enterprise is associated to the list:

- If the enterprise that the rule was exported from exists, the system associates the list with that enterprise.
- If the enterprise that the rule was exported from does not exist, a red warning icon displays next to the System List option. Click on the warning to open a new panel where you can select the correct enterprise.

Note that both the source and target systems must have the 2020 Q3A KB or later loaded for this functionality to work.

| Note | Data associated with a list is not imported and must be manually entered or imported into the list after it is created and saved in the system. |

Additional possible warnings related to importing custom DDR rules can be found in the DDR Rule Import Warning Messages section.

| Important! | Importing the same rule more than once will result in previous versions of the rule being overwritten. This also applies if a custom rule with the same name and the same rule ID is changed; if you re-import the same custom rule again, it will overwrite the original rule because they are saved by EID (external ID) instead of rule name/ID. |

Exporting Custom DDR Rules

Exporting custom rules is performed from the Active Rules panel in DDR.

| Note | If a custom rule references a system list created by a user, the list will be exported but not the data in the list. |

To export one or more custom rules:

1. Navigate to the Active Rules panel under the appropriate Enterprise in the DDR UI.
2. To export a single rule, select the rule, and then select the Tools menu in the Active Rules panel.
3. Select Export selected rule. You can use Shift or Ctrl to select multiple custom rules for export.
4. After selecting Export selected rule, the user will be prompted to save the rule as a *.json file. Select Save As and save the *.json file to the desired location.
Same Provider Configuration - Panel-based UI

During claims analysis, some rules require the system to recognize when separate references to “Provider” are actually referring to the same provider. You can use this screen to define (for the system) what to look for in making this determination.

Prerequisites

- 2019 Q2A KnowledgeBase +

SYSTEM > Same Provider > Same Provider Rules

The Same Provider Rules tab in the SYSTEM navigation menu displays a list of all custom same provider rules in the system and provides the ability to create a new same provider rule that can be used in ruleset route properties.

Note

There is no default system Same Provider configuration in the panel-based UI. Same Provider configurations created in the Legacy UI are still available for use and are displayed within route properties with (Legacy) at the end.

Filter Options for the Same Provider tab

<table>
<thead>
<tr>
<th>Filter Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule Name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Type</td>
<td>Select the rule type, same provider or same provider NPT.</td>
</tr>
<tr>
<td>Claim Type</td>
<td>Select the claim type of Professional or Facility.</td>
</tr>
</tbody>
</table>

Note

The Manage Custom DDR privileges are required to create same provider configuration rules.

SYSTEM > Same Provider > Same Provider Rules > Add

The Add button provides the ability to create a same provider rule.
List of fields on the Same Provider Rules > Add > Properties panel

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule Name</td>
<td>Enter a rule name or any portion of the name.</td>
</tr>
<tr>
<td>Claim Type</td>
<td>Select claim type of Professional or Facility.</td>
</tr>
<tr>
<td>Rule Type</td>
<td>Select the same provider type of Same Provider or Same Provider NPT.</td>
</tr>
<tr>
<td></td>
<td>• Same Provider: Indicates the rule applies to Data-Driven Rules that contain logic for same provider.</td>
</tr>
<tr>
<td></td>
<td>• Same Provider NPT: Indicates the rule applies to Data-Driven Rules that contain logic for same provider NPT, such as New and Established Patient rules.</td>
</tr>
<tr>
<td>Notes</td>
<td>Enter notes related to the Same Provider rule.</td>
</tr>
</tbody>
</table>

Same Provider Rules > Add > Expression panel

1. Select the **Expression** tab to open the panel to define the same provider criteria.

2. Select the **+ Claim Field Statement** option.

3. From the Statement section of the panel choose the "(select a claim field...)" slide-out panel and another panel will appear to the right displaying the available claim line fields that can be used in the rule expression.

4. Select the claim fields that the system must use to identify “Same Provider.”

SYSTEM > Same Provider > Same Provider Rules > Copy

The Copy button provides the ability to copy an existing same provider rule.

List of fields on the Same Provider Rules > Copy > Properties panel

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule Name</td>
<td>Name of the copied rule with the prefix “copy of” is displayed. Enter a rule name to be displayed here.</td>
</tr>
<tr>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Claim Type</td>
<td>Claim type of the copied rule. Claim type cannot be changed for the copy of the same provider rule.</td>
</tr>
<tr>
<td>Notes</td>
<td>Notes related to the copied Same Provider rule. These notes can be updated for this copy.</td>
</tr>
</tbody>
</table>

**Same Provider Rules > Copy > Expression panel**

Select the *Expression* tab to open the panel to see the same provider criteria.

The same provider criteria can be modified within the copied rule by selecting the statement.

**Same Provider Rules > Delete Same Provider rule**

The *Delete Rule* button provides the ability to delete a same provider rule. A notification displays with the details of the ruleset and enterprise where this same provider rule is being used in the route properties.

---

**Example: Creating a Same Provider rule**

The scenario: Create a professional Same Provider configuration rule where the Adjusted Billing Provider Specialty or the Billing Provider ID is the same for the same provider criteria.

1. From the *System > Same Provider > Same Provider Rule* tab, select *Add*.
2. Provide the name of the rule in the Properties tab and select the claim type *Professional*.
3. Select the *Same Provider* option from the *Rule type* dropdown list.
4. Select the *Expression* tab.
5. Choose + a claim field.
6. Select *Adjusted Billing Provider Specialty* which defaults to the history claim line’s Adjusted Billing Provider Specialty.
7. Choose the + = equal to operator.
8. Select + a value from another claim field and select *Adjusted Billing Provider Specialty* which defaults to the current claim line’s Adjusted Billing Provider Specialty.
9. Click the New icon and click in the box directly under the adjusted billing provider statement that you just created. Select + a claim field.

10. Select Billing Provider ID which defaults to the history claim line’s Billing Provider ID.

11. Choose the = equal to operator.

12. Select + a value from another claim field and select Billing Provider ID which defaults to the current claim line’s Billing Provider ID.

13. At the top of the expression, select the all of the following option and in the drop down choose either condition. This changes it to any of the following.

14. Select the Save button. The same provider rule is now available to use within the ruleset route properties.

**Important!** User-Defined Fields will not display as available fields unless they are marked as visible within User-Defined Fields. (Refer to the User-Defined Fields - Panel-based UI section for details.)

### Export Ruleset details to a spreadsheet

The ability to export rule and flag details to a spreadsheet can be done for a single, multiple or global enterprises.

#### Export a single ruleset’s details to a spreadsheet

**To export the rule and flag details of a single ruleset to a spreadsheet:**

1. Select the ruleset, select the Rules or Flags tab and select the Tools gear option. From the gear menu, choose Export listing to spreadsheet.

2. A message will appear at the bottom of the screen. Select Save As and save the spreadsheet to a desired location.

The spreadsheet will contain rule and flag information related to this enterprise.

The results in the spreadsheet are displayed consistent with the Rules tab display. Filtering can be done in the spreadsheet or you can filter the Rules tab to show only items you would like exported and then choose the Export listing to spreadsheet option.
Export multiple rulesets’ details to a spreadsheet

To export the rule and flag details of multiple rulesets to a spreadsheet:

1. Go to the Tools gear menu on the Rulesets tab and choose Select all rulesets.

2. All rulesets will be highlighted and the UI will display the number of rulesets (in this case, four rulesets) and all related rules on the Rules tab. From the Tools gear menu, select Export listing to spreadsheet.

3. A message will appear at the bottom of the screen. Select Save As and save the spreadsheet to a desired location.

The spreadsheet will contain rule and flag information related to all of the enterprises.

Export global rulesets’ details to a spreadsheet

To export the rule and flag details of global level rulesets to a spreadsheet:

1. Choose a Global level enterprise and an option will appear to Show rulesets from child enterprises. When this box is selected, all rulesets (including children) will display.
The Priority column that allows the ability to change the priority of the rulesets is removed from this view since prioritizing child/sibling enterprises will not apply.

2. From the Tools gear menu dropdown, choose Select all rulesets.

3. All the rulesets will be highlighted and it will display the number of rulesets (in this case, 21 rulesets) and all related rules will display on the Rules tab. From the Tools gear menu, select Export listing to spreadsheet.
4. A message will appear at the bottom of the screen. Select **Save As** and save the spreadsheet to a desired location.

The spreadsheet will contain rule and flag information related to all of the enterprises.

**Procedure Reduction Records - Panel-based UI**

**Note**

Redirection of Reduction Records to the panel-based UI is available only in 5.4.

**To access procedure reduction records:**

1. Open the **Rules** module from the **Enterprise** entry-level screen.

2. Select **Reduction Records**. A tab is displayed with a default system record which is not editable. User-defined reduction records can be created, edited and deleted. These records are identified with the pencil icon.

The following information describes the properties on the Reduction Records tab.

<table>
<thead>
<tr>
<th>Tab</th>
<th>Property Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Properties</td>
<td>Reduction Record Name</td>
<td>User-Defined Name</td>
</tr>
<tr>
<td>Properties</td>
<td>Ranking type</td>
<td>Relative Value, APC Value (Ambulatory Payment Classification) Submitted Charge: High to Low</td>
</tr>
</tbody>
</table>
General Reductions | Assistant Surgeon | Indicates percentage that Assistant Surgeon will be paid.
--- | --- | ---
General Reductions | Bilateral procedure | Indicates percentage that Bilateral procedure will be paid.
General Reductions | Co-surgeon | Indicates percentage that Co-surgeon will be paid.
General Reductions | Team Surgeon | Indicates percentage that Team Surgeon will be paid.

Multiple Procedure Reductions

By default, MPR comes with “Pay procedure record,” where the required range could be covered. It also includes “Pay all others at,” where the remaining procedures can be included.

The Add additional record function allows for the addition of up to three records.

Working with Procedure Reductions

From the Procedure Reduction screen you can add, copy, edit, or remove reduction records.

**To add a procedure reduction record:**

1. Select the New Reduction Record button.
2. Enter information in the fields described above.
3. Select Save.

**To copy an existing procedure reduction record:**

1. Select the record you want to copy.
2. Select the Copy Reduction Record button.
3. Enter a name for the new record in the Name field.
4. Modify information in the remaining fields.
5. Select Save.
To edit a procedure reduction record:

1. Select the record you want to edit.
2. Modify information in the appropriate fields.
3. Select Save.

To delete a procedure reduction record (non-system only):

1. Select the record you want to remove.
2. Select the **Delete Reduction Record** button.
3. When the system asks you to confirm the action, select the **Delete** button.

| **Note** | Inherited records cannot be modified or deleted. Also, a reduction record cannot be deleted if it is attached to any DDR or ILOG routes. |
Connection Configuration

Connections in the Claims Edit System

The Claims Edit System program runs as a server that communicates with several other entities (including end-user machines, the host system, etc.).

```
<table>
<thead>
<tr>
<th>Host System</th>
<th>CES Server</th>
<th>Host System</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Real-Time Claims)</td>
<td></td>
<td>(Batch Claims)</td>
</tr>
</tbody>
</table>

Internet Link

End-User Machines
```

Note

The configuration above is merely an illustration, and the exact configuration at your site is likely to vary.

Each machine that communicates with Claims Edit System does so through one of two basic types of connections to the Claims Edit System server:

- **Browser Connection**: End-user machines connect to the server through an internet browser. (Refer to the Starting Up and Logging In section.) The URL used to access the server depends on where Claims Edit System was installed. The URL is always as follows (unless you establish an alias to replace this URL):

  ```
  [Server Name]:8080/ices/app
  Example...
  ITServer001:8080/ices/app
  ```

- **Network Data Connection**: Most other machines that interact with the the Claims Edit System server will do so over some type of network. For these machines, you must set up specific data connections in Claims Edit System before the server can interact with each of these entities.

**Managing Data Connections**

To set up network data connections, you must access the connection configuration module.
To Access the Connection Configuration:

1. Open the System Settings module from the Main Menu screen.
2. Select Connection Configuration.

This screen shows a list of the connections that have been defined on your system. The following information displays for each connection:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>A name describing the connection.</td>
</tr>
<tr>
<td>Message Format</td>
<td>Indicate the format for messages that will be transmitted through this connection. The following formats may appear in this field:</td>
</tr>
<tr>
<td></td>
<td>• IMF - This is the traditional Import/Export Message Format used by Claims Edit System.</td>
</tr>
<tr>
<td></td>
<td>• XML - Claims Edit System supports an interface to the host system, based on the X-tensible Markup Language (commonly used in web-based technologies). This interface supports two types of input messages (QueryClaimResults and AnalyzeProfessionalClaim) and two types of output messages (ClaimResponse and Error). For details on how to set up this interface, refer to the XML Interface Specification (available from Optum).</td>
</tr>
<tr>
<td></td>
<td>• Facets - The Cognizant Group has partnered with Optum to develop an interface that allows Claims Edit System (version 4+) to communicate with their Facets® System.</td>
</tr>
<tr>
<td>Note</td>
<td>If you use batch files (including the TVLM format), please contact technical support for information on how to set up the batch-file loader or any corresponding translators.</td>
</tr>
<tr>
<td>Status</td>
<td>Indicates whether the connection is enabled or disabled.</td>
</tr>
</tbody>
</table>

General settings

On the Connection Configuration screen are certain settings that apply to all connections you define.
To access General Settings:

1. Open the System Settings module from the Main Menu screen.
2. Open the Connection Configuration module.
3. Select the General Settings button.

Once you access the general settings, the following options are available:

Export Overpayment Flags Messages

This option is only available if you have a license for the Overpayment Detection module. (Refer to the Overpayment Detection section.) With this option, you can choose whether you want the system to send the results of overpayment analysis back to your host adjudication system. The options you can choose are as follows:

- **Yes** - Send overpayment results back to the host system.
- **No** - Do not send overpayment results back to the host system.

Creating a new connection

To create a new connection:

1. Open the System Settings module from the Main Menu screen.
2. Open the Connection Configuration module.
3. Select the New Connection button.
4. At the top of the screen, enter information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Enter a name describing the connection. We recommend that you name each connection with a descriptive name, such as the name of the office where the connection is located. This makes it easier to manage each connection’s properties.</td>
</tr>
<tr>
<td>Message Format</td>
<td>Indicate the format for messages that will be transmitted through this connection. The following formats may appear in this field:</td>
</tr>
<tr>
<td></td>
<td>- <strong>IMF</strong> - This is the traditional Import/Export Message Format used by Claims Edit System.</td>
</tr>
</tbody>
</table>
Field | Description
--- | ---
XML - Claims Edit System supports an interface to the host system, based on the X-tensible Markup Language (commonly used in web-based technologies). This interface currently supports two types of input messages (QueryClaimResults and AnalyzeProfessionalClaim) and two output message types (ClaimResponse and Error). For details about how to set up this interface, refer to the XML Interface Specification document.

Facets - The Cognizant Group has partnered with Optum to develop an interface that allows Claims Edit System (version 4+) to communicate with their Facets System.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Indicate whether you want this connection to be enabled or disabled.</td>
</tr>
<tr>
<td>Inbound Port</td>
<td>Indicate the number of the port this connection will use to receive claim data from the host system.</td>
</tr>
<tr>
<td>Outbound Port</td>
<td>Indicate the number of the port this connection will use to send claim results back to the host system. You can leave this field blank if claims are coming in and out of the same port.</td>
</tr>
</tbody>
</table>

5. In addition to the fields mentioned above, there will be several other settings to define at this time. However, these settings will vary, depending on what you selected in the Message Format field (above). For details about these additional settings, refer to the sections below:

- IMF
- XML
- Facets

6. When you finish, select Save to exit.

**Important!** Any time you change connection configuration settings, you must restart services before these changes can take effect.

**IMF Connection Settings**

When setting up a connection, if you selected IMF as the Message Format, you must define the following additional fields:
## Input Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Default Enterprise</td>
<td>Define a default enterprise for this connection. If no routing ID (security ID) is present on a claim coming through this connection, the system will put the Routing ID for the Default Enterprise in that field because it is required by the system.</td>
</tr>
<tr>
<td>Note</td>
<td>Only a leaf enterprise may be selected here. (Refer to the Parental Hierarchy in Enterprises section.)</td>
</tr>
<tr>
<td>Acknowledge Timeout</td>
<td>Define (in milliseconds) the amount of time the system should wait for acknowledgement from the host system.</td>
</tr>
<tr>
<td>Message Queue Wait</td>
<td>Define (in milliseconds) the amount of time that messages can wait in the queue.</td>
</tr>
</tbody>
</table>
| ICD-10 Effective Date| Because the system handles both ICD-9 and ICD-10 codes, it needs to determine which type of code applies for each claim that enters the system. In many cases, claims will come through with a “Code Type” indicator to make this distinction. However, for claims that do not have a code type, the system will use an effective date instead (i.e., claims dated prior to the effective date will be considered under ICD-9 while those dated on or after the effective date will be considered under ICD-10). The ICD-10 Effective Date setting consists of two interactive fields:  
  - (Checkbox) Set ICD-10 Effective Date in Claim Route - If you leave this checkbox unmarked, the system assumes you want to set the effective date here on this screen (refer to Effective Date in the next bullet). If you select this checkbox, the system assumes you do not want to set an effective date here, but rather will set it using the Claim Routes screen.  
  - Effective Date - This screen is only active when you do not select the checkbox described above. Here you can define the ICD-10 threshold date for claims that will use this connection. |
| Claim History Source | For claims using this connection, indicate where you want the sys-                                                                                                                                               |
### Setting

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>tem to look for claims history. The following options are available:</td>
</tr>
<tr>
<td>• <em>Message</em> - The system assumes the history segment is part of the claim message sent from the host system.</td>
</tr>
<tr>
<td>• <em>Database</em> - The system assumes the history segment is not part of the claim message sent from the host system, and therefore it will look in the database for claim history.</td>
</tr>
<tr>
<td>• <em>Auto</em> - The system tries to detect whether or not the history segment is part of the claim message sent from the host system. If it does not detect a history segment, it will look in the database for claim history.</td>
</tr>
</tbody>
</table>

### Crosswalk Claim Line Status

In Claims Edit System, claim lines are flagged with one of the following status settings:

- **A (Active)** - The line is open and valid and will be included in analysis.
- **P (Profile Only)** - The line is included in the analysis but does not return any edits back to the host system.
- **D (Deleted)** - The line is deleted. It is not included in any analysis.

These are the only claim-line-status settings recognized by Claims Edit System. However, in some cases, claims may enter the system that contain different line settings than those listed above. When this is the case, you can use this field to crosswalk non-recognized values to one of the three listed above.

To enter crosswalk values, type them in the box next to the corresponding letter (A, P, or D). You can enter more than one value in each box, as long as you separate them by commas.

### Output Settings

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Recursion Result Format</td>
<td>In this field, indicate whether “Recursion Results” are enabled or disabled for this connection. When this field is enabled, the results sent back to the host system contain three additional fields of information:</td>
</tr>
<tr>
<td>a.</td>
<td>An indicator of which recursive pass each result comes from (1st pass, 2nd pass, etc.). Analysis pass defaults to 1.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field b.</td>
<td>An indicator of whether each flag is final or interim (I = Interim, F = Final)</td>
</tr>
<tr>
<td>Field c.</td>
<td>The Line ID for each virtual line created during analysis. If you leave this field disabled, the system will use the standard results format (which does not include this additional information).</td>
</tr>
<tr>
<td>Report Interim Flags</td>
<td>Select this checkbox if you want the results to include interim flags. However, if you would rather have results that include only final flags, leave this checkbox unselected.</td>
</tr>
<tr>
<td>Note</td>
<td>This option is not available unless you place a check-mark in the Use Recursion box.</td>
</tr>
<tr>
<td>Return Modified Lines</td>
<td>Select this checkbox if you want to return modified lines to the host system.</td>
</tr>
<tr>
<td>Return Submitted Lines</td>
<td>Select this checkbox if you want the original claim lines (sent to Claims Edit System) to be part of the results message (going back to the host system).</td>
</tr>
<tr>
<td>Pad Empty Segments</td>
<td>With the IMF, transmitted messages are divided into segments. For example, the CLAIM message is divided into five segments: 1) Message ID, 2) Route, 3) Header, 4) Lines, and 5) History Lines. (Refer to the IMF/EMF Specification document for a detailed explanation of these segments.)</td>
</tr>
<tr>
<td></td>
<td>In some cases, entire segments of a message may be empty (i.e., containing no data to transmit). When this is the case, the system can “pad” the empty segments with characters to mark the empty data blocks or it can leave the segments blank.</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong></td>
</tr>
<tr>
<td></td>
<td>1) <strong>Original Line Segment</strong> — <code>{ padded}</code></td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Original Line Segment - {padded}" /></td>
</tr>
<tr>
<td></td>
<td>2) <strong>Original Line Segment</strong> — <code>{empty segments not padded}</code></td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Original Line Segment - {empty segments not padded}" /></td>
</tr>
<tr>
<td></td>
<td>If you select this checkbox, the system expects empty segments to be pad-</td>
</tr>
</tbody>
</table>
### Field Description

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
</table>
| Return Profile Results       | Select this checkbox if you want the system to return Profile flags. Otherwise, the system will store any Profile flags for lookup while returning the profiled lines as “clean.”  
Optional - if this option is unchecked, results will be returned as “clean.”                                                                                                                                                                                                                                                                                                                                                     |
| Return Deleted Lines         | If this checkbox is selected, the system returns claims results even if the claim is marked as deleted by the host.                                                                                                                                                                                                                                                                                                                                                                          |
| Build Claims                 | This option tells the system how to handle claims storage. Typically, every claim in each batch is stored separately. However, sometimes the same claim (i.e., a claim with the same claim number and patient ID) can be submitted more than once - in different batches. When this is the case, the claim can be “built” by taking the additional information from the later submission and adding it to the original claim. When you select this checkbox, the system builds claims in this manner. However, if this option is unchecked, claims with the same claim number and patient ID in different batches are treated as separate claims. |
| Return All Results           | You must select **Build Claims** (above) before using this option. By selecting this option, you can get compounded results. For example, suppose you submit two lines of a claim on day 1, two more lines of a claim (4 total) on day 2, and then two more on day 3 (6 total). By marking this option, when you analyze the claim on day 1, two line results may be returned, the second day four line results, and the third day six line results. If this option is not selected, the system will only return the most recent lines of information, in this case two line results per day.                                           |

### XMP Connection Settings

When **setting up a connection**, if you selected **XMP** as the **Message Format**, you must define the following additional fields:

**Input Settings**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
</table>
| Return Profile Flags         | Select this checkbox if you want the system to return Profile flags. Otherwise, the system will store any Profile flags for lookup while return-
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise</td>
<td>Define an enterprise for this connection. If no routing ID (security ID) is present on a claim coming through this connection, the system will put the Routing ID for the enterprise in that field because it is required by the system.</td>
<td>Only a leaf enterprise may be selected here. (Refer to the Parental Hierarchy in Enterprises section.)</td>
</tr>
<tr>
<td>Queue Message Timeout</td>
<td>Define (in seconds) the amount of time messages can wait in the queue before a timeout occurs.</td>
<td></td>
</tr>
</tbody>
</table>
| ICD-10 Effective Date | Because the system handles both ICD-9 and ICD-10 codes, it needs to determine which type of code applies for each claim that enters the system. In many cases, claims will come through with a Code Type indicator to make this distinction. However, for claims that do not have a code type, the system will use an effective date instead (i.e., claims dated prior to the effective date will be considered under ICD-9, while those dated on or after the effective date will be considered under ICD-10). The ICD-10 Effective Date setting consists of two interactive fields:  
  - (Checkbox) Set ICD-10 Effective Date in Claim Route - If you leave this checkbox unselected, the system assumes you want to set the effective date here on this screen (refer to Effective Date on the next bullet). If you select this checkbox, the system assumes you do not want to set an effective date here, but rather will set it using the Claim Routes screen.  
  - Effective Date - This screen is only active when you do not select the checkbox described above. Here you can define the ICD-10 threshold date for claims that will use this connection. |
| History               | For claims using this connection, indicate where you want the system to look for claims history. The following options are available:  
  - Message - The system assumes the history segment is part of the claim message sent from the host system.                                                                                              |                                                                                                                                                                                                                                           |
### Field Description

- **Database** - The system assumes the history segment is not part of the claim message sent from the host system and therefore it will look in the database for claim history.
- **Auto** - The system tries to detect whether or not the history segment is part of the claim message sent from the host system. If it does not detect a history segment, it will look in the database for claim history.

### XML Connection Settings

This type of connection communicates with an interface to the host system, based on the Extensible Markup Language (commonly used in web-based technologies). This interface supports two types of input messages (QueryClaimResults and AnalyzeProfessionalClaim) and two types of output messages (ClaimResponse and Error). These can be for real or hypothetical claims. For details about how to set up this interface, refer to the XML Interface Specification document (available from Optum).

When setting up a connection, if you selected **XML** as the **Message Format**, you must define the following additional fields:

<table>
<thead>
<tr>
<th>XML Setting</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim ID Prefix (or Suffix)</td>
<td>In either of these two fields (but not both), enter a prefix (or suffix) to be added to the Claim ID. The system uses this prefix/suffix to distinguish hypothetical claims from real claims.</td>
</tr>
</tbody>
</table>

**Important!**

A hypothetical claim looks like a real claim to Claims Edit System, and the system itself does not contain a mechanism to distinguish between these two types of claims. To overcome this, you must instruct the Claims Edit System XML Interface software to add a special tag that you define, to the claim ID, patient ID and the provider ID for all hypothetical claims that come in. The tag is a string of characters that you select. A char-
### XML Setting

<table>
<thead>
<tr>
<th>XML Setting</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Important!</strong> acter can be a letter, number or other printable character. This string must comply with Claims Edit System constraints for these IDs, and must comply with the string value constraints for the database system that you are using.</td>
</tr>
<tr>
<td>Patient ID Prefix (or Suffix)</td>
<td>In either of these two fields (but not both), enter a prefix (or suffix) to be added to the Patient ID.</td>
</tr>
<tr>
<td>Provider ID Prefix (or Suffix)</td>
<td>In either of these two fields (but not both), enter a prefix (or suffix) to be added to the Provider ID.</td>
</tr>
</tbody>
</table>

### Facets Connection Settings

When setting up a connection, if you selected Facets as the Message Format, you must define the following additional fields:

#### Facets Settings

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
</table>
| ICD-10 Effective Date         | Because the system handles both ICD-9 and ICD-10 codes, it needs to determine which type of code applies for each claim that enters the system. In many cases, claims will come through with a “Code Type” indicator to make this distinction. However, for claims that do not have a code type, the system will use an effective date instead (i.e., claims dated prior to the effective date will be considered under ICD-9 while those dated on or after the effective date will be considered under ICD-10). The ICD-10 Effective Date setting consists of two interactive fields:  
  - **Checkbox Set ICD-10 Effective Date in Claim Route** - If you leave this checkbox unselected, the system assumes you want to set the effective date here on this screen (refer to Effective Date in the next bullet). If you select this checkbox, the system assumes you do not want to set an effective date here, but rather will set it using the |
<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <strong>Claim Routes</strong> screen.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Effective Date</strong> - This screen is only active when you do not select the checkbox described above. Here you can define the ICD-10 threshold date for claims that will use this connection.</td>
</tr>
<tr>
<td>Inpatient Type of Business Override</td>
<td>Enter any type-of-business codes you want to “override” on inpatient claims. Separate your entries by commas.</td>
</tr>
<tr>
<td>Outpatient Type of Business Override</td>
<td>Enter any type-of-business codes you want to “override” on outpatient claims. Separate your entries by commas.</td>
</tr>
<tr>
<td>Bypass Medical</td>
<td>Select this checkbox if you do not want to process professional claims during claims processing. The system will then bypass (or skip) these claims.</td>
</tr>
<tr>
<td>Bypass Facility</td>
<td>Select this checkbox if you do not want to process facility claims during claims processing. The system will then bypass (or skip) these claims.</td>
</tr>
<tr>
<td>Bypass Zero Charges</td>
<td>Select this checkbox if you do not want to process claims with zero charges during claims processing. The system will then bypass (or skip) these claims.</td>
</tr>
<tr>
<td>History Filter</td>
<td>Select this checkbox if you want to use the history filter. This filter lets you exclude history data that is older than a specified number of months, while including more recent history data. This checkbox works in conjunction with the History Filter Months field (below).</td>
</tr>
<tr>
<td>History Filter Months</td>
<td>If you select the History Filter checkbox (above), use this field to indicate how many months of claim history data you want to include. You can enter any value greater than zero in this field.</td>
</tr>
</tbody>
</table>

**Modifying a connection**

**To modify the settings for a connection:**

| Important! | When you change connection configuration settings, you **must** restart services before these changes can take effect. |
1. Open the **System Settings** module from the *Main Menu* screen.

2. Select **Connection Configuration**.

3. From the list of available connections, select the one you want to modify. The *Edit Connection* screen displays.

4. Modify any of the fields. Specific details about each of these fields can be found in the *Creating a New Connection* section.

5. When you finish modifying the settings, select **Save**.

### Disabling or enabling a connection

**Important!** When you change connection configuration settings, you **must** restart services before these changes can take effect.

**To change the Enabled/Disabled status of a connection:**

1. Open the **System Settings** module from the *Main Menu* screen.

2. Select **Connection Configuration**.

3. From the list of available connections, select the checkbox for the one you want to enable or disable.

4. Select the **Change Status** button. The *Status* field for this connection then changes to reflect the new status.

5. When you finish, select **Save** to exit.

### Deleting a connection

**Important!** When you change connection configuration settings, you **must** restart services before the changes can take effect.

**To delete a connection:**

1. Open the **System Settings** module from the *Main Menu* screen.

2. Select **Connection Configuration**.
3. From the list of available connections, select the checkbox for the one you want to delete.

4. Select the **Delete** button. The system displays a message letting you know the deletion has occurred.

5. When you finish, select **Save** to exit.

### Facility Server Connection

If you have the Facility module, you can set up your system to communicate with the Facility Server - also known as the Easy Group Server.

**To set up a connection with the Facility Server:**

1. Open the **System Settings** module from the **Main Menu** screen.

2. Select the **Facility Server Connection** button.

3. On this screen, enter information in the following fields:

   **Host Address**
   
   Enter the IP address you will use to connect to the Facility Server.

   **Port Number**
   
   Enter the ID for the TCP/IP port you will use to connect to the Facility Server.

4. When you finish, select **Save**.
The KnowledgeBase and Code Repository

KnowledgeBase Overview

The Claims Edit System KnowledgeBase is comprised of individual data components:

a. Data from the CMS Correct Coding Initiative (CCI)
b. Optum Claims Editing data

The CCI contain industry-standard Medicare data and bundling/unbundling data, are published regularly. Also, Optum updates and republishes its store of claims editing data on a regular basis. Together, these sources of data form the basis of information exchange and claims analysis in Claims Edit System.

Rules in the system compare incoming claims data (from your host system) to the KnowledgeBase and flag inappropriate coding relationships and inappropriate line item information. Using the Code Repository portion of the Claims Edit System interface, you can modify most coding relationships in the KnowledgeBase to control how claims are edited during claim analysis. You can change data and relationships within the KnowledgeBase by creating Overrides.

The Claims Edit System KnowledgeBase module provides limited access to the tables in the Optum Claims Editing KnowledgeBase™ and coding parameters; many tables and parameters cannot be modified by the user. These limitations make the KnowledgeBase module manageable in size and capability. In addition, user access to the KnowledgeBase is limited to help decrease the risk of small errors adversely affecting the analysis process and results.

For more information about changes you can make, and how the system uses them, refer to the Overrides section.

Note

The KnowledgeBase contains some professional codes and lists that may not be applicable to Facility. One example of this is Place of Service (POS). You may see some POS information in the KnowledgeBase, but this information will not be acted on by the Facility system rules.
Managing KnowledgeBase Data

To maximize clinical accuracy, Optum continually improves the KnowledgeBase data (for example, updating edits based on sourcing from organizations with recognized medical coding expertise such as CMS and the AMA). Therefore, because this data is constantly changing, new versions of the KnowledgeBase must be released on a regular basis.

Releases of the KnowledgeBase occur at least quarterly on the following schedule:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Release Date</th>
<th>Data Becomes Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter</td>
<td>Mid-December (approx. 15th)</td>
<td>January 1st</td>
</tr>
<tr>
<td>2nd Quarter</td>
<td>Mid-March (approx. 15th)</td>
<td>April 1st</td>
</tr>
<tr>
<td>3rd Quarter</td>
<td>Mid-June (approx. 15th)</td>
<td>July 1st</td>
</tr>
<tr>
<td>4th Quarter</td>
<td>Mid-September (approx. 15th)</td>
<td>October 1st</td>
</tr>
</tbody>
</table>

In addition to these scheduled releases, there are also interim KnowledgeBase releases that occur regularly. An interim release occurs when Optum receives changes (from organizations like the CMS or AMA) on a date that is too late for them to be developed into a major quarterly release.

Notification of KnowledgeBase Updates

Whenever a new version of the KnowledgeBase is ready for release, Optum sends an email notification to all clients registered as subscribers to the KnowledgeBase. These notifications contain detailed information about where you can access and download the new KnowledgeBase from the Claims Edit System client website. To subscribe to the KnowledgeBase, contact Optum Client Services at (800) 765-6818, option 1.

Loading the KnowledgeBase

After you download the latest version of the KnowledgeBase, you must load the KnowledgeBase for use in Claims Edit System.

Download the desired version of the KnowledgeBase (usually the most current release). The file may be placed at a convenient location on your workstation (PC) or may be copied to the extracts folder in the installation path of Claims Edit System on the server where it is running. By default, the extract folder is in the following location on the Claims Edit System server:

<InstallDir>\ICP\KB_Extracts (Example: C:\Optum\ICP\KB_Extracts)
Special Considerations for Multi-Node Configurations

Clients with high claim volume requirements often use multiple application servers in the overall system configuration to meet these requirements. Two different configurations are commonly used. The steps for loading the KnowledgeBase so that all nodes in the configuration correctly utilize the new KnowledgeBase data are slightly different and are identified in the instructions below.

*High Availability (HA) Cluster* - This is the recommended configuration where every application node in the system communicates with other nodes via a message broker. Although multiple message brokers can be configured in the system for High Availability, there is only one active Claim Connector at a time. After the KnowledgeBase is loaded, all application nodes are notified so they can refresh cached data.

*Multi-App* - This configuration is commonly used by payers when patient history claims are sent with the claim to be analyzed. This frees Claims Edit System from needing to ensure serial processing of claims for the same patient because appropriate patient history for the claim is provided by the payer’s adjudication system. This allows each application node in the system to have its own Claim Connector and operate independently from the other application nodes. Only the database is shared and there is no communication between the nodes.
For an HA Cluster multi-node system, it is recommended that each Claim Connector (primary and standby) be restarted after connections are disabled via the user interface. The JBoss application server will remain running and you will be notified when the new KnowledgeBase has been loaded.

For a Multi-App multi-node system, it is recommended that all ICP services on secondary nodes (the nodes that do not participate in the loading of the KnowledgeBase) be stopped during the time the KnowledgeBase is being loaded and then be restarted after the load completes. This ensures that cached data will be current. On the primary node, only the ICP Connector service must be restarted to disable and re-enable the connections.

**Instructions for Loading the KnowledgeBase**

**Important!** Because the data upon which claim analysis depends is being replaced, all claim processing must be stopped during the time the KnowledgeBase is being loaded. It may be possible to do this from the claim source (adjudication system), but if not, instructions are included below for disabling connections to the Claim Connector.

**To load the KnowledgeBase:**

1. Log in to the Claims Edit System user interface. (For more information about logging in and creating users, refer to the Security section.)

2. Disable connections in the Claim Connector. From the Main Menu, navigate to System Settings > Connection Configuration. Disable each connection that is used for claim input via the following steps.
   a. Select the connection name to open the Edit Connection screen.
   b. Change the Status Field from enabled to disabled.
c. Select the **Save** button.

3. Restart the **ICP Connector** service. This causes the configuration change to be recognized by the Claim Connector.
   a. Open the **Windows Services** dialog. (In the search field of the start menu, enter `services.msc` and press `<ENTER>`.)
   b. Right-click on the **ICP Connector** service and select **Restart** from the shortcut menu.
   c. Leave the dialog open so that the ICP Connector service can be restarted again later.

<table>
<thead>
<tr>
<th>Important!</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your system is deployed as a Multi-App configuration, then stop ICP Services on all nodes other than the one to which your browser is connected. They will be restarted after the KnowledgeBase is loaded.</td>
</tr>
</tbody>
</table>

4. Navigate to **Main Menu > KnowledgeBase Utilities > SmartLoad Import**.
   a. The KnowledgeBase file name is displayed on top of the page if the file is present in the KB_Extracts folder.
   b. If the file is not present in the KB_Extracts folder, select the **Browse** button and select the **KnowledgeBase file** that you just downloaded to your local workstation. Then select the **Upload** button. The file is uploaded to the server’s KB_Extracts folder to become ready for import.

5. Select one of the following options:

   **Full KnowledgeBase**

   Use this option to load the entire KnowledgeBase. If this is the first time you are loading the KnowledgeBase, you should choose this option. If an older version of the KnowledgeBase was previously loaded, all data from the existing version will be replaced with data from the new version. This option takes the most time because the system must load the complete KnowledgeBase.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Full KnowledgeBase option is useful if you need to revert to an older version of the KnowledgeBase. This option will delete all existing data and replace it with the older version of the KnowledgeBase data.</td>
</tr>
</tbody>
</table>

   **Update KnowledgeBase**

   If you select this option, the system compares the version date assigned to each KnowledgeBase table (i.e., the version you are trying to load with the existing version on your system). If the version date in the
KnowledgeBase file is greater than the version date for the existing data table, it will load that table. Selecting this option can save time because many tables will not be loaded.

**Note**

If you attempt to load a KB that is older than the current version on your server, a warning message will be displayed. The system also prevents loading of an incompatible KB (wrong product type).

If multiple versions of the KnowledgeBase file exist in the KB_Extracts directory on the server, the SmartLoad process will automatically select the most recent file.

6. Select the **Begin Import** button to start loading the KnowledgeBase into your database. As it is loading, you will see the following status information.

**Note**

It is safe to navigate away from the SmartLoad Import screen. If you return later, the current status will be displayed.

*Import Status:* This displays the progress percentage of the import process.

*Last KB Load Status:* This message at the bottom of the SmartLoad Import screen reflects details for the last KB load including the version, date completed, the load completion status (success/failure), and how many tables were updated.

7. After the KB load completes, there are some post-load operations that must complete before claim processing can be resumed (i.e., recreate indexes for DDR tables, DDR cache reload). Verify that the system is ready for claim processing by looking for the following three log messages in the current jboss.server.log file:

a. “Forcing a cache refresh on KB data”

b. “DDR Load completed on node <hostname>. Reinitializing DDR Object Cache”

c. “Finished Initializing DDR Object Cache”

8. Re-enable all connections that were disabled in step #2 above. (Follow the same procedure outlined in that step.)

9. Restart the **ICP Connector** service using the **Services** dialog that was previously left open, and then close the dialog. It is now safe to resume claim processing.

**Note**

If your system is deployed as a Multi-App configuration, start ICP Services on all other nodes at this time.
Automatic Configuration Backup

Beginning with the 2017 Q4A KB, the KnowledgeBase load process automatically creates a pre-KB load configuration backup if the KB being loaded contains a different DDR engine than what currently exists in the system. This is done before loading the new extract for capturing a snapshot of the current system configuration.

There are certain situations where loading a KB will result in changes to the database and rule structure. This backup provides a restoration point and is equivalent to the configuration backup available via the Support screen. It is equivalent to running the saver.bat tool with the options selected to save RULES AND CONFIGURATION and OVERRIDES. Should the need arise to restore the configuration backup, this can be accomplished using the Configuration Loader tool (loader.bat). Refer to the Technical Configuration and Tools Guide 5.4 on the Client Portal for more information about running the Configuration Loader.

The resulting configuration backup files will be saved in the KB_Extracts folder, which is where KnowledgeBase extract files are normally placed when not uploaded from the local PC. The naming convention for these files is:

[new extract name]_PRE_KB_LOAD_CFG_BACKUP_[date]_[time].h2.db.gz

The pre-KB load configuration backup functionality is enabled by default but can be disabled if desired by running the following SQL script:

insert into DDR_PROPERTIES(PROP_TYPE,PROP_NAME,VALUE) VALUES('DDR_LOAD','BACKUP_CONFIG','no');

Determining Version of KnowledgeBase Tables

Once you load a KnowledgeBase to your system, you can view the versions of specific data tables within the KnowledgeBase. If you loaded a full KnowledgeBase, all tables should have the same version number. However if you load updates, some of the version numbers could vary.

To determine the version of KnowledgeBase Tables:

1. Log in to the Claims Edit System interface.
2. Select the KnowledgeBase Utilities icon.
3. Select the KnowledgeBase Version icon.
4. Select one of the following tabs (upper left portion of the screen):
   PE KB Details
Select this option to view details about the KnowledgeBase for Professional Editing (PE). This option is selected by default.

**FE KB Details**

Select this option to view details about the KnowledgeBase for Facility Editing (FE).

Once you select the desired tab, the following information displays for each of the KnowledgeBase tables:

**KB Version**

This column identifies the KnowledgeBase version that applies to the corresponding table. The version number indicates the year, month, and day on which the KnowledgeBase was released - in YYYYMMDD format. (The example below shows the version name for a KnowledgeBase released on April 1, 2019.)

![20190401](Year Month Day)

**KB Build ID**

This column contains a "build" number - a number generated by Optum to identify the specific data build internally. This number may be useful if you have a need to contact Technical Support.

**Table Name**

This column identifies the name of the corresponding KnowledgeBase table.

**Row Count**

This column displays the row count for the corresponding table (as it exists in the database). This row count should always match the Expected Row Count (below). If it does not, it indicates there was some kind of problem when you loaded the KnowledgeBase (e.g., a partial KB load). In this situation, Optum recommends you force a full KB load to correct the issue.

**Expected Row Count**

This column displays the number of rows in the corresponding table, based on the KnowledgeBase extract.

**Import Date**
This is the date and time on which data was last imported (loaded) to the corresponding KnowledgeBase table. If you loaded a full KnowledgeBase, this import date should be the same for all tables. However, if you loaded updates, the import date for some tables could vary. (This is because an update only loads data that has changed since the last update and ignores data tables that have no changes.)

**Table Version**

This column displays the date on which the corresponding table was last updated with KnowledgeBase data. For example, if the ADD_ON table hasn’t been updated since the release on January 1, 2019 it would retain a value of 2019-01-01.

**Modifying the KnowledgeBase**

The records in the KnowledgeBase contain parameters and coding relationships for billing codes, which create the foundation for claim analysis. You can customize the records to fit your organization’s needs.

Generally, there are four ways you can modify data in the KnowledgeBase:

1. Add Records and set parameters to make Claims Edit System flag your custom codes properly.
2. Override Records to create a custom record that modifies system parameters for individual codes and changes how these codes are flagged. When you create overrides, the system or inherited record you select is not changed. Rather, your override is a copy of the selected record that you modify and then enable so that the system uses your record instead of the original system or inherited record. For more information, refer to the **Overrides** section.
3. Enable negative relationship records for specific codes to prevent them from triggering flags. A negative relationship record is one that, if found in a table, is considered invalid (e.g., unbundle codes that cannot be billed together).
4. Disable positive relationship records for specific codes to trigger flags. A positive relationship record is one that, if found in a table, is considered valid (e.g., Appropriate Modifier). If you turn off (disable) a modifier under the appropriate modifier tab, the system flags any claims from that patient because they “do not exist” in the table (they are turned off).

For steps to modify the KnowledgeBase, refer to the **Working with Codes** section.

New KnowledgeBase versions often reclassify deleted codes and update existing codes, descriptions, and edits. Code definitions, instructions, and guidelines from the AMA, Medicare and physician specialty organizations, and specialized clinical knowledge from Optum all influence the establishment and maintenance of the coding relationships found in the KnowledgeBase.
Lists and Codes in the KnowledgeBase

Claims Edit System delivers a variety of code tables, system lists, and validation lists for your use. While the system and code lists help you ensure the integrity of your business data and provide clinically accurate codes for your claims, validation lists are included for you to populate yourself.

For more information about the other types of codes and their attributes, select:

- **Procedure Codes**
- **Diagnosis Codes**
- **Modifiers**

For steps to add, find, change or delete codes, refer to the Working with Codes section.

For information about Procedure code combinations (unbundle, typical diagnosis, valid POS, and so forth) refer to the Procedure Code Relationships section.

Refer to the System Lists and Crosswalks section for steps to work with the pre-populated lists and crosswalks in your system.

Code Repository

Claims Edit System groups all activities related to the codes used on your claims under the Code Repository. This provides easy-to-find lists of the most important data. It also helps you ensure the accuracy of the claims within your system by giving you a central location from which you can create overrides or add applicable codes and code relationships.

In the Code Repository you can find lists of appropriate Procedures, Diagnoses, and Modifiers, as well as their descriptions. This information helps you identify and manage the proper coding relationships, such as procedure to diagnosis relationships, modifiers, anesthesia crosswalks, and unbundled codes by providing tables of valid or properly recognized codes to use in your claims.

The lists available to you and any crosswalks that you create are managed here as well. Similarly, RVU codes (Relative Value Units) are accessed within the Code Repository. Additionally, in the Code Repository you can access tools for provider management, code relationships, CCI and Medicare Physician Fee Schedule.

Optum delivers this information to you in several KnowledgeBase tables. The system may flag any codes or combination of items that are not included in these tables. For example, Claims Edit System may flag current codes and modifiers as “invalid” if you are using an older version of the KnowledgeBase.
Within each of the types of data in the code repository, you have the ability to override default or custom settings, view either system or custom disclosure, change status, and add and remove codes and data as necessary.

**Accessing the Code Repository**

The Code Repository is located on the Control Panel, on the first level after you access the interface. It provides the lists of valid data and is a central location from which to customize your relationships and data.

**To Access the Code Repository:**

1. Log in to the Claims Edit System interface. For more information on logging in and creating users, refer to the [Security](#) section.

   The system displays the Main Menu.

2. Select the [Professional](#) icon to access your system.

3. Select the appropriate enterprise if you have more than one. For more information, refer to the [Enterprises](#) section.

4. Select **Code Repository**.

**Procedure Codes**

When Claims Edit System analyzes a claim, it looks at the codes on the claim and their relationship to each other and identifies valid relationships between acknowledged procedure codes and applicable diagnosis codes.

The Procedure code table contains valid procedure codes (CPT codes and HCPCS Level II codes) for the current year and the previous two years. During claims analysis, the system flags any invalid codes on your claims. An invalid procedure code is any code that is not listed in the Procedures table.

The information in the Procedure table may also trigger procedure-specific flags for surgical assistant, multiple procedure reduction, inappropriate gender, maximum allowed frequency per day, global follow-up days, place of service and patient age, among others.

You can add new codes needed for your organization, change the effective and expiration dates on a code relationship, or change codes and their relationships by creating an override through the Code Repository. You can also delete any codes you have previously created or inherited from your parent Enterprise.
To View Procedure Code Information:

If the code you need is already in the system, you can find it using the selection criteria that displays when you access procedures.

1. Follow the steps to Accessing the Code Repository.
2. Select Procedures.
3. Enter the applicable search criteria in the Search Dialog at the top of the table. The fields available for this are as follows:

   **Code**
   
   In this field, enter the valid CPT/HCPCS codes.

   **Description**
   
   In this field, enter the standard abbreviated description for the desired procedure code.

   **Override**
   
   In this field, indicate whether the code has an override.

   **Category**
   
   This field identifies the code as a CPT or as a HCPCS code. When you add a code, you can choose the appropriate type from the dropdown menu.

   **Sub Category**
   
   This field shows more information about the category the code is in. There are four sub-categories:

   1. **Anesthesia**
   2. **Category II**
   3. **Category III**
   4. **E/M for Evaluation and Management**

4. When you finish selecting criteria, select **Find**.

   The system displays a list of code(s) matching your search criteria.

5. From the list of codes, select the link to the procedure.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001E</td>
<td><strong>BLOOD PRESSURE, MEASURED</strong></td>
<td>HCPCS</td>
</tr>
<tr>
<td>0001</td>
<td><strong>ENDOVAS REPR ASST AC ANE</strong></td>
<td>HCPCS</td>
</tr>
</tbody>
</table>
The system then displays the details for that procedure code.

For more information about specific procedures and code sets, refer to the latest KnowledgeBase Edit Rationale documentation. This documentation is available at http://optum.force.com/CustomerPortal.

To access, add, find, delete, or make changes to the Procedure Codes or their attributes, refer to the Working with codes section.

To work with codes that are related to a specific procedure, such as Pay and Deny codes (unbundle), appropriate modifiers, valid POS and others refer to the Procedure code relationships section.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

Procedure Code Relationships

A procedure code may have several different groups of codes that are combined to form a complete picture of the care a patient receives. These codes add detail to the basic procedure code that may affect payment. Therefore, the KnowledgeBase provides various clinically accurate groups of codes for use in verifying your claim data.

Some of these groups of codes are allowed (appropriate) to be billed with a given procedure and some are not allowed (inappropriate). Some codes, when combined with the procedure, may be paid instead of the procedure itself while others may be denied by insurance companies if the procedure is paid.

Since your organization has its own policies and procedures surrounding which code relationships you may allow and which you may deny, you can remove existing codes, add your own codes, or override (change) code groupings yourself. For steps on how to do this, refer to the Modifying code relationships section.

Once you access a specific procedure code, you can work with the various groups by using the tabs at the top of the screen.

Generic fields that display for selected items

The following are descriptions of the various fields that may display as you work with different types of code combinations. These fields vary, depending on the properties of the code you select.

Effective/Expiration Dates
These fields show the effective and expiration dates for the procedure.

**Origin**

This field contains the name of the Enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the enterprise you are in and its children. For more information, refer to the [Overrides](#) section.

**Status**

This field indicates whether the code is currently Enabled (turned on) or Disabled (turned off).

**Basic Attributes**

When you first open a procedure code, the Attributes tab displays (by default). This tab may contain the following fields of information (depending on which procedure code you select):

| Note | Although there are many attribute fields listed below, it is unlikely that any individual procedure code will contain all of them. Most procedure codes will contain only a select few, and this will vary depending on which procedure you are working with. Thus, the following is a list of all possible attributes. |

- **Valid Age**

  This field contains the age range that is appropriate for this procedure. If the procedure is not specific, the range will be between 0-124. Claims containing an age-specific code will be flagged if the age on the claim is not within the correct range.

- **Inappropriate Gender**

  This field is checked by the system rules and identifies the gender that is not appropriate for the procedure. If the procedure is appropriate for either gender, this field will be empty. If the system finds a procedure on the claim with the wrong gender listed, a flag will be raised during processing.

- **Follow Up Days**

  This field identifies the appropriate number of follow-up days incorporated into the “surgical package.” Separate reimbursement claims analyzed within the number of allowed follow-up days (i.e., the global follow-up period) will be flagged with the appropriate global period mnemonic.

- **Maximum Frequency Per Day**
This field lists the maximum number of services that are allowed in one day for a given procedure code. Claims processed with a CPT code that has reached the maximum number allowed will be flagged with the mnemonic.

**Important!** When a procedure code has no value in this field (i.e., the field is blank), the system will not insert a default value. Rather, the system assumes Maximum Frequency per Day (MFD) does not apply in this case, and therefore MFD will not be considered when processing rules.

**Multiple Procedure Reduction**

This field indicates when a procedure qualifies for a reduced reimbursement when billed with multiple procedures containing MPR (Multiple Procedure Reduction) modifiers. The system raises a flag when multiple procedures are listed with one or more of them set as eligible for reduction and at least one appropriate MPR modifier is also included on a processed claim.

**Prior Approval**

This field indicates that this procedure requires prior approval.

**Surgical Assistant Required**

This field identifies that the procedure will not be reimbursed when it is billed with the surgical assistant modifiers (-80, -81, -82, and AS). Claims containing a procedure code with this option will be flagged and the accompanying modifier will also be flagged during analysis.

**Unlisted**

This field indicates that this procedure code requires documentation. The system will flag an unlisted procedure code on the claim results and the claim line status will be set to AD - Analyzed, needs documentation (15000 - 19999).

**Medically Unlikely Edit (MUE)**

This field indicates whether the procedure code has an MUE value in the KnowledgeBase. The related MUE value indicates the maximum number of units for the code that may be billed on a claim (as determined by CMS).

**Medicare Medically Unlikely Edit (mMUE)**
This field indicates whether the procedure code has an mMUE value in the KnowledgeBase. The related mMUE value indicates the maximum number of units for the code that may be billed on a Medicare claim (as determined by CMS).

In addition to the Attributes tab, each code also displays the following tabs of information:

- **Unbundle codes** (Pay and Deny Codes)
- **Typical Diagnosis**
- **Appropriate modifiers**
- **Add-On codes**
- **Transfer codes**
- **Valid POS**
- **Anesthesia crosswalk**
- **Modifier 26**
- **Medicare Unbundle** (NOTE: The information on this tab works the same as with the standard unbundle codes, except it applies to Medicare.)

For more information about specific procedures and their related codes, refer to the latest KnowledgeBase Edit Rationale documentation available at http://optum.force.com/CustomerPortal.

Refer to the **Overrides** section for more information about what you can and should change within a procedure.

Refer to the **Enterprises** section for more information about what your changes apply to.

**Unbundle**

The unbundle functionality in Claims Edit System identifies procedure codes that should not be billed together by the same provider for the same date of service, provider, and patient.

When a claim is processed, each CPT code on the claim is compared to all the other codes on the claim to determine if any of the codes should not be billed together (Deny codes).

Refer to the latest KnowledgeBase Edit Rationale documentation for more information about specific procedures and code sets. This documentation is available at http://optum.force.com/CustomerPortal.

You can access the Pay and Deny codes for each procedure to view which ones are delivered to you by default. If you want, you can add, remove or override the Pay and Deny codes associated with a particular procedure. Refer to the **Modifying Code Relationships** section for steps on how to add, find, override, set the scope for or remove a code from a code relationship.
Deny Codes

Each record in the Deny codes section contains a procedure code that will not be paid when submitted on the same claim as the selected procedure code. If any codes on the Deny list are submitted with the selected Procedure, the Procedure code itself would be paid, but any codes on the list below would be denied. This is indicated by the (deny code) indicator next to the code name at the top of the screen.

Pay Codes

Conversely, each record in the pay codes section contains a code that can be successfully submitted and paid with the selected procedure code. If any of the codes on the Pay list were submitted with a particular procedure, the procedure code itself would be denied payment, but any codes on the list below would be paid. This is indicated by the (pay code) indicator next to the code name at the top of the screen.

If you want to add additional codes that should have payment denied if they are billed with a procedure code you can do so. If you want to change (override) or remove a code from the list, you can do that also.

Deny and Pay Code Fields

When you add or override a code, the following fields are available to you:

Deny/Pay Code

This field contains the code abbreviation identifying the code being added or changed.

Unbundle Type

This field contains one of three types designating the relationship that the code has with the primary procedure code:

Unbundle - These procedures are the basic steps necessary to complete the primary procedure. They are included in the reimbursement of the primary procedure.

Incidental - These procedures can be included with the primary procedure, but they are not essential to complete the primary procedure. They are not separately reimbursable when performed with the primary procedure.

Exclusive - These procedures are mutually exclusive of the primary procedure (i.e., they cannot be submitted together). Only one of two mutually exclusive procedures are allowed.

Modifier Override List

This field contains the type of modifier that could suppress (stop) the unbundle flag if appended (added to the code). There are five of these:
Specific Bilat/Digit - These modifiers indicate that more than one extremity, digit, eyelid or other bilateral structure is involved, or that a different location (site), separate incision or injury is involved as a separate and distinct service on the same day.

Distinct Service - These modifiers identify that a service or services was performed on separate lesions/sites/injuries or at a separate session.

Lab - These modifiers indicate that both the procedures will be allowed if certain modifiers are added to the procedure code to indicate that a repeat or distinct lab test was performed on the same day.

E/M - These modifiers indicate that both of the procedures will be allowed if certain modifiers are added to the submitted E/M code.

None - There is no modifier associated with this code that will override, or change, the unbundle relationship.

**Effective Date**

This field contains the date when the code relationship becomes active.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Status**

This field contains the disposition of the code. The code you add or change will be either Enabled (turned on) or Disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. Refer to the Disclosure section for more information.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

This field contains the name of the enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the enterprise you are in and its children. Refer to the Overrides section for more information.

**Scope**
This field contains the name of the enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying code relationships section for more information about specifying the scope.

Refer to the Working with codes section for more information about adding, finding, changing or removing procedure, diagnosis and modifier codes.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

**Medicare Unbundle**

In addition to the Pay and Deny Code tabs (for commercial unbundle relationships), some procedures also have a Medicare Unbundle tab.

The settings you enter on this tab apply to the system Medicare Unbundle Rule. This rule verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicare. If there is another procedure in the patient’s history that should not be billed with the current line’s procedure code, the system fires the respective Medicare Unbundle flag (i.e., mUB or mUM).

If you want to add additional codes that should have payment denied if they are billed with a procedure code, you can do so. If you want to change (override) or remove a code from the list, you can do that also.

**Medicare Unbundle Code Fields**

When you add or override a code, the following fields are available:

*From - To*

These fields contains the range of codes being added or changed.

*Unbundle Type*

This field contains one of three types designating the relationship that the code has with the primary procedure code:

Unbundle - These procedures are the basic steps necessary to complete the primary procedure. They are included in the reimbursement of the primary procedure.

Incidental - These procedures can be included with the primary procedure, but they are not essential to complete the primary procedure. They are not separately reimbursable when performed with the primary procedure.
Exclusive - These procedures are mutually exclusive of the primary procedure (i.e., they cannot be submitted together). Only one of two mutually exclusive procedures are allowed.

**Code Type**

This field contains one of two types designating if the code being added is to be a pay or deny code related to the primary procedure code.

**Modifiers**

This field contains the modifiers that can override the unbundle relationship. Individual or multiple modifiers can be added in this field. If multiple modifiers can override the relationship, they can be entered with a comma separating them.

**Effective Date**

This field contains the date when the code relationship becomes active. There is a Calendar Lookup available for this field.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Status**

This field contains the disposition of the code. The code you add or change will be either Enabled (turned on) or Disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure source and disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. Refer to the Disclosure section for more information.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

This field contains the name of the enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the enterprise you are in and its children. Refer to the Overrides section for more information.

**Scope**
This field contains the name of the enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying Code Relationships section for more information about specifying the scope.

**Appropriate Modifiers**

Claims Edit System provides a code relationship that determines if the modifiers listed on the claim with the submitted CPT/HCPCS code are valid to be billed with that procedure. This list contains frequently used modifier codes for a specific procedure. During claims processing the system uses this code relationship to determine whether a procedure code on a claim corresponds accurately to any listed modifiers on the claim.


If a code in the appropriate modifier table for a given procedure is found on a claim with that procedure, the system will deem the code appropriate (valid) and will not flag the code. If a modifier code is not listed in the table for a particular procedure, the system will flag that modifier as invalid or inappropriate.

Claims Edit System gives you the ability to add, override or remove modifiers that you have added to this table at any time. Once you have changed (overridden) a modifier, you can create a custom disclosure statement for your change. For steps on how to add, find, override, set the scope for or remove a code from a code relationship, refer to the Modifying a code relationship section.

For more information about the Origin, Scope, or Disclosure fields, refer to the Procedure code relationships section.

The fields available to you when you add or override a modifier are:

* **Modifier Code**
  
 Contains the code abbreviation identifying the code being added or changed.

* **Type**
  
 Indicates whether the code relationship applies to Commercial or Medicare claims.

* **Effective Date**
  
 Contains the date when the code relationship becomes active.

* **Expiration Date**
  
 Contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

* **Status**
Contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. Refer to the Disclosure section for more information.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

Contains the name of the enterprise that this setting was inherited from. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the enterprise you are in and its children. Refer to the Overrides section for more information.

**Scope**

Contains the name of the enterprise or specific ruleset to which this setting applies. If you add or override a record you can specify what your change applies to. Refer to the Modifying a code relationship section for more information about specifying the scope.

Refer to the Working with codes section for more information about adding, finding, changing, or removing procedure, diagnosis, and modifier codes.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

**Transfer**

The Transfer functionality in Claims Edit System provides the ability to see procedure codes that, when billed together with other procedure codes, should transfer to a more appropriate code procedure.

If inappropriate code combinations are found on the claim, they will be automatically transferred to the correct codes. When a claim is processed, each procedure code on the claim is compared to all the other procedure codes on the claim to determine if the codes should be combined into another procedure (Transferred).

You can access the transfer codes for each procedure to view which combinations are delivered to you by default. To maintain the integrity of the system’s claim analysis process, the Transfer table and the process of transferring codes to other valid ones cannot be modified in the Code Repository (KnowledgeBase).
Transfer is a system-defined option; you cannot add a new record or assign it to transfer. However, you can access the transfer tab for each procedure to see the transfers that are delivered to you by default. For information about the transfer code relationship, refer to the Modifying a code relationship section.

For more information about the Origin and Disclosure fields, refer to the Procedure code relationships section.

Refer to the latest KnowledgeBase Edit Rationale documentation for more information about specific procedures and code sets. This documentation is available at http://optum.force.com/CustomerPortal.

For steps on how to add, find, override, set the scope for, or remove a code from other code relationships, refer to the Modifying a code relationship section.

For more information about adding, finding, changing, or removing Procedure, Diagnosis, and Modifier codes, refer to the Working with codes section.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

**Typical Diagnosis**

Claims Edit System provides you with a Typical Diagnosis (Procedure to Diagnosis) code combination that contains a list of valid diagnosis codes for a given Procedure code. This list is designed to contain frequently assigned diagnosis codes for a specific procedure.

During claims processing the system uses this code relationship to determine whether a procedure code on a claim corresponds accurately to any listed diagnosis codes on the claim. If a code in the typical diagnosis table for a given procedure is found on a claim with that procedure, the system will deem the code appropriate (valid) and will not flag the diagnosis code.

For more information about specific procedures and code sets, refer to the latest KnowledgeBase Edit Rationale documentation available at http://optum.force.com/CustomerPortal.

Claims Edit System gives you the ability to add, override, or remove diagnosis codes that you have added to this table at any time. Once you have changed (overridden) a diagnosis code, you can create a custom disclosure statement for your change. Refer to the Modifying Code Relationships section for information about how to add, find, change, set the scope for or remove codes in this relationship.

Refer to the Procedure Code Relationships section for more information on the Origin, Scope, or Disclosure fields.

The fields available to you when you add or override a diagnosis code are:

*Diagnosis Code/Range (Dx)*
These fields (From and To) contain the range of codes being added or changed.

**Code Type**

In this field, indicate whether the associated codes are ICD-9 codes or ICD-10 codes.

**Allow All?**

In this field, indicate whether you want all codes of the type specified (ICD-9 or ICD-10) to apply under broad diagnostic. Setting this to Yes negates the individual relationship and applies broad diagnostic.

**Effective Date**

This field contains the date when the code relationship becomes active.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Status**

This field contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. For more information, refer to the Disclosure section.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

This field contains the name of the Enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the Enterprise you are in and its children. Refer to the Overrides section for more information.

**Scope**

This field contains the name of the Enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying Code Relationships section for more information about specifying scope.
Refer to the Working with Codes section for information about working with the Procedures, Diagnosis and Modifiers themselves.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

Add-on codes

The add-on functionality in Claims Edit System identifies CPT/HCPCS codes that are identified as add-on procedures. An add-on procedure code should not be billed as a stand-alone procedure; it is reported in addition to the primary procedure.

When a claim is processed, each CPT code on the claim is compared to all the other codes on the claim to determine that all the codes can be billed together.

For more information about specific procedures and code sets, refer to the latest KnowledgeBase Edit Rationale documentation. Existing customers can access this documentation at http://optum.force.com/CustomerPortal.

You can access the Add-On codes for each procedure to view which ones are delivered to you by default. If you wish, you can add, remove or override the Add-On codes associated with a particular procedure. Refer to the Modifying code relationships section for steps to work with Add-On codes.

Refer to the Procedure Code Relationships section for more information on the Origin, Scope, or Disclosure fields.

The fields available to you when you add or override an Add-On code are:

**Code**

This field contains the code abbreviation identifying the code being added or changed.

**Type**

The type of the code that is being added in relation to the Procedure code that has been accessed.

- **Add-On** codes are those that can be billed in addition (Added-On) to the Primary Procedure code that you have accessed (displayed at the top of the screen).

- **Primary** codes are those that are the Primary Procedure in relation to the Add-on code that you have accessed (displayed at the top of the screen).

**AMA Indicator**

You can choose your new code from three types:
AMA - codes that the American Medical Association recognizes as being valid to be billed with the selected Procedure.

Ingenix - codes that Optum provides as valid to be billed with the selected Procedure.

Medicare Exception - codes that Medicare recognizes as being valid to be billed with the selected Procedure.

Effective

This field contains the date when the code relationship becomes active.

Expiration

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

Status

This field contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

Disclosure

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. Refer to the Disclosure section for more information.

In addition to these fields, the following fields may also display for items on the list:

Origin

This field contains the name of the Enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the Enterprise you are in and its children. Refer to the Overrides section for more information.

Scope

This field contains the name of the Enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying Code Relationships section for more information about specifying scope.

Refer to the Working with Codes section for more information about adding, finding, changing or removing Procedure, Diagnosis and Modifier codes.
Refer to the **Overrides** section for more information about what you can and should change.

Refer to the **Enterprises** section for more information about what your changes apply to.

**Valid POS**

The Valid POS (Place of Service) code relationship table contains valid CMS two-digit POS codes that are used by Claims Edit System to check that the procedure and the place it is performed are “typical” or expected.

If a procedure is billed with an unusual POS code, the system will flag this relationship. If you have specific places of service where certain services are performed, you can add these here.

Refer to the latest KnowledgeBase Edit Rationale documentation for more information about specific procedures and code sets. This documentation is available at [http://optum.force.com/CustomerPortal](http://optum.force.com/CustomerPortal).

You can access the Valid POS codes for each procedure to view which ones are delivered to you by default. If you want, you can add, remove or override the POS codes associated with a particular procedure. Refer to the **Modifying Code Relationships** section for more information about how to do this.

You can also look up valid POS codes using the column header link on the claim line section of the claim when you are entering claims manually.

Refer to the **Procedure Code Relationships** section for more information about the Origin, Scope, or Disclosure fields.

The fields available to you when you add or override a code are:

**Place of Service**

This field contains the name of the code being added or changed.

**Allow All?**

In this field, indicate whether you want the code to apply under broad diagnostic. Setting this to Yes negates the individual relationship and applies broad diagnostic.

**Effective Date**

This field contains the date when the code relationship becomes active.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Status**
This field contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. Refer to the Disclosure section for more information.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

This field contains the name of the Enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the Enterprise you are in and its children. Refer to the Overrides section for more information.

**Scope**

This field contains the name of the Enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying Code Relationships section for more information about specifying the scope.

Refer to the Working with Codes section for more information about adding, finding, changing or removing Procedure, Diagnosis and Modifier codes.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

**Anesthesia crosswalk**

The anesthesia code relationship in Claims Edit System identifies anesthesia codes that should be billed in place of a Surgical Procedure Code.

The system uses the Anesthesia Crosswalk table when the claim lists the provider’s specialty as anesthesiology and the submitted procedure code is not a designated anesthesia code.

For more information about specific procedures and code sets, refer to the latest KnowledgeBase Edit Rationale documentation. This documentation is available at [http://optum.force.com/CustomerPortal](http://optum.force.com/CustomerPortal).

You can access the valid Anesthesia codes that should replace each Surgical Procedure to view which ones are delivered to you by default. If you wish, you can add, remove, or override the Anesthesia codes for a
particular procedure. For steps on how to add, find, override, set the scope for or remove a code from a code relationship, refer to the Modifying Code Relationships section.

The fields available to you when you add or override an Anesthesia code are:

**Anesthesia Code**

This field contains the code abbreviation identifying the anesthesia code that is cross-walked to the procedure code you are in (identified by the heading on the screen).

**Relationship Type**

You can choose from three types of relationships:

- **By Report** - This type identifies anesthesia cross-codes that are not readily available due to the nature of the CPT code description. These codes cannot automatically replace (cross-walk) to the procedure code because the submitted surgical procedure does not usually require anesthesia or the surgical CPT code is a “by report” procedure. Most unlisted codes and subsidiary codes are included in this category. This type of code must by reviewed and the appropriate anesthesia code entered manually to replace the surgical CPT code.

- **Direct Crosswalk** - A surgical CPT code with a Direct Cross-code Match status crosswalked to a single, appropriate anesthesia code. When billed by an anesthesiologist or CRNA, the surgical code is replaced by the matching anesthesia code. A flag is generated during analysis to indicate that the submitted CPT surgical code was matched to the appropriate anesthesia cross-code.

- **Individual Consideration** - A CPT code with Individual Consideration status has two or more possible anesthesia cross-codes listed in the KnowledgeBase. When an analyzed claim contains a CPT code with this status, and the provider’s specialty is anesthesiology, a flag is generated. If a flag is raised this means that you may need to manually review and replace the surgical CPT code with the appropriate anesthesia code.

**Effective Date**

This field contains the date when the code relationship becomes active.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Status**

This field contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

**Disclosure**
These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. For more information, refer to the Disclosure section.

The following fields may also display for items on the list:

Origin

This field contains the name of the Enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the Enterprise you are in and its children. For more information, refer to the Overrides section.

Scope

This field contains the name of the Enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying Code Relationships section for more information on specifying the scope.

Refer to the Working with Codes section for more information about adding, finding, changing, or removing Procedure, Diagnosis and Modifier codes.

Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

Modifier 26

The Modifier 26 code relationship in Claims Edit System identifies POS (Place of Service) codes that require a modifier -26.

The POS field contains a valid POS code representing the location where both a professional (e.g., exam by a provider) and a technical (e.g., laboratory work) component are performed on a patient. These POS codes require a Modifier -26 for procedures with a TC/PC (Technical Component/Professional Component) split.

For more information on specific codes represented by these values, refer to the POS section of the latest KnowledgeBase Edit Rationale documentation. This documentation is available at http://optum.force.com/CustomerPortal.

The fields available when you add or override a code are:

POS for which Modifier 26 is Required
This field contains the name of the code being added or changed. The system uses these names to make sure the correct POS is combined with Modifier 26.

**Effective Date**

This field contains the date when the code relationship becomes active. There is a [Calendar Lookup](#) for this field.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship. There is a [Calendar Lookup](#) for this field.

**Status**

This field contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. Refer to the Disclosure section for more information.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

This field contains the name of the Enterprise from which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the Enterprise you are in and its children. Refer to the Overides section for more information.

**Scope**

This field contains the name of the Enterprise or specific ruleset to which this setting applies. If you add or override a record, you can specify what your change applies to. Refer to the Modifying Code Relationships section for more information on specifying scope.

Refer to the Working with Codes section for more information about adding, finding, changing or removing Procedure, Diagnosis and Modifier codes.

Refer to the Overides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.
Diagnosis Codes

The list of diagnosis codes contains all the ICD-9-CM\(^1\) codes or ICD-10-CM\(^2\) codes for the current year and the past two years. Any diagnosis codes listed on claims are compared with and validated by the records on this list.

This list also provides information that indicates if the code requires additional characters (i.e., a fourth, fifth, sixth, or seventh digit). These extra characters on the diagnosis code allow you to include specific codes on your claims. Diagnosis codes with four to seven characters have an assumed decimal point after the third character. Multiple codes on the claim are separated by commas, with the first one being the most significant.

When an analyzed claim contains a diagnosis code that is not in the Diagnosis code list, the ICD flag is fired and displayed in the claim results. By adding codes to this table, you can specify which codes will receive an ICD flag during processing. You can add, find, edit and delete diagnosis codes, and apply changes to the enterprise you are in and all of its children.

Fields

When you add a code, the fields available to you are:

* **Code**

  This is the mnemonic of the diagnosis code. This field is used to validate the diagnosis code on a claim. If a code is not on this list, it is not valid, and a flag will be raised. Refer to the [Working with codes](#) section for steps to add or override codes.

* **Code Type**

  This column indicates whether the code is an ICD-9-CM code or an ICD-10-CM code.

* **Description**

  This column lists the standard abbreviated diagnosis code descriptions.

---

\(^1\)International Classification of Diseases (ICD), Ninth revision (-9), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval.

\(^2\)International Classification of Diseases (ICD), Tenth revision (-10), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval. These codes allow more specific reporting of diseases and patient conditions.
Attributes (Tab)

This section contains the basic attributes that apply to the diagnosis. Refer to the Working with codes section for information about how to add, override, or remove attributes. The following attributes are available:

**Age**

This field contains the appropriate age range for the diagnosis code - listed in years and months.

**Inappropriate Gender**

This field shows inappropriate gender if the correct gender is not selected on the claim.

**Incomplete**

This option is for ICD diagnosis codes that require a 4th, 5th, 6th, or 7th character/digit to be considered acceptable for analysis. Turning on this option allows the system to accept extra digits on the submitted codes to make the diagnosis as specific as possible.

**Prior to version 4.8, this attribute said Missing 4th/5th digit (when it only applied to ICD-9 diagnosis codes). The name was changed to account for the fact that the system now processes ICD-10 diagnosis codes that are missing the 4th through 7th characters/digits.**

**Note**

This field indicates that the code cannot be billed in the primary position on the claim line.

**Third Party Liability**

This field is checked by the third-party liability rule, which identifies codes that could involve third-party liability and/or subrogation (substitution) of benefits. When that is the case, Claims Edit System will display the mnemonic “TPL” in the claim results.

**Primary Diagnosis Only**

Primary Diagnosis Only (PDO) is a Data-Driven Rule for ICD-10 editing. This edit is used to identify ICD-10 diagnosis codes that may only be used as first-listed or in the primary diagnosis position. For further details on the new Data-Driven rule, refer to the July 2015 Documentation of Edit Rationale located at http://optum.force.com/CustomerPortal. The PDO is a Professional-only rule.
Inappropriate Modifiers (Tab)

This tab contains a list of modifiers considered inappropriate for the diagnosis. Refer to the Working with codes section for information about how to add, override or remove items on this tab. The following fields apply when working on this tab:

**Modifier Code**

This field contains the code abbreviation identifying the code being added or changed.

**Effective Date**

This field contains the date when the code relationship becomes active.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Status**

This field contains the disposition of the code. The code you add or change will either be enabled (turned on) or disabled (turned off) and reserved for future use.

**Disclosure**

These fields contain the disclosure statement associated with this code relationship. When you create an override, the system no longer associates the code relationship with the system disclosure statement. You have the opportunity to specify your own disclosure when you create the override. For more information, refer to the Disclosure section.

In addition to these fields, the following fields may also display for items on the list:

**Origin**

This field contains the name of the enterprise form which this setting was inherited. System records that have been inherited cannot be accessed or modified, but you can create an override for any system setting. Be aware that any override you create is valid only for the enterprise you are in and its children. Refer to theOverrides section for more information.

For more information about specific diagnoses and code sets, refer to the latest KnowledgeBase Edit Rationale documentation available at http://optum.force.com/CustomerPortal.

Refer to the Working with codes section to access, add, find, delete, or make changes to the Diagnosis Codes in your system.
Refer to the Overrides section for more information about what you can and should change.

Refer to the Enterprises section for more information about what your changes apply to.

Modifiers

Modifiers are alphanumeric indicators (from two to five digits in length) that provide more detail about reported CPT and HCPCS codes. They add information to the basic Procedure code reported on a claim.

Depending on what they are, modifiers may alter or change the service that is reported.

The Modifier list in the Code Repository contains valid CPT/HCPCS modifiers for the current year and the previous two years. Claims Edit System will flag CPT/HCPCS modifiers that are not listed in this table. Multiple modifiers on a claim are separated by commas.

The fields here are:

**Code**

This is the modifier. This field is used to validate the modifier submitted on a claim. If a code is not on this list, it is not valid and a flag will be raised. Refer to the Working with Codes section for steps to add or change dates and status of codes.

**Description**

This field contains the standard abbreviated description for each procedure that the modifier applies to.

**Category**

This field identifies whether the procedure that this modifier applies to is a CPT or a HCPCS code.

CPT modifiers are used to indicate that a service or procedure was altered by special circumstances, but was still correct in its definition or code. CPT modifiers can be reported as a two-digit code (e.g., -21). Refer to the Guidelines topic in each section of the current CPT reference book for commonly used CPT Modifiers.

HCPCS modifiers are Level II National Modifiers developed by CMS. Modifiers in this category may be added to either Level I or Level II codes.

**Sub-Category**

This field contains additional information about the modifier itself. For example, the sub-category might distinguish whether the modifier is Ambulance or a Pet Scan.
**Ambulance** - These sub-category modifiers are two-digit modifiers created by combining two single-digit modifiers for the origin and destination of ambulance transport. The first digit indicates the patient pickup location and the second digit indicates the drop-off location.

**Pet Scan** - This modifier is a two-digit code that indicates the results of a current PET scan and a previous test.

| Note | PET Scan modifiers are listed in the KnowledgeBase as two-character codes (e.g., EP, SP, etc.). If you were to examine the list of all the modifiers you may see some instances where one modifier can have different meanings. For example, EP can refer to the HCPCS “Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program” modifier. EP can also refer to PET scan “Equivocal/Positive” modifier. In these cases the descriptions of both codes are listed together in the list. |

Refer to the latest KnowledgeBase Edit Rationale documentation for more information about specific procedures and code sets. This documentation is available at [http://optum.force.com/CustomerPortal](http://optum.force.com/CustomerPortal).

Refer to the [Working with Codes](#) section for information on how to add, find, change, or delete codes in this table.

Refer to the [Appropriate Modifiers](#) section for more information about this code relationship.

Refer to the [Overrides](#) section for more information about what you can and should change.

Refer to the [Enterprises](#) section for more information about what your changes apply to.

**Modifying a Code Relationship**

This section contains steps to help you work with code relationships in Claims Edit System. You can access groups of codes that are related to a particular Procedure code and view and change relationships within that Procedure.

In Claims Edit System, you can also add, find, modify or delete Procedures, Diagnosis Codes and Modifiers. To work with these codes, refer to the [Working with Codes](#) section.

| Important! | Any changes that you make apply to the Enterprise you are in and any children of that enterprise. Refer to the [Enterprises](#) section for more information. |

After you create an override, you can add a custom disclosure to it.
Refer to the System Lists section to add, override, delete or make changes to the codes in System Lists.

This topic covers:

- Accessing a code relationship
- Adding a code relationship
- Finding a code relationship
- Changing dates for a code relationship
- Overriding a code relationship
- Defining the Scope for a code relationship
- Removing a code relationship

**Important!**

In the Claims Edit System interface, any gray record is a system or inherited record from a parent Enterprise that cannot be changed or deleted. White records are user-created and can be changed or deleted. Refer to the Enterprises section for more information about inherited records.

**Note**

For your convenience, you can also access existing codes and add new ones when you are working with your claims. Refer to the Lookups section for more information about how to do this.

**To Access a Code Relationship:**

There are two methods you can use to access a code relationship: a) using the Code Relationships icon, or b) using the icon for Procedures, Diagnosis, or Modifiers.

**Method 1 - Using the Code Relationships screen**

1. Follow the steps to Access the Code Repository.
2. Select the icon for Code Relationships.
3. Select the tab for the type of code with which you want to work. The options are Procedure Attributes, Anesthesia Cx, Diagnosis Attributes, Procedure to Modifier, Procedure to Diagnosis, Unbundle, or Place of Service.
4. Find the code you want in the list. You can use the search criteria at the top of the screen to find a specific procedure code (filter the list).
5. Select the Code link.
6. From here you can choose to add new codes, find specific ones, create overrides, or delete codes that you have created.

Method 2 - Directly Using a Procedure/Diagnosis/Modifier

1. Follow the steps to Access the Code Repository.
2. Select the icon for Procedures, Diagnosis, or Modifiers; depending on which type of code you want to work with.
3. Find the code you want in the list. You can use the search criteria at the top of the screen to find a specific procedure code (filter the list).
4. Select the Code link.
5. Select the Code link for that one. The system displays the Attributes screen. Refer to the Procedures, Diagnosis, or Modifiers topics for more information about these.
6. Select the applicable tab.

7. From here you can choose to add new codes, find specific ones, create overrides, or delete codes that you have created.

To Add a Code Relationship:

If a code your organization uses is not in the system code list, you can add it.

1. Follow the steps to Access a Code Relationship (above).
2. Select the Add button.
3. Enter the appropriate information to create your custom code. The system displays your new code in the table and it can now be used.

To Find a Code Relationship:

If the code you need is already in the system, you can find it using the search criteria at the top of each code list.
1. Follow the steps to Access a Code Relationship (above). The system displays all codes in the relationship.

2. Enter the applicable search criteria in the Search Dialog at the top of the table (e.g., Unbundle).

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching broader criteria.</td>
</tr>
</tbody>
</table>

3. Select Find. The system displays the code(s) for which you searched. Some search dialogs have ranges where appropriate. Simply enter the appropriate range to find a particular group of codes.

To Override a Code Relationship:

1. Follow the steps to Access a Code Relationship (above).

2. Select the checkbox next to the Code (abbreviation) you want to change.

3. Select Override. The system displays the Override window. For more information about the fields that you can change, refer to the description of each code type in the Procedure Code Relationships section.

4. Enter the changes you want to make. If the effective and expiration dates fields exist in the Override window, you can use a Calendar Lookup to choose these dates.

5. Make your changes and select Save.

To Define the Scope of a Code Relationship:

1. Follow the steps to Override a Code Relationship (above).

2. After you select Save the system displays the Define Scope screen.

3. Mark the box next to the ruleset(s) or Enterprise you want this change to apply to. For more information refer to the Enterprises section.

4. Select Complete Override. The system makes a copy of the original record and displays your override as white in the table. Since you created this override, you can change or delete it at any time.

Now that you have created your override, you can change the default disclosure associated with it. Refer to the Disclosure section for more information.
To Remove a Code Relationship:

1. Follow the steps to Access a Code Relationship (above).

2. Select the checkbox next to the code you want to remove from the relationship. You can only remove custom relationships. System and inherited records cannot be deleted. Refer to the Enterprises section for more information.

3. Select Remove. The system saves your change. Refer to the Disclosure section if you want to create a new disclosure statement for this override.

Working with Codes

As you set up your system or work with claims, you can add new Procedure, Diagnosis, or Modifier codes, find existing codes or delete any codes you have created in the KnowledgeBase (Code Repository) tables.

Additionally, you can access a particular Procedure code and view and change its relationships to other codes. To work with code relationships in a Procedure Code, refer to the Modifying a code relationship section.

| Important! | Any changes that you make apply to the Enterprise you are in and any children of that enterprise. Refer to the Enterprises section for more information. |

If you want to add a disclosure statement to an override you have already created, refer to the Disclosure section.

To find, add, override, or delete the codes in System Lists, refer to the System Lists section.

This topic covers:

- Accessing a code
- Adding a code
- Finding a code
- Changing dates for a code
- Deleting a code
- Overriding a code
To Access a Code:

Note: You can also access existing codes and add new ones when you are working with your claims. For more information on how to do this, refer to the Lookups section.

1. Follow the steps to Access the Code Repository.
2. Select the applicable icon for the type of code you want to access (Procedures, Diagnoses, etc.). The system displays the appropriate page.

Important! In the Claims Edit System interface, any gray record is a system or inherited record from a parent Enterprise that cannot be changed or deleted. White records are user-created and can be changed or deleted. For more information about inherited records, refer to the Enterprises section.

3. From here you can choose to add new codes, find specific ones, create overrides or delete codes that you have created.

To Add a Code:

If a code your organization uses is not in the system code list, you can add it.

1. Follow the steps to Access the Code Repository.
2. Select the applicable icon for the type of code you want to access (Procedures, Diagnoses, etc.).
3. Select the Add Code button.
4. Enter the appropriate information to create your custom code. If you need more information about each of the fields, go to:
   a. Procedures
   b. Diagnosis
   c. Modifiers
5. Select Save. The system displays your new code, which can now be used on claims, in the table.
To Find a Code:

If the code you need is already in the system, you can find it using the search criteria at the top of each code list.

1. Follow the steps to [Access the Code Repository](#).
2. Choose the type of record you want to find and select it (Procedures, Diagnoses, etc.). The system displays all codes in the list.
3. Enter the applicable search criteria in the Search Dialog at the top of the table.

   **Note**

   To aid your search, remember that the wildcard character % indicates that you want to search for "any number of characters." For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching broader criteria.

4. Select Find. The system displays the code(s) for which you searched. Some search dialogs have ranges where appropriate. Simply enter the appropriate range to find a particular group of codes.

To delete a code:

You cannot delete a system or inherited code (displayed in gray in the interface). If you need to change a user-defined (custom) code, follow the steps in this topic to either add a new code or override an existing code.

1. Follow the steps in the To Find a Code section (above).
2. Select the checkbox next to the Code name (abbreviation) you want to delete (e.g., Modifier - OA). You can only delete codes that have been created locally. System and inherited records cannot be deleted. Refer to the Enterprises section for more information.
3. Select Delete. The system deletes your list and displays the remaining codes on the appropriate page (Procedures, Diagnoses, or Modifiers).

To override attributes for a code:

1. Follow the steps in the To Find a Code section (above).
2. Select the Code (abbreviation) link you want to change.
3. Select the checkbox next to the Code name (abbreviation) you want to change.
4. Select Override. The Attributes of the code display.
5. Select the checkbox next to the value you want to override (e.g., Follow Up Days on Procedure 10060).
6. Select **Override**. The system displays the Override window.
7. Enter the changes that you want to make. If effective and expiration dates fields exist in the Override window, you can use a [Calendar Lookup](#) to choose these dates.
8. Make you changes and select **Save**.

**Overrides**

An override is a new copy of the existing record that you can change to meet your needs. This is important because you cannot change system records or code sets (clinically updated data) in any way. This ensures that the Claims Edit System core data retains its integrity. Optum is then able to provide you with the latest updates and changes because the data structure remains intact.

However, Claims Edit System provides the flexibility of an override functionality, which allows you to customize your data and code combinations. Any override you create is stored in the database. The system automatically checks to determine if any change (override) exists when processing a claim. You can override many items in the code repository, including any system list\(^1\), code set\(^2\), or record\(^3\). The system uses any override you create instead of the original data. The original data remains unchanged in case you need to use it again later. When you apply a new KnowledgeBase update, any overrides you have created are maintained.

Also, you can add (insert) new records specific to your organization into the KnowledgeBase. This gives you the ability to add data, records, and lists specific to your organization for claims processing. You have the ability to change or delete any record or code set that you have added yourself.

| Note | In the Claims Edit System interface, any gray record is a system or inherited record that cannot be changed or deleted. White or light blue records are user-created and can be changed or deleted. For more information about inherited records, refer to the [Enterprises](#) section. |

---

\(^1\)A list maintained by the Clinical Research and Development (CR&D) team and used for rule validation.

\(^2\)Medical code and the associated records (e.g., procedure code 71010 and the max frequency, gender, and age range associated with 71010).

\(^3\)The KnowledgeBase relationship that applies to a code set (e.g., procedure code and appropriate gender).
Important! Before analyzing claims, wait at least five minutes after creating or modifying an override. Otherwise, changes may not be recognized.

There are two statuses associated with overrides: enabled and disabled. Whenever you create an override (or a change) to a system or inherited record, you have the option to make your change active (enable it) or leave it turned off for future use (disable it). If you choose to enable your override, the system will use it in claims processing. If you choose to disable your override, it will not be used during claims analysis. If a disabled override is in place, not only will that override not be used during claims analysis, but the original system record will also be ignored. The same concept applies to making an override effective as well as expiring an override.

Overrides that you create have priorities. Make sure you are in the correct location in the system when you create your overrides. Any override you create applies to the current enterprise and any children of that enterprise. It may also be necessary for you to define a scope that your override will apply to. A scope can be either the entire enterprise or one or more rulesets associated with that enterprise.

For steps to create an override, or define the scope of an override, refer to the Working with codes section.

Claims Edit System will use the first applicable override that it finds, based on the following hierarchy:

1. Claims Edit System checks for a ruleset override within the current enterprise that is effective for the KB selection date specified in the ruleset.
2. If a ruleset Override is not found, the system checks for an enterprise override within the current enterprise that is effective for the KB selection date specified in the ruleset.
3. If an enterprise override is not found, Claims Edit System moves up one enterprise and repeats steps 1 and 2 until there are no enterprises above the current enterprise.
4. If no override is found, Claims Edit System will use the system record.

After you create an override, you can add a custom disclosure to it. Refer to the Disclosure section for more information about disclosure statements and steps to create one.

Disclosure

The Claims Edit System disclosure functionality allows you to modify the clinical rationale, or disclosure, associated with code combinations in the database. Using this functionality, you can find and edit the disclosure notes tied to individual attributes and code relationships. There is one active disclosure statement per relationship. Default disclosure statements are delivered from the KnowledgeBase for the following code-to-code combinations:
Unbundle (Pay and Deny) codes

Procedure attributes

Diagnosis attributes

Procedure to modifier (appropriate modifiers)

Procedure to Diagnosis (Typical Diagnosis)

Add-on codes

Transfer

Place of Service (Valid POS)

Anesthesia crosswalk

Claims Edit System allows you to access default disclosure statements associated with the procedure and diagnosis code attributes through the Code Repository.

Once you create an override, you can create a custom disclosure statement to take the place of any given default rationale in your system. You may choose to do this if the default disclosure statement associated with an inappropriate relationship is not specific enough for your organization. Additionally, you could create a disclosure statement for new codes or code relationships to indicate why the code is necessary and what organization, procedure, or policy establishes its validity.

There are two ways to access the disclosure module in Claims Edit System, from claim results or through the Code Repository. First, if you are looking at claim results and want to view the disclosure statement (Edit Rationale statement) for a particular edit, select the link (if present) in the Disclosure field on claim results. If there is no link, a disclosure statement does not currently exist in the system for that edit.

The other way to see disclosure is through the Code Relationship module of the interface. Follow the steps below if you want to access the disclosure from the Procedure or Diagnosis modules in the Code Repository.

**To create a custom disclosure statement:**

1. Follow the steps to create an override or navigate to the override with the disclosure statement you want to change.

2. Select the checkbox next to the attribute you have overridden.


4. Select the Disclosure Detail checkbox, enter your statement, and select Save.
System Lists and Crosswalks

Claims Edit System provides several system lists containing valid information that the system uses to process incoming claims.

A variety of system lists are sent to you in the Code Repository (KnowledgeBase). Some other lists delivered with the system are Global Procedure Codes, Type of Bill and Patient Status. You can use these lists as they are or make changes to them. You can also override them. In addition, with some of these lists you can import data from external files to populate the list. Refer to the Importing external data to a list section for more information.

You can modify these lists by adding new ones, overriding existing ones or removing lists that you have created. However, to maintain clinical integrity there are some limitations on what can be changed. Refer to the Overrides section for more information.

| Important! | When you create or modify any system list or crosswalk, make sure you wait at least five minutes before analyzing claims. Otherwise, the change may not be recognized by all of the system rules during analysis. |

To add a list:

| Important! | Any list added in a child enterprise will be visible in the parent enterprise as well. However, the data associated with the list will only be available in the child enterprise. Refer to the Parental hierarchy in enterprises section for details about enterprise relationships. |

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Lists and Crosswalks icon.
4. Add the name and description of your new list.
5. Enter information in the following fields:
   - Name of List
     Enter a name to identify the list.
Type of List

Choose the appropriate Type from the dropdown menu. The following options are valid:

- **Simple List**: Use this option for lists that contain a single value (or range of values) per item.
- **Association List**: Use this option for lists that map one value (or range of values) to another.

Category

Define the appropriate category for the list. The following options are valid:

- **Existing**: Select this option if you want to use a category that already exists in the system.
- **New**: Select this option if you want to define a new custom category (i.e., one that does not already exist in the system). Specify a name for your category in the text box next to this field.

List Accessibility

In this field, define the enterprise level at which the list should apply.

- Select **Scope**. The system displays a list of enterprises you can apply to the list.
- Select an enterprise.

Description

Enter a detailed description of the list.

6. Select **Create List**. The system creates your user-defined list and displays it as a white or light blue modifiable record.

To override codes in a list:

1. Open the **Code Repository** module from the **Enterprise** entry-level screen.
2. Select the **Lists and Crosswalks** icon.
3. Enter the applicable search criteria in the Selection Criteria box and select **Find** to display a specific list - **OR**- choose one from the list.
4. Select the name of the list you want to override (e.g., POS or Anesthesia Codes). The system displays the default or inherited code sets in that list.
5. Select the checkbox next to the code relationship you want to change in the list.
6. Select **Override**. The system displays the Override window.
7. Enter a single code and effective and expiration dates for the override.

8. Choose the appropriate Status (enabled or disabled) from the dropdown menu.

9. Select **Save**. The system adds your code changes to the list and displays your change as a white or light blue modifiable record.

**To change dates for a code on a list:**

1. Open the **Code Repository** module from the **Enterprise** entry-level screen.

2. Select the **Lists and Crosswalks** icon.

3. Select the system list with the code (or code range) in it that you want to change (POS, Bilateral Procedure Modifiers, Anesthesia Codes, etc.).

4. Select **Override**.

5. Enter the effective and expiration dates for your override.

6. Choose the appropriate Status (enabled or disabled).

7. Select **Save**. Go to the **Define the scope of a change on a list** section to continue.

**To define the scope of a change on a list:**

1. Once you select **Save**, the system displays the Define Scope screen.
2. Select the box next to the ruleset(s) or the enterprise you want this change to apply to. Refer to the sections for defining enterprises and managing rulesets.

3. Select Complete Override. The system saves the change and displays the user-defined list as a white or light blue record.

**To export a list:**

You can export certain data from system lists into a .csv (comma-separated values) file for use outside the system.

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Lists and Crosswalks icon.
3. Find the system list you want to export data from and open that list.
4. Using the Selection Criteria, find the data elements to export.
5. Select the checkbox next to each item to export.
6. Select Export Data. The system then asks you if you want to open or save the export file.
7. Select Save.
8. Browse to the location on your hard drive where you want to save the file and select OK. The system saves the file.

**Note**

If a code range is selected to export to a .csv file, the start code and end code will be extracted in two separate columns.
To delete a list:

Any list you want to delete must be displayed in white or light blue. The gray items are system lists and cannot be deleted.

If you need to change a list, follow the steps to Override codes in a list. A new list will be created with your changes.

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Lists and Crosswalks icon.
3. Enter the applicable search criteria in the Selection Criteria box and select Find to display a specific list - OR-choose from the list.
4. Select the checkbox next to the list you want to delete. You can only delete codes or lists that have been created locally. System and inherited records cannot be deleted. Refer to the Defining enterprises section.
5. Select Delete User List. The system deletes your list and displays the remaining lists on the System Lists screen.

Importing External Data to a List

Many system lists provide an option to import data from external files. Using this option, you can quickly populate the system with information that is not delivered with the system, but is needed for system setup, customization, reporting and custom rules.

To import external data:

1. Follow the steps to access the Code Repository.
2. Select the System Lists icon.
3. From the items listed on the screen, select the name of the system list you want to work with (e.g., POS or Anesthesia Codes). If you want to narrow down the items to select from, enter the applicable search criteria in the Selection Criteria box and select Find.

After you select the desired system list, a screen displays that lists the components of that list.

4. Select Import System List Data.
5. Select the Browse button. The Choose File dialog box displays.
6. Browse to select the file you want to import, and then select Open.
Be sure the file you import has the correct format to match the system list you are working with. For details about the correct file format, refer to the CSV Import File Formats 5.2.1 and Above - CES document on the Customer Portal.

7. After you select the desired file, select **Begin Import**. A screen showing the progress of the import displays.

8. When the import is complete, select **OK**.

**Crosswalks**

During the analysis process, Claims Edit System looks for valid data in each field. Within some fields, the system only recognizes certain pre-defined values as valid. These valid data are the crosswalk values. For Claims Edit System to recognize values that are unique to your organization, you must first match each of your values to an equivalent crosswalk value. This matching process is called crosswalking. After you crosswalk your custom values, the system recognizes them as valid entries during claims analysis.

Claims Edit System includes a number of crosswalks within system lists. You can update and maintain the Provider Specialty, Place of Service (POS), Type of Service (TOS), New Patient to Established Patient, Procedure, and Modifier codes. You can add, edit and delete crosswalk (or replacement) designations for many of the codes entered for a claim.

For information about how to access your system lists and make changes to them, refer to the **System lists and crosswalks** section.

The following crosswalk lists are delivered to you blank so that you can crosswalk values unique to your own organization:

- Provider Specialty
- TOS (Type of Service)
- POS (Place of Service)
- Procedure
- Modifier

**Note**  
System-defined crosswalks are initially used in the System ruleset. You can change the data for these crosswalks, but you cannot delete any System or inherited crosswalks. However, you can delete crosswalks that you have created yourself.
Refer to the [Defining enterprises](#) section for more information about inherited records.

Refer to the [Managing rulesets](#) section for more information about what you can do with rules.

## Accounts and Plans

Accounts and plans lists are provided for your convenience in populating claims and maintaining accurate data within your system. You can find the lists of accounts and plans among the system lists in the Code Repository. (Refer to the [System lists and crosswalks](#) section for more information.)

These pages allow you to look up records already in your database. From this portion of the interface you can manage your list of accounts and their associated plans by finding specific ones, adding new ones and deleting obsolete records.

An account in your organization can have many plans associated with it, if necessary. For example, you could have an account for a major customer called XYZ Company, and this account could have three different health plans: an in-network plan, an out-of-network plan and a catastrophic-coverage-only plan. Both the account ID and the plan ID have to be included in the header of a submitted claim to process the claim correctly.

Refer to the [Claim routes](#) section for more information about how to route claims correctly. When you add a new payment plan, any claims that have that Plan ID on them are analyzed by the system ruleset until a new ruleset is created and assigned.

Within Claims Edit System, the particular set of rules used to analyze a claim is called a ruleset. There can be many rulesets, and the Account and Plan numbers identified in the header of each claim determine which ruleset is used to analyze that claim.

Refer to the [Managing rulesets](#) section for more information about rulesets.

## Accounts

Account records are made up of an account ID and the name associated with it.

### To view the list of accounts:

1. Open the [Code Repository](#) module from the [Enterprise](#) entry-level screen.
2. Select the [Lists and Crosswalks](#) icon.
3. In the Selection Criteria, enter [Accounts](#) in the List field.
4. Select [Find](#). The system displays the Accounts system list.
5. Select the [Accounts](#) link. On this screen, accounts appear with the following fields:
**Value**

This field contains the Account ID number. This identifier is a unique alphanumerical combination that identifies the account. Each Account ID can be up to 30 characters long. Account IDs are case sensitive.

**Description**

This field contains the name of the account within your organization. Each account name can be up to 75 characters long.

**Effective Date**

This field contains the effective date associated with the account.

**Expiration Date**

This field contains the expiration date associated with the account.

---

**Plans**

Payment Plan records include the Plan ID and the Plan Description.

**To View the List of Plans:**

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Lists and Crosswalks icon.
3. In the Selection Criteria, enter Plans in the List field.
4. Select Find. The system displays the Plans system list.
5. Select the Plans link. On this screen, accounts appear with the following fields:

**Value**

This field contains the Plan ID number. This identifier is a unique alphanumerical combination that identifies a specific plan within your organization. Each ID can be up to 30 characters long. ID numbers are case sensitive.

**Description**

This field contains the name of the plan within your organization. Each plan name can be up to 255 characters long.

**Effective Date**

This field contains the effective date associated with the plan.
Expiration Date

This field contains the expiration date associated with the plan.

Working with accounts and plans

Accounts and plans are system lists, and therefore you can manage them in the same way you work with other system lists. Refer to the System lists and crosswalks section for details.

System Lists and Crosswalks - Panel-based UI

Prerequisites

<table>
<thead>
<tr>
<th>Application version</th>
<th>KnowledgeBase version</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Edit System 5.4 or later</td>
<td>2019 Q3A KnowledgeBase</td>
<td>Initial release in panel-based UI</td>
</tr>
<tr>
<td></td>
<td>2020 Q1A KnowledgeBase</td>
<td>Add list data import/export function</td>
</tr>
</tbody>
</table>

Lists & Crosswalks Tab (Enterprise Panel)

The Lists and Crosswalks tab is accessed by selecting an enterprise in the ENTERPRISES section of the Enterprise panel. You can view system lists (those that come with the KnowledgeBase) and create custom lists for use in rules associated with the selected enterprise and its child enterprises.

If a custom list was created in this enterprise, it can be edited as indicated by the pencil icon ( ) that displays by the list name. For a system list, which is indicated by an S icon ( ) next to the list name, overrides can be created and additional data elements can be added.

A number of filters can be applied to the data in the table to limit which lists are included and to make it easier to find the particular list that you are looking for. These are described in the table below.

<table>
<thead>
<tr>
<th>Filter Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>List Name</td>
<td>Enter any fragment of the list name. Lists that include this fragment anywhere in their name will be included.</td>
</tr>
<tr>
<td>Filter Option</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Category</td>
<td>Select a category from the dropdown list to limit the display to those lists that belong to the selected category.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter any fragment of the list description. Lists that include this fragment anywhere in their description will be included.</td>
</tr>
<tr>
<td>Value</td>
<td>Enter a value to search within data elements associated with the system lists. You can use a wildcard (*) to indicate any character. All lists that have one or more data element that matches the specified value will be included.</td>
</tr>
<tr>
<td>Origin Enterprise</td>
<td>Origin enterprise indicates where the list was created (list owner). Select an enterprise from the dropdown list.</td>
</tr>
<tr>
<td>List Type</td>
<td>Only lists of the selected type (System and/or Custom) will be included.</td>
</tr>
</tbody>
</table>

By selecting one of the rows in the table, the System List panel for the selected list is opened to the right. The panel includes three tabs which are described in the following sections.

**Properties Tab (System List Panel)**

The Properties tab displays details about the system list as outlined in the table below. Note that these property values can only be changed for custom lists.

<table>
<thead>
<tr>
<th>Column name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>List name</td>
<td>The name of the list. If the name of a custom list is changed, data-driven rules that use the list are automatically updated with the new list name. However, ILOG rules must be manually updated. The ILOG Rules tab allows you to check in advance which rules will be affected and export a list of these rules (using the Gear menu) for future reference.</td>
</tr>
</tbody>
</table>
| Type of list | One of the following list types:  
  - *Simple list*: A list of single or range values. These lists are typically used to validate a code for a specific reason. For example, “Hyperbaric Wound Therapy ICD-10 Codes” contains a list of specific diagnosis codes that would be valid for specific procedures.  
  - *Association list*: A list that associates one value or a range of values with another value. For example, the “Inappropriate Modifier
<table>
<thead>
<tr>
<th>Column name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>The code or value that is the primary identifier for the list data element. This can be a single value or a range (such as the beginning and ending values of the range separated by a dash, e.g., “99200-99214”).</td>
</tr>
<tr>
<td>List type</td>
<td>Simple, Association</td>
</tr>
</tbody>
</table>

**Data Tab (System List Panel)**

The Data tab displays a table of data elements associated with the selected list. Any overrides that have been applied to the system data are also included in the table. Multiple filters can be applied to restrict what data is included in the table (Value, Description, Effective Date, etc.).

When a list has a large number of data items, only the first 500 rows of data is initially displayed in the table. After scrolling to the bottom of the table, a Load More button is displayed. Selecting this button causes the next 500 rows of data to be displayed. Of course, when searching for specific data items it is advisable to use filters rather than scrolling through large amounts of data.

Depending on the list type, the columns in the table can vary. All possible columns that can be displayed are described in the following table along with the system list types with which they are associated.
<table>
<thead>
<tr>
<th>Column name</th>
<th>Description</th>
<th>List type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>The code or value that is associated with the Value column. For example, in the Inappropriate Modifier Combination list, the modifier code in the Associate column cannot be used in combination with the modifier code in the Value column.</td>
<td>Association</td>
</tr>
<tr>
<td>From</td>
<td>The code or value that is the primary identifier for the list data element. A range is not allowed because only single values can be crosswalked to a different value.</td>
<td>Crosswalk</td>
</tr>
<tr>
<td>To</td>
<td>The code or value that is an alias for the primary identifier in the From column.</td>
<td>Crosswalk</td>
</tr>
</tbody>
</table>
| Code Expired| This column applies only to system lists which are assigned the Procedural or Diagnosis category. In this case, the list will contain procedure or diagnosis codes that are defined in an associated KnowledgeBase table (valid procedure codes or valid diagnosis codes) and which have their own expiration date. This column informs you about the status of the code in one of these external tables. The following values are possible:  
  - **Yes** - The code in the external table is expired for the current date (but may be valid for an older date of service).  
  - **No** - The code in the external table is not expired.  
  - **Mixed** - This value is always used for system list values that are code ranges because specific codes within the range could be either expired or not expired. To view the status of each code within the range, select the table row, then select the Values tab in the Data Value panel that is displayed. The table in this | Simple, Association |
## Column name | Description | List type
--- | --- | ---
| | • panel also has a Code Expired column that shows the status for each individual code in the range.  
• **Blank** - Indicates that the code in the list data element cannot be found in the associated external table. |  
| Enabled | Has a checkmark if the data element is enabled. If blank, it is disabled. | Simple, Association, Crosswalk |
| Description | A description of the primary identifier for the data element ("Value" or "From" column). For example, if it is a procedure or diagnosis code, it describes the procedure or diagnosis. | Simple, Association, Crosswalk |
| Effective Date | The date the data element became effective. For example, if one procedure code is replaced by another, the old code must be expired as of a particular date and the new code is specified as "effective" the day after. | Simple, Association Crosswalk |
| Expiration Date | The date the data element expires or is no longer effective. For example, if one procedure code is replaced by another, the old code must be expired as of a particular date and the new code is specified as "effective" the day after. | Simple, Association Crosswalk |
| Enterprise Scope | Specifies the enterprise that the data element is associated with. System data is associated with one of the top-level enterprises (Professional System Enterprise or Facility System Enterprise) and can be inherited by all of their child enterprises. Custom data can be associated with specific enterprises and rulesets when it is created. | Simple, Association, Crosswalk |
| Ruleset Scope | Specifies the ruleset with which the data element is associated. It can be blank if not tied to a specific ruleset. Because different rulesets are typically created for different lines of business (Commercial, Medicaid, Medicare), this is a way to customize list data by line of business. | Simple, Association, Crosswalk |
## Adding List Data

**To add list data:**

1. Select the Add button. The Add List Data panel displays with a focus on the Manual Entry tab. This tab includes a table with the following columns. Data can be entered into the top row as you would a spreadsheet.

<table>
<thead>
<tr>
<th>Column name</th>
<th>Description</th>
<th>List type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has Disclosure</td>
<td>Has a checkmark if the data value has disclosure. The disclosure text can be viewed in a separate panel by selecting the table row. List data typically does not have disclosure information, but it may be useful in some cases.</td>
<td>Simple, Association, Crosswalk</td>
</tr>
</tbody>
</table>

### Column | Description
---|---
Value, Associate, From, To | Enter a code or value for this list data element. As soon as you begin to type in this field, a new table row is added below. Note that this value is also the primary identifier for this particular data element. It must be unique unless duplicate rows are assigned different Effective and Expiration dates that do not overlap.
Validations | Cannot be left blank. Cannot include special characters (only upper and lowercase alphabetic characters and numbers are allowed).
Description | Enter description for list data value.
Effective Date | Initially, this field is set to 1/1/1990, but can be changed by either entering a date in mm/dd/yyyy format or by selecting the calendar icon to select the date. You can enter future effective dates, but only up to three (3) years from the current date.
Expiration Date | This field is initially filled with the date format template (mm/dd/yyyy) indicating that it is not specified and that the data value never expires (is always effective).
Enabled | This checkbox is initially checked, indicating that the data value is enabled. Uncheck it to disable the value.

The red X at the end of the row may be selected to delete the row.
2. After manually entering the data, select the **Next** button or select the **Scope** tab to specify the enterprise or ruleset scope for the data. First select one of the following radio buttons:

   - **Entire enterprise (current enterprise):** This option is selected by default and indicates that the list data applies to all rulesets within the current enterprise.
   
   - **Apply to selected rulesets:** Select this option to display a list of rulesets in the enterprise (including rulesets inherited from parent enterprises). Check the checkboxes next to rulesets in the list.

3. Select the **Save** button. The system adds your list data to the list and displays the pencil icon for each record.

### Copying or Overriding List Data

The Override button on the Data tab of the **System List** panel is enabled when a system data row is selected in the table of data items. (Note that system data rows can be recognized because they do not have the pencil icon after the first column value.) However, when a custom data row is selected (a row that does include the pencil icon), the button is renamed and becomes a Copy button.

The actual function of the Override/Copy button is the same regardless of how it is named. It provides the ability to create a new data item based on the properties of the selected list data item. The following instructions assume that you have already selected a list and that focus is on the Data tab.

#### To override or copy list data:

1. Select the list data item that you want to override. A **Data Value** panel displays with a Properties tab.

   - If the selected data item is system data, all fields will be non-editable and the Override button is now enabled.

   - If the selected data item is custom data, only the “Value” field (or “From” and “To” fields in the case of a crosswalk list) and the two scope fields are non-editable. The Override button is renamed to the **Copy** button.

2. Select the **Override/Copy** button. A new record is added below the selected data item and the fields in the Properties tab all become editable. A Scope tab is added below the Properties tab.

3. Make changes to the values.

4. Before selecting the **Save** button, you should select the Scope tab to choose which rulesets should be affected by the override. (Note that the default scope is **Entire Enterprise**, so it’s okay to select the **Save** button at this time if that is the desired scope.)
5. The Scope tab provides radio buttons for the following options:
   - *Entire enterprise (current enterprise)*: This option is selected by default and indicates that the list data applies to all rulesets within the current enterprise.
   - *Apply to selected rulesets*: Select this option to display a list of rulesets in the enterprise (including rulesets inherited from parent enterprises). Check the checkboxes next to rulesets in the list.

6. Select the **Save** button after choosing the ruleset scope of the override.

### Importing List Data

The Import button on the Data tab of the System List panel is used to import data into the selected list using a CSV file (text file in Comma-Separated Value format) that is stored on the user’s workstation. When clicked, an Import List Data panel is opened to the right. List data is imported in the steps that are listed in the left-hand pane of the Import List Data panel.

1. Select a file.
   - a. Select the **Browse** button to open a file explorer dialog on the local workstation.

   | **Note** | Only files with a “.csv” file name extension are included in the file browser dialog.
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List data must have between six to nine fields, so if the selected file does not have the required number of fields, an error message is displayed.</td>
</tr>
</tbody>
</table>

   - b. Navigate to the directory where the CSV file with the list data is stored, select it, and then select the **Open** button to continue. The name of the selected file is displayed in the Import List Data panel. If the incorrect file was selected, you can revert your choice by selecting the red **X** at the end of the file name.

   - c. Specify the desired Data handling option:
     - Append to existing values: All entries in the selected CSV file will be added to existing entries. (A check for duplicate values in the import file is performed against existing values.)
     - Replace all existing values: All existing data for the current list are first deleted and then the entries in the selected CSV file are imported. (A check for duplicate entries within the file is performed.)

   - d. Select the **Next** button to continue to the next step.

2. Select the scope.
   - a. The **Select the scope** tab provides radio buttons for the following options:
     - Entire enterprise (current enterprise): This option is selected by default and indicates that the list data applies to all rulesets within the current enterprise.
Apply to selected rulesets: Select this option to display a list of rulesets in the current enterprise (including rulesets inherited from parent enterprises). Select the checkboxes next to the desired rulesets in the list.

b. Select the **Next** button to continue to the next step.

3. Check the file.

a. A progress bar is displayed while the data in the file is validated. A green "success" message bar is displayed if the initial validation succeeded. The following validations are performed:

<table>
<thead>
<tr>
<th>Validation</th>
<th>Description</th>
</tr>
</thead>
</table>
| Empty Value Check           | *Simple List:* From Value, To Value, Description, and Effective Date cannot be empty.  
*Crosswalk:* From Code, To Code, Adjusted Code, Description, and Effective Date cannot be empty. |
| Character Set for Codes     | Alphanumeric characters and the period (.), but two consecutive periods are not valid (e.g., A770.01 is valid but A770..01 is invalid). |
| Date Range                  | Must be >= to 1990 and <= to the current year plus 3.                        |
| Expiration Date             | Must be >= 1-Jan-1990 and <= 01-Jan-9999. Cannot be less prior to the effective date. |
| Code Ranges                 | a. The Begin Code (From Value) must be less than the End Code (To Value). Note that this applies to both the first and second codes in association lists.  
b. A range is not allowed for crosswalk value. In other words, a crosswalk must map one unique value to another unique value. |
| Uniqueness                  | Multiple records with the same Code (From Value), date range (effective to expiry), and scope (enterprise, ruleset) are not allowed. |
| Overlapping Date Range      | Multiple records with the same Code (From Value) and scope (enterprise, ruleset) where the effective to expiration date ranges overlap are not allowed. |

**Successful Validation Check**
If any validation errors occurred during the file check, a red “failure” message bar is displayed. Each error is displayed in a table. In this case, the Import button is disabled and you must repair the errors in the file before retrying the import.

Failed Validation Check

b. When no validation errors are reported and you are ready to proceed with importing of the data, select the Import button. A progress bar is displayed to track the status of the data import. Further checks for “Overlapping Effective Date Range” are performed during the data import. This check verifies that when new records for the existing code(s) are imported, the effective to expiration date range of the new records do not overlap the effective to expiration date range of any existing records where the code(s) match.

Any “Overlapping effective date range” errors will cause the entire import operation to be aborted. These errors must be corrected in the CSV file in order for
the import to be successful.

Select the **Return to step 1** link above the table of errors to return to the previous step. Before doing so, you may also want to export the list of failures by selecting the **Export Error List** link so it can be referenced while correcting errors in the data file.

When data imports successfully, a message bar displays along with statistics for the number of rows that were imported and the number of invalid rows (which will be zero for successful imports).

Select the **Import another file** link in the message bar when you are ready to perform additional data imports.

**Note**

Only two CSV files can be loaded simultaneously. The purpose of this restriction is to avoid impacting claim analysis performance due to the increased load on the database.

**Viewing Imported Data**

After importing list data, it will automatically be included in the System List panel to the left of the Import List Data panel.

**Exporting List Data**

The Tools menu (gear icon near the upper right-hand corner of the Data tab of the System List panel) includes a single Export list to spreadsheet option. Selecting this option will export the data to your local workstation (normally to the Downloads directory). The file name matches the name of the system list and has a .CSV file extension.

**Used In Tab (System List Panel)**

The **Used In** tab displays statistics regarding various types of rules (data-driven rules, claim routes, route properties, ruleset exceptions, same provider rules, and ILOG rules) where the selected list is being used. There is a separate subtab to display a complete list of specific rules for each of these rule categories.

**Used In > Rules subtab**

The **Rules** subtab displays a table of all data-driven rules (both system and custom) in which the selected list is being used. For each rule, the ID, rule name, status (Live, Test, etc.), flag and effective and expiration dates are displayed.
Used In > Claim Routing subtab
The Claim Routing subtab displays a table of rulesets with a routing Condition Expression that uses the list in its logic. For each ruleset, the ruleset name, its “environment” (Test or Live) and the enterprise to which it belongs are displayed.

Used In > Route Properties subtab
The Route Properties subtab displays a table of rulesets that have one or more route properties that use the selected list in the logic of their Condition Expression. For each ruleset, the ruleset name, its “environment” (Test or Live) and the enterprise to which it belongs are displayed.

Used In > Exceptions subtab
The Exceptions subtab displays table of ruleset exceptions that use selected system lists in their conditional expression. For each ruleset exception, its ID and name are displayed.

Used In > Same Provider Rules subtab
The Same Provider Rules subtab displays a table of Same Provider rules that use the selected system list in their conditional expression. For each rule, its name and type (Same Provider or Same Provider NPT) are displayed.

ILOG Rules subtab (System List panel)
The ILOG Rules subtab displays a table of ILOG rules in which this selected system list is being used. For each rule, the rule name, category (System or Custom) and origin enterprise are displayed.

Creating a Custom List
The New List button in the Lists & Crosswalks panel provides the ability to create a custom list for use in the selected enterprise and its children.

To add a list:
1. Select the New List button to open a System List panel in which to enter data for the custom list. You must fill in the form for the Properties tab and save it before the Data tab can be used to view the data elements associated with the list.
2. Enter a name for the list in the List name field. This name must not match the name of any other list that is usable for the selected enterprise (this includes lists inherited from parent enterprises); otherwise, an error message displays and the panel data cannot be saved.
3. Select the **Type** of list from the dropdown. (The options are described in detail in the Properties Tab (System List panel) section above.)

4. Select an appropriate **Category** from the dropdown list. (If a new category is needed, it can be created using the List Categories subtab of the Lists & Crosswalks tab.)

5. You may optionally enter a description for the list in the **Description** field.

6. Save the entered data by selecting the **Save** button. The custom list is now included in the Lists and Crosswalks panel.

**Deleting a List**

Only custom lists (those with the pencil icon after the list name) can be deleted. Read the following warning for further restrictions on deleting lists.

| Important! | Deleting a custom list is only allowed within the enterprise where it was created. Use the Origin enterprise filter to identify the enterprise where the list was created. |

A custom list cannot be deleted if it is used in Data-Driven rules, Rule-set claim routing, Ruleset route properties, Exceptions, or Same Provider rules. When any one of these conditions exists, the Delete List button is disabled.

A custom list can be deleted if it is used in ILOG rules. However, a warning message is displayed with the name of the ILOG rule(s) and enterprise to which it belongs. Each rule must be manually edited to remove the list from its logic or it will cause errors when executed.

If a custom list is deleted, all associated data is also deleted and cannot be restored.

**To delete a list:**

1. Select a custom list from the Lists and Crosswalks panel. A System List panel displays with a **Delete List** button at the bottom left side of the panel.

2. Select the **Delete List** button. A confirmation dialog displays in the panel with the **Delete** and **Cancel** buttons.

3. Select the **Delete** button to continue with the deletion or the **Cancel** button to abort the operation.
Deleting List Data

Only custom list data elements (overrides) can be deleted. These are indicated by the pencil icon in the first column.

| Note | You can only delete the list data after navigating to the enterprise where it was created (origin enterprise). |

To delete list data:

1. Select a list from the Lists and Crosswalks panel. A System List panel displays with a Data tab that shows all data elements associated with the list.
2. Select a custom data element (one with the pencil icon). The Data value panel opens to the right with full details for the data element and a Delete List Data button at the bottom left side of the panel.
3. Select the Delete List Data button. A confirmation dialog is displayed in the panel with the Delete and Cancel buttons.
4. Select the Delete button to continue with the deletion or the Cancel button to abort the operation.

Renaming a list

Only custom lists (those with the pencil icon after the list name) can be renamed. The Properties tab of the System List panel includes a List name field that is editable when the selected list is a custom list. Type in a new name and select the Save button.

If the list is used in data-driven rules, the list name is automatically updated in those rules. However, if the list is used in ILOG rules, they cannot be automatically updated. For this reason, a warning message is displayed which identifies the ILOG rules where this list is used in the rule logic.

| Important! | You must manually update each of these rules and change the list name to match the new name. Failure to do so will cause errors to occur when the rule executes and will prevent claims from being correctly edited. |

You can view the list of ILOG rules by selecting the view full list link on the warning message or by selecting the Used In > ILOG rules subtab.
To assist with the manual update of the rules, you can select the **Export full list** link on the warning message.

The list can be saved to a CSV file (for importing as a spreadsheet in Excel). This can also be done via the *Tools* gear menu at the upper right corner of the panel and choosing the **Export listing to spreadsheet** option. Optum recommends that you export and save the list of ILOG rules where the list is used before selecting the **Save** button.

**List Categories subtab**

The *List Categories* subtab provides the ability to create categories that can be assigned to lists. Several list categories are shipped with the KnowledgeBase (Procedural, HCPCS, Diagnosis, Modifiers, Crosswalks, Type of Bill, etc.), but you can add your own categories to customize the way you work with lists.

Categories are intended to aid in list management. Related lists can be grouped together by assigning them a common category, which can then be used as a filter to restrict what is displayed to just the lists that belong to a particular category. Because there are hundreds of lists, using a category filter can make it much easier to find a particular list and work with the associated list data.

The *List Categories* panel displays a table of all categories that have been defined. Although it is initially only a short list, as more categories are added, the following filters provide some convenience:

<table>
<thead>
<tr>
<th>Filter option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category name</td>
<td>Enter any fragment of the category name. Categories that include this fragment anywhere in their name will be included.</td>
</tr>
<tr>
<td>Description</td>
<td>Enter any fragment of the category description. Categories that include this fragment anywhere in their description will be included.</td>
</tr>
</tbody>
</table>

**Adding a List Category**

The **New Category** button (located below the filters bar) provides the ability to add a new list category.

**To add a list category:**

1. Select the **New Category** button on the List Categories panel. A Category panel will open to the right with a *Properties* tab for information to be entered.

2. In the Category panel (Properties tab), enter a category name and its description. Try to enter a description that will make it clear what types of lists should be grouped by this category.

3. Select the **Save** button. The list category is now available for use.
Deleting a list category

Any list category can be deleted by selecting the category on the List Categories panel, then selecting the Delete List Category button in the bottom left corner of the Category panel.

| Note | Some categories (Procedural, Diagnosis and Modifiers) cause lists that are assigned to the category to have special handling. When data values are entered for lists with these categories, they are validated against the values (codes) that are included in the KnowledgeBase tables for valid procedure, diagnosis and modifier codes. Therefore, these categories should not be deleted or renamed. |

RVU (Relative Value Unit)

The Relative Value Unit (RVU) is a numerical value assigned to a health care service (e.g., office visits, procedures, etc.). These units allow special comparisons (for example, surgery to primary care visits) and can determine the allowable payment for any service in any specialty. The total RVU for a service is multiplied by a conversion factor and several adjustment factors to set a dollar amount for payment.

Claims Edit System provides three RVU tables for use in claims processing:

- Ingenix - Values derived from Optum data, and provided for you by Procedure code
- MPFS - Values based on the National MPFS (Medicare Physicians Fee Schedule)
- CMS Gap Filled - Values based on the Medicare Physicians Fee Schedule

RVUs are values expressed in numeric units that represent the unit of measure for provider services. You can access any of these RVU tables within the Code Repository. Within these screens, you can add new RVU values to Procedure Codes, override default values or delete any changes you have made.

Ingenix RVU

Optum relative value units are established on a procedure’s difficulty, time, work, risk and resources. These values are developed by Optum staff members, including Optum’s Medical Director; on-site clinicians; Certified Professional Coders (CPCs); and analysts.

Once an Ingenix RVU has been established, it is assigned based on a knowledgeable understanding of how its procedure code is billed and how that code relates to other procedures. Optum personnel regularly check the RVU against the way the particular procedure code is billed to maintain the RVU’s integrity.

Ingenix RVU Fields

These fields are present when you view the Ingenix RVU values delivered to you:
Code
This field contains the code abbreviation identifying the procedure code.

RVU
This field contains the RVU value that applies to the code.

Origin
This field contains the name of the enterprise that created or delivered this RVU. “System” indicates that a record is part of the KnowledgeBase and is applicable system-wide.

Effective Date
This field contains the date when the code relationship becomes active.

Expiration Date
This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

Scope
This field contains the name of the Enterprise or Ruleset that this RVU applies to. “System” indicates that a record is applicable system-wide.

Status
This field contains the disposition of the code. The code you add or change will either be Enabled (turned on) or Disabled (turned off) and reserved for future use.

MPFS RVU
The Medicare Physicians Fee Schedule RVU values are updated within the KnowledgeBase each quarter. This RVU list contains the Non-Facility Total RVU, if available. For codes that do not have a Non-Facility Total RVU, the Facility Total RVU is used.

Generally, under the resource-based system, the facility practice expense RVUs are used for services performed in inpatient or outpatient hospital locations, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs). The non-facility practice expense RVUs are used for services provided in all other settings and locations.

MPFS RVU Fields
These fields are present when you view the MPFS RVU values delivered to you:
**Code**

This field contains the code number identifying the procedure code.

**Work**

This field contains the value associated with the work required (how hard it is to complete) by the physician for a procedure.

**Non-Facility Practice Expense**

This field contains the RVU associated with the practice expense for a procedure performed outside a facility. Non-facility practice expense represents the physician’s direct and indirect costs related to each service when that service is provided in the physician’s office, patient’s home, or other non-hospital setting such as a residential care facility. Direct expenses required for each procedure include non-physician labor, medical equipment, and medical supplies. Indirect expenses include the cost of general office supplies, rent, utilities and other office overhead that cannot be directly tied to a specific procedure.

**Facility Practice Expense**

This field contains the RVU of a physician’s direct and indirect costs related to each service performed at a facility. A facility includes inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs). Direct expenses required for each procedure include non-physician labor, medical equipment, and medical supplies. Indirect expenses include the cost of general office supplies, rent, utilities, and other office overhead that cannot be directly tied to a specific procedure.

**Total Non-Facility**

This field contains the RVU representing the total sum of the work, practice expense, and malpractice for a procedure performed outside a facility. A non-facility can include the physician’s office, patient’s home, or other non-hospital setting, such as a residential care facility.

**Total Facility**

This field contains the RVU representing the total sum of the work, practice expense, and malpractice for a procedure performed at a facility. A facility includes inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs).

**Modifier**

This field contains the modifier code abbreviation identifying the service or component being added. Some examples of what might appear in these fields are:

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A blank indicates a global procedure, a modifier “26” indicates a Professional component, or a “TC” indicates a Technical Component. If a “53” appears, this indicates that the procedure was discontinued. Refer to the Modifiers section for more information about how these codes are used elsewhere in the system.

**Origin**

This field contains the name of the enterprise that created or delivered this RVU. “System” indicates that a record is part of the KnowledgeBase and is applicable system-wide.

**Effective Date**

This field contains the date when the code relationship becomes active.

**Expiration Date**

This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

**Scope**

This field contains the name of the enterprise or ruleset that this RVU applies to. System indicates that a record is applicable system-wide.

**Status**

This field contains the disposition of the code. The code you add or change will either be Enabled (turned on) or Disabled (turned off) and reserved for future use.

**CMS Gap Filled RVU**

The CMS Gap Filled RVU values are updated within the KnowledgeBase each quarter. This RVU list contains the Non-Facility Total RVU, if available. For codes that do not have a Non-Facility Total RVU, the Facility Total RVU is used. If both of these types of Total RVU are “0” (zero), a “Gapped” Total RVU is listed.

**CMS RVU Fields**

These fields are present when you view the CMS RVU values delivered to you:

**Code**

This field contains the code number identifying the procedure code.

**Work**

This field contains the value associated with the work required (how hard it is to complete) by the physician for a procedure.
Non-Facility Practice Expense

This field contains the RVU associated with the practice expense for a procedure performed outside a facility. Non-facility practice expense represents the physician’s direct and indirect costs related to each service when that service is provided in the physician’s office, patient’s home, or other non-hospital setting such as a residential care facility. Direct expenses required for each procedure include non-physician labor, medical equipment, and medical supplies. Indirect expenses include the cost of general office supplies, rent, utilities, and other office overhead that cannot be directly tied to a specific procedure.

Facility Practice Expense

This field contains the RVU of a physician’s direct and indirect costs related to each service performed at a facility. A facility includes inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs). Direct expenses required for each procedure include non-physician labor, medical equipment, and medical supplies. Indirect expenses include the cost of general office supplies, rent, utilities, and other office overhead that cannot be directly tied to a specific procedure.

Malpractice RVU

This field contains the RVU assigned to the malpractice insurance component for a specific service.

Total Non-Facility

This field contains the RVU representing the total sum of the work, practice expense and malpractice for a procedure performed outside a facility. A non-facility can include the physician’s office, patient’s home or other non-hospital setting such as a residential care facility.

Total Facility

This field contains the RVU representing the total sum of the work, practice expense, and malpractice for a procedure performed at a facility. A facility includes inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities or ambulatory surgical centers (ASCs).

Origin

This field contains the name of the enterprise that created or delivered this RVU. “System” indicates that a record is part of the KnowledgeBase and is applicable system-wide.

Effective Date

This field contains the date when the code relationship becomes active.

Expiration Date
This field contains the date when the code relationship will no longer be applicable (it will no longer be considered) in the relationship.

Status

This field contains the disposition of the code. The code you add or change will either be Enabled (Turned on) or Disabled (Turned off) and reserved for future use.

Scope

This field contains the name of the enterprise or ruleset that this RVU applies to. System indicates that a record is applicable system-wide.

Working with RVU Values

Optum provides the CMS Gap-Filled RVU and Ingenix RVU values by procedure code. Presently you can find any RVU value delivered to you. The system uses these values in your claims processing. (For more information about where to find the RVU on a claim, refer to the Claim results section.)

You can add new RVUs to each of these tables. You can also edit or override an existing RVU that is delivered to you with the system.

When you make a change to your default RVU tables, you must define the scope (identify where your change applies) of your change. If you create or make a change to the default values in these tables, you can delete this change.

For more information about what you can and should change, refer to the Overrides section.

To add a new RVU:

1. Follow the steps in the Accessing the Code Repository section.
2. Select either the Ingenix RVU, MPFS RVU, or CMS Gap-Filled RVU icon.
3. Select the New RVU button.
4. Enter your new values in the fields. Refer to the applicable fields (described above) for more information.
5. Select Save.

To find an RVU:

1. Follow the steps to Access the Code Repository.
2. Select either the Ingenix RVU, MPFS RVU, or CMS Gap-Filled RVU icon. The system displays the list of codes with RVUs assigned to them.
3. Find the code you want in the list displayed or type it into the Code box at the top of the screen and select Find.

<table>
<thead>
<tr>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria.</td>
</tr>
</tbody>
</table>

The system displays the code that matches your search criteria.

**To override an RVU:**

1. Follow the steps to Access the Code Repository.

2. Select either the Ingenix RVU, MPFS RVU or CMS Gap-Filled RVU icon. The system displays the list of codes with RVUs assigned to them.

3. Select the checkbox next to the Code (abbreviation) that you want to change the RVU for.

4. Select Override.

5. Enter your changes in the fields. Refer to the applicable fields (described above) for more information.

6. Select Save. The system displays the Define Scope screen. Go to the Define the scope of an RVU section (below) to continue.

**To define the scope of an RVU:**

1. Follow the steps to either Add, Edit or Override an RVU.

2. When you select Save, the system displays the Define Scope screen.

3. Select the checkbox next to the ruleset(s) or the enterprise you want this change to apply to. For more information, refer to the Enterprises section.

4. Select Complete Override.

The system makes a copy of the original record and displays your override. Since you created this override, you can change or delete it at any time.

Now that you have created your override, you can change the default disclosure associated with it. For more information, refer to the Disclosure section.
To remove a custom RVU:

1. Follow the steps to Access the Code Repository.

2. Select either the Ingenix RVU, MPFS RVU or CMS Gap-Filled RVU icon. The system displays the list of codes with RVUs assigned to them.

3. Select the checkbox next to the Code (abbreviation) that you want to delete. You can only delete RVU records that have been created locally. System and inherited records cannot be deleted. For more information, refer to the Enterprises section.

4. Select Delete. The system displays the list of RVUs again without the one you deleted.

Provider Management

The system lets you keep a list of providers. This list also helps you maintain accurate data within your system.

To open the Provider Management screen:

1. Open the Code Repository module from the Enterprise entry-level screen.

2. Select the Provider Management icon.

This screen allows you to look up providers already in the database. From this screen you can choose to proactively manage your list of providers by adding new ones and deleting obsolete records. Within the Provider Management screen, you can add, find, edit, import, and delete provider records.

The following fields are available when you work with provider records:

Provider ID

This field contains the number used in your host adjudication system to identify the doctor providing care. Each identification number can be up to 80 alphanumeric characters in length.

UPIN

This field contains the Unique Provider Identification number, assigned by the government to identify the doctor. (On some systems, this may be the same as the Provider ID, above.)

Last Name

This field contains the provider's last name. Each last name can be up to 60 characters in length.

First Name
This field contains the provider’s first name. Each first name can be up to 35 characters in length.

**Middle Name**

This field contains the provider’s middle name or initial. Each middle name can be up to 25 characters in length.

**Department**

This field contains the ID number of the provider’s department. You can customize the entries that appear in this field by editing the Department system list. (Refer to the System lists and crosswalks section for an explanation of how to edit this list.) Each department ID can be up to 20 characters in length.

**Specialty**

This field contains the abbreviation or term for a provider’s specialty. A specialty is the primary activity or area of expertise that the doctor practices, such as hematology or oncology.

You can customize the entries that appear in this field by editing the Provider Specialty system list. (Refer to the System lists and crosswalks section for an explanation of how to edit this list.) Each specialty designation can be up to 50 characters.

**Provider Type**

This field contains the type of provider: Service Provider, Billing Provider or Referring Provider. You can also add custom entries that will appear in this field by editing the Provider Type system list. (Refer to the System lists and crosswalks section for an explanation of how to edit this list.)

### Populating the Provider Tables

There are two ways to populate the provider data tables:

**Method 1: Import a List of Providers**

You can import a list of providers created outside of the system.

**To import provider data from an external file:**

1. On the Provider Management screen, select the Import Data button.
2. Select the Browse button to find the CSV file containing the data you want to import.

   ![](image) When you import a CSV file, it is important to ensure all CSV records have correct entries for Department, Specialty and Provider Type. (“Correct” means
that these entries match the ones currently listed in the system.) If you import a record with incorrect entries, the system will skip that record without import-ing it and move on to the next record in the CSV file.

3. After you select the file, indicate how you want to handle this data upon import:

- **Append** - When you select this radio button, the system adds all new providers to the list. For any existing providers, the system appends any new relationships it finds in the import file. If the system runs into duplicate entries, it acts as follows:
  - **Duplicate Provider IDs**: Only skip this if there are no new relationships associated with the Provider ID.
  - **Duplicate Provider Names**: Rely upon the Provider ID.
  - **Duplicate Specialty**: Rely upon the Provider ID. Skip if already part of the Provider ID.
  - **Duplicate Department**: Rely upon the Provider ID. Skip if already part of the Provider ID.
  - **Duplicate Type**: Rely upon the Provider ID. Skip if already part of the Provider ID.
- **Replace All** - When you select this radio button, the system purges all existing entries and replaces them with those of the imported file.

| Important! | If you import a provider with the same ID but the spelling of the name is different, the imported name will replace the existing name. |

4. After you select the desired settings, select the **Import** button.

5. Select **Save** when finished.

**Method 2: Manual Entry**

You can also create provider records manually.

**To add a provider:**

1. On the Provider Management screen, select the **Add** button.

2. Enter the data on the provider you want to have available.

3. Select **Save**.
Working with Provider Data

To search for a provider:

1. On the Provider Management screen, enter information in one or more of the fields in the search criteria box at the top of the screen.

   **Note** To aid your search, remember that the wildcard character % indicates that you want to search for "any number of characters." For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria.

2. Select the **Find** button.
3. Locate the desired provider on the list displayed.

To edit a provider record:

1. On the Provider Management screen, search to find the desired provider.
2. Mark the box(es) to the left of the provider record(s) that you need to edit.
3. Select the **Edit** button.
4. Modify the desired data for the provider that you want to have available.
5. Select **Save** when finished.

To delete a provider:

1. Follow the steps to **search for a provider**.
2. Select the box(es) to the left of the provider record(s) that you need to delete.
3. Select the **Delete** button, and confirm your action.

**Max Frequency**

In some cases, medical procedures are not covered by insurance or are only covered a certain number of times within a specified period. You can create a “Maximum Frequency” edit for any procedure.

**Note** This table works in conjunction with the **Frequency History** table.
By default this table is empty, which means that (initially) all procedures and services are considered to be covered for an unlimited number of times. By making your own entries in this table, you can customize the system so that specific procedure codes will be flagged as exceeding the allowed maximum for that service.

**To access the Maximum Frequency table:**
1. Open the Code Repository module from the Enterprise entry-level screen.
2. Open the module to Max Frequency.

**To search the Maximum Frequency table:**

By default, the Maximum Frequency table is blank. Therefore, unless someone at your organization has made entries, the system will return no results when you search. However, if entries have been made, you can search for specific items in the following manner:

1. Go to the Selection Criteria area.
2. Enter any search criteria in the following fields (or leave them blank to find all entries on the table):
   
   **Code**
   
   Enter the range of procedure codes.
   
   **Effective**
   
   Enter the range of effective dates.
   
   **Expiration**
   
   Enter the range of expiration dates.
   
   **Scope**
   
   Select a specific ruleset to restrict the search by ruleset.

   **Note** To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching broader criteria.

3. When you finish selecting search criteria, select **Find**. The system displays a list of applicable entries from the table.
To create entries on the Maximum Frequency table:

1. Select the **New Group** button.

2. Enter information in the following fields, and then select **Save** when finished.

**Code Group**

Enter the procedure codes that apply. You can enter them as a range (for example, 00160-00164) or as individual codes separated by commas (for example, 00120, 0140, 00145). However, you cannot do use both ranges and commas at this time.

**Code Group Accounting**

Indicate how you want the system to treat the group of codes you entered:

- **Treat as Group** - This means that any codes in the range can apply toward the frequency limit. In other words, the frequency increases when any code in the range is found, and not merely when the same code is found more than once.

- **Treat as Individual Codes** - This means only individual codes apply toward the frequency limit. In other words, the frequency increases only when the same procedure code is found more than once, and not when other codes in the range are found.

**Effective Date**

Enter the date on which the system should start using the Maximum Frequency protocol you are defining. (In other words, the system should not start counting the frequency until after this date.)

**Expiration Date**

Enter the date on which the system should stop using the Maximum Frequency protocol you are defining. (In other words, the system should discontinue counting the frequency after this date.)

**Maximum Allowed**

Enter the maximum number of times the procedures may occur during the Frequency period. For example, if a procedure was allowed twice during a given time period, this field would contain the number 2.

**Frequency Duration**

Enter the duration of the Frequency period. For example, if a procedure were allowed several times during a three-year period, this column would contain the number 3 (indicating the number of years). The number in this field is relative to the Time Span (below).
**Time Span**

The number in this field is relative to the *Frequency Duration* (above). It contains one of the following indicators:

- **Lifetime** - Indicates that the frequency limit applies to a patient’s lifetime.
- **Calendar Year** - Indicates that the frequency limit applies to the calendar year during which service occurred.
- **Elapsed Year** - Indicates that the frequency limit applies to a period of time one year from the date of service.
- **Quarter** - Indicates the frequency limit applies to a specific number of 3-month periods. (In the system, quarterly calculations are based on 91 days.)
- **Month** - Indicates the frequency applies to a specific number of months. (In the system, monthly calculations are based on 30 days.)
- **Week** - Indicates the frequency applies to a specific number of weeks. (In the system, weekly calculations are based on 7 days.)
- **Day** - Indicates the frequency period applies to a specific number of days.

**Diagnosis Exceptions**

You can also create exceptions to the Maximum Frequency protocol you are defining. This means if a specified diagnosis code were used for one of the procedures in the group, it would not count toward the frequency limit.

**To add a diagnosis exception:**

1. Select the **Add** button.
2. Enter the following information in the pop-up dialog box:
   - Diagnosis code (or range of diagnosis codes)
   - Code type (ICD-9 or ICD-10)
3. Select **Save** on the dialog box.

**To remove a diagnosis exception:**

1. From the list of existing diagnosis exceptions, select the checkbox next to the item you want to remove.
2. Select the **Remove** button.
3. Confirm the removal action.
Correct Coding Initiative (CCI)

The National Correct Coding Initiative (CCI) was developed by the CMS (Centers for Medicare and Medicaid Services) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

In Claims Edit System, CCI data is used by some of the Medicare and Medicaid rules for editing. This data is delivered with the KnowledgeBase on a regular basis.

The CCI contains data about “code pairs” that should not be billed together (for reasons explained in the Coding Policy Manual). You can view CCI data by accessing the CCI module.

To view CCI data:

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select either of the following icons:

   Medicare CCI   Medicaid CCI

   The Medicare CCI icon displays data used by Medicare rules, while the Medicaid CCI icon displays data used by the Medicaid rules.
3. Use this screen to search for a desired list of the CCI data. You can display all CCI data items by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow down the list, you can use the following criteria to do so:

   **Code 1**
   
   Use this option to find a specific procedure code in column 1 of the code pair.

   **Code 2**
   
   Use this option to find a specific procedure code in column 2 of the code pair.

   **Effective Date**
   
   Enter the range of effective dates to restrict the search by this criterion.

   **Expiration Date**
   
   Enter the range of expiration dates to restrict the search by this criterion.
Type

In this field, select the type of CCI code relationships you want to view (i.e., mutually exclusive codes, gender-specific codes, etc.).

| Note | To aid your search, remember that the wildcard character % indicates that you want to search for "any number of characters." For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching broader criteria. |

4. After you finish defining the search criteria, select Find. The system then displays a list of the CCI data items. The fields of information displayed in this list are the same as those described above (i.e., Code 1, Code 2, Effective Date, Expiration Date and Type) - except for one additional field:

Modifier Allowed

This field indicates whether the CCI relationship allows for a modifier.

(Medicaid Only) - Adding, Overriding or Removing CCI Data

For the Medicaid CCI module, you can add, override or remove items.

To add Medicaid CCI data:

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Medicaid CCI icon.
3. Select the Add button.
4. In the Add dialog, enter information in the main fields (as described above). In addition, enter information in the following fields:
   
   **Status**
   
   This field indicates the disposition of the item. The code you add will either be Enabled (turned on) or Disabled (turned off) and reserved for future use.

   **Disclosure**
   
   These fields contain the disclosure source and disclosure statement associated with this item. For more information, refer to the Disclosure section.

5. When finished, select Save.
To override Medicaid CCI data:
1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Medicaid CCI icon.
3. Enter the desired search criteria, and then select Find. The system displays a list of CCI data items.
4. Select the checkbox next to the item you want to override, and then select the Override button.
5. In the Override dialog, modify the settings as desired.
6. When finished, select Save.

To remove Medicaid CCI data:
1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Medicaid CCI icon.
3. Enter the desired search criteria, and then select Find. The system displays a list of CCI data items.
4. Select the box(es) next to the item(s) you want to remove.
5. Select the Remove button and confirm your action.

Medicare Physician Fee Schedule (MPFS)
The National Medicare Physician Fee Schedule (MPFS or NPFS) is a complete listing of fees used by health plans to pay providers who give services to Medicare beneficiaries. It is published by the CMS (Centers for Medicare and Medicaid Services) and is updated on a regular basis when there are payment and policy changes. In Claims Edit System, MPFS data is used by some of the Medicare rules for editing. This data is regularly delivered with the KnowledgeBase.

The MPFS table displays detailed information about MPFS billing policies (organized by procedure code). You can view MPFS data by accessing the Medicare Physician Fee Schedule module.

To view Medicare Physician Fee Schedule data:
1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the Medicare Physician Fee Schedule icon.
3. Use this screen to look up MPFS data for specific procedure codes. You can display MPFS data for all procedure codes by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow the list, use this criteria:

Procedure
Use this option to find a specific range of procedure codes. Enter the first code in the From field and the second code in the To field.

**Effective Date**

Enter the range of effective dates to restrict the search by this criterion.

**Expiration Date**

Enter the range of expiration dates to restrict the search by this criterion.

4. After you finish defining the search criteria, select Find. The system displays a list of procedure codes.

The fields of information are:

- **Procedure Code**
  
  Displays the procedure code for each item in the list.

- **Modifier**
  
  Displays the modifier (if any) that applies to the MPFS policy for the corresponding procedure code.

- **Description**
  
  Displays a description of the procedure.

- **Effective Date**
  
  Displays the effective date that applies to the MPFS policy for the procedure code.

- **Expiration Date**
  
  Displays the expiration date that applies to the MPFS policy for the procedure code.

5. You can expand an item to show greater detail by selecting the arrow to the left of the list item. The following additional information displays:

- **Status**

  Displays one of the following status codes:

  - A = Active Code
  - B = Bundled Code
  - C = Carriers price the code
  - D = Deleted Codes
  - E = Excluded from Physician Fee Schedule by regulation
  - F = Deleted/Discontinued Codes
  - I = Not valid for Medicare purposes
  - J = Anesthesia Services
  - M = Measurement Codes
  - N = Non-covered Services
  - P = Bundled/Excluded Codes

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G = Not valid for Medicare purposes (subject to a 90-day grace period)
H = Deleted Modifier
R = Restricted Coverage
T = Injections
X = Statutory Exclusion
Q = Therapy functional information code (for required reporting purposes only)

Professional Component/Technical Component (PC/TC Indicator)

Displays one of the following PC/TC codes:

- 0 = Physician Service Codes
- 1 = Diagnostic Tests for Radiology Services
- 2 = Professional Component Only Codes
- 3 = Technical Component Only Codes
- 4 = Global Test Only Codes
- 5 = Incident To Codes
- 6 = Laboratory Physician Interpretation Codes
- 7 = Physical therapy service, for which payment may not be made
- 8 = Physician interpretation codes
- 9 = Not Applicable

Follow Up Days (FUD)

Provides timeframes that apply to each surgical procedure.

Preoperative Percentage (Pre Op)

Percentage for preoperative portion of global package.

Intraoperative Percentage (Intra Op)

Percentage for intraoperative portion of global package.

Postoperative Percentage (Post Op)

Percentage for postoperative portion of global package.

Multiple Procedures (Multi Proc)

Displays one of the following codes to indicate applicable payment adjustment for procedures:

- 0 = No payment adjustment rules for multiple procedures.
- 1 = Standard payment adjustment rules in effect before January 1, 1995.
- 2 = Standard payment adjustment rules for multiple procedures.
- 3 = Special rules for multiple endoscopic pro-
- 6 = Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and there-
- 7 = Subject to 25% reduction of the second
4 = Special rules for the technical component (TC) of diagnostic imaging procedures.
5 = Subject to 50% of the practice expense component for certain therapy services.

highest and subsequent procedures to the TC of diagnostic ophthalmology services, effective for services January 1, 2013, and thereafter.
9 = Concept does not apply.

Bilateral Surgery (Bilat Surg)

Displays one of the following codes to indicate services subject to payment adjustment:

0 = 150% payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category.
1 = 150% payment adjustment for bilateral procedures applies.
2 = 150% payment adjustment DOES NOT apply. RVUs are already based on the procedure being performed as a bilateral procedure.
3 = The usual payment adjustment for bilateral procedures does not apply.
9 = Concept does not apply.

Assistant at Surgery (Asst Surg)

Displays one of the following codes to indicate service where an assistant surgeon is never paid:

0 = Payment restriction for assistants at surgery
1 = Statutory payment restriction for assistants at surgery
2 = Payment restriction for assistants at surgery does not apply
9 = Concept does not apply

Co-surgeons (Co-Surg)

Displays one of the following codes to indicate service for which two surgeons with different specialties may be paid:

0 = Co-surgeons not permitted
1 = Co-surgeons could be paid (needs documentation)
2 = Co-surgeons permitted (no documentation required)
9 = Concept does not apply

Team Surgeons (Team Surg)

Displays one of the following codes to indicate services for which team surgeons may be paid (Modifier 66):

0 = Team surgeons not permitted
Endoscopic Base Code (Endo Base)

Identifies an endoscopic base code for each code with a multiple surgery indicator of "3".

Physician Supervision of Diagnostic Procedures (SPV DxPx)

Displays one of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Procedure must be performed under the general supervision of a physician.</td>
</tr>
<tr>
<td>02</td>
<td>Procedure must be performed under the direct supervision of a physician.</td>
</tr>
<tr>
<td>03</td>
<td>Procedure must be performed under the personal supervision of a physician.</td>
</tr>
<tr>
<td>04</td>
<td>Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.</td>
</tr>
<tr>
<td>05</td>
<td>Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.</td>
</tr>
<tr>
<td>06</td>
<td>Procedure must be performed by a physician or a physical therapist (PT).</td>
</tr>
<tr>
<td>21</td>
<td>Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.</td>
</tr>
<tr>
<td>22</td>
<td>May be performed by a technician with online real-time contact with physician.</td>
</tr>
<tr>
<td>66</td>
<td>May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.</td>
</tr>
<tr>
<td>6A</td>
<td>Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.</td>
</tr>
<tr>
<td>77</td>
<td>Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.</td>
</tr>
<tr>
<td>7A</td>
<td>Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.</td>
</tr>
</tbody>
</table>
certification may supervise another PT, but only the PT with ABPTS certification may bill.

09 = Concept does not apply.

Diagnostic Imaging Family Indicator (Diag Imag)

Displays one of the following codes to identify the applicable diagnostic service family for that HCPCS codes with a multiple procedure indicator of "4":

01 = Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical)

02 = CT and CTA (Chest/Thorax/Abd/Pelvis)

03 = CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)

04 = MRI and MRA (Chest/Abd/Pelvis)

05 = MRI and MRA (Head/Brain/Neck)

06 = MRI and MRA (Spine)

07 = CT (Spine)

08 = MRI and MRA (Lower Extremities)

09 = CT and CTA (Lower Extremities)

10 = MR and MRI (Upper Extremities and Joints)

11 = CT and CTA (Upper Extremities)

88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after).

99 = Concept does not apply
Durable Medical Equipment Fee Schedule (DME)

The Durable Medical Equipment Fee Schedule (DME) is a listing of fees used by Medicare to pay for medical equipment that is deemed medically necessary. It is published by the CMS (Centers for Medicare and Medicaid Services) and is updated on a regular basis when there are payment or policy changes.

In Claims Edit System, DME data is used by some of the Medicare rules for editing. This data is delivered with the KnowledgeBase on a regular basis.

To view DME Fee Schedule data:

1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the DME Fee Schedule icon.
3. Use this screen to look up DME data for specific procedure codes. You can display DME data for all procedure codes by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow down the list, you can use the following criteria to do so:

   **Procedure**

   Use this option to find a specific range of procedure codes. Enter the first code in the From field and the second code in the To field.

   **Effective Date**

   Enter the range of effective dates to restrict the search by this criterion.

   **Expiration Date**

   Enter the range of expiration dates to restrict the search by this criterion.

   **State**

   Enter the abbreviation for a specific state (for example, AZ for Arizona) to restrict the search by this criterion.

   **Category**

   Enter a specific category code to restrict the search by this criterion. The following category codes are valid:

   - CR = Capped Rental Items
   - FS = Frequently Serviced Items
   - IN = Inexpensive and Routinely
   - PO = Prosthetics and Orthotics
   - SD = Surgical Dressings
   - SU = Supplies
Purchased Items
OS = Ostomy, Tracheostomy, and Urological Items
OX = Oxygen and Oxygen Equipment
TE = Transcutaneous Electrical Nerve Stimulators
TS = Therapeutic Shoes

Jurisdiction

Enter a specific jurisdiction code to restrict the search by this criterion. The following codes are valid:

D = DME/MAC Jurisdiction (National)
L = Local Carrier Jurisdiction
P = Joint Jurisdiction (Local and DME/MAC)

Note

To aid your search, remember that the wildcard character % indicates that you want to search for "any number of characters." For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria.

4. After you finish defining the search criteria, select Find. The system then displays a list of procedure codes. The fields of information displayed in this list are as follows:

Procedure Code

Displays the procedure code for each item in the list.

Description

Displays a description of the procedure.

Modifier (1&2)

Displays the modifiers (if any) that apply to the DME policy for the corresponding procedure code.

Effective Date

Displays the effective date that applies to the DME policy for the procedure code.

Expiration Date

Displays the expiration date that applies to the DME policy for the procedure code.

State
Displays the abbreviation for the state (for example, AZ for Arizona) that applies.

Category
Displays the category code that applies.

Jurisdiction
Displays the jurisdiction code that applies.

Fee Amount
Displays the fee amount that applies.

Parenteral and Enteral Nutrition Fee Schedule (PEN)
The Parenteral and Enteral Nutrition Fee Schedule (PEN) is a listing of fees used by Medicare to pay for PEN items and services. This schedule is published by the CMS (Centers for Medicare and Medicaid Services) and is updated on a regular basis when there are payment or policy changes.

In Claims Edit System, PEN data is used by some of the Medicare rules for editing. This data is delivered with the KnowledgeBase on a regular basis.

To view PEN Fee Schedule data:
1. Open the Code Repository module from the Enterprise entry-level screen.
2. Select the PEN Fee Schedule icon.
3. Use this screen to look up PEN data for specific procedure codes. You can display PEN data for all procedure codes by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow down the list, you can use the following criteria to do so:

Procedure
Use this option to find a specific range of procedure codes. Enter the first code in the From field and the second code in the To field.

Effective Date
Enter the range of effective dates.

Expiration Date
Enter the range of expiration dates.
To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria.

**4.** After you finish defining the search criteria, select **Find**. The system then displays a list of procedure codes. The fields of information displayed in this list are as follows:

**Procedure Code**
- Displays the procedure code for each item in the list.

**Description**
- Displays a description of the procedure.

**Modifier (1 & 2)**
- Displays the modifiers (if any) that apply to the PEN policy for the corresponding procedure code.

**Effective Date**
- Displays the effective date that applies to the PEN policy for the procedure code.

**Expiration Date**
- Displays the expiration date that applies to the PEN policy for the procedure code.

**National Fee Amount**
- Displays the fee amount that applies.

**ICD-10 to ICD-9 Diagnosis Comparison**

Claims Edit System can process claims with diagnosis codes of either the **ICD-9-CM**¹ format and/or the **ICD-10-CM**² format. However, during claims analysis, some rules must look at claim history to process the

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¹International Classification of Diseases (ICD), Ninth revision (-9), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval.

²International Classification of Diseases (ICD), Tenth revision (-10), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval. These codes allow more specific reporting of diseases and patient conditions.
claim correctly. (Refer to the Historical claims section for detailed information.) Because of this, an issue arises when the following conditions exist:

- A current claim/line for a particular patient contains an ICD-10 diagnosis code.
- A history claim/line for the same patient contains an ICD-9 diagnosis code that is relevant to the analysis. (For example, when considering whether or not a global period edit should be raised.)

When this is the case, the system needs to know which “historical” ICD-9 diagnosis codes may be considered comparable to the ICD-10 code on the current claim. This would be a simple process if a one-to-one relationship existed between the two code types. However, there are often several ICD-10 codes that could be considered comparable to a given ICD-9 code and vice-versa. Therefore, the system needs a way to let you know when an ICD-9 diagnosis code on a history claim may be considered comparable to an ICD-10 diagnosis code on a current claim.

To do this, Claims Edit System uses a backward comparison file created by the Centers for Medicare and Medicaid Services (CMS). “Backward” means the file first identifies the newer ICD-10 source code and then lists one or more alternative ICD-9 target codes that may be considered comparable. With that information, you can then review the patient’s documentation to determine whether an ICD-9 code on a history claim should be considered comparable to the ICD-10 code assigned on the current claim.

The CMS has also created a “forward mapping” ICD-9 to ICD-10 comparison file. However, this file is not included with Claims Edit System since forward mapping is not practical when there is no access to the detail found in the original medical record.

Viewing comparison files

To view a comparison file:

1. Follow the steps to access the Code Repository.
2. Select the ICD-10 to ICD-9 Diagnosis Comparison icon.
3. Using this screen, you can display a list of comparison files in the system. You can display a list of all files by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to search for a specific file, enter the name of the file in the Comparison File Name field and then select Find. The system then displays the following information for each file in the list:
   - Comparison File Name
     - This column shows the name of each file.
   - Version Date
This column is optional, and can be left blank. It contains a date (entered by the person importing the file) indicating when the file was created.

**Import Date**

For custom files, this column shows the date on which you last imported the file.

**Origin**

This column shows whether it is a system file or a custom file.

4. To view the contents of a specific file, select the underlined name in the first column. The system then displays the following fields for each item in the file:

**ICD-10 Source Code**

This column shows the name of each ICD-10 code (used as the starting point in the comparison).

**ICD-9 Target Code**

This column shows the ICD-9 code listed as potentially comparable to the corresponding ICD-10 code.

**Source**

If relevant, this column can display sourcing information (entered by you) about the defined relationship. For example, you could indicate if the source was the GEM file or a custom file you imported.

5. By default, the system lists relationships for the first 250 ICD-10 codes in the file. (Due to size limits, it cannot display more than 250 items.) However, if you want to search for one specific code, you can do so by entering that code in the ICD-10 Source Code field at the top of the screen and selecting **Find**.

**Note**

If the list contains more than 250 items, the system does not display any forward or back buttons to help you move through the list of results page by page. However, you can cause the system to display pagination arrows in the following manner:

1. Enter the wildcard character % in the ICD-10 Source Code field of the search criteria.
2. Select the **Find** button.

**Note**

The wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the...
wildcard character to search for multiple items matching a broader criteria. By entering only the wildcard character, the system will display everything in the list.

For many clients, the GEM file is adequate. However, some clients prefer a more customized approach, designing their own ICD-10 “comparison file scheme” or purchasing one from a third party vendor. In these cases, as long as the custom scheme can be exported to a file with CSV format (Comma Separated Values), you can import that file for use in Claims Edit System.

**CSV File Structure**

The basic structure of each line in the CSV file should be as follows:

```
[ICD-10 Code],[ICD-9 Code],[Source]
```

For example:

```
H65.115,381.02,CMS GEM  
H65.115,381.03,CMS GEM  
H65.115,381.04,CMS GEM  
H65.115,381.05,CMS GEM  
H65.115,381.06,CMS GEM  
```

Similarly, if you were to create this list in a spreadsheet program and then export to CSV format, it would look as follows:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-9 Code</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>H65.115</td>
<td>381.02</td>
<td>CMS GEM</td>
</tr>
<tr>
<td>H65.115</td>
<td>381.03</td>
<td>CMS GEM</td>
</tr>
<tr>
<td>H65.115</td>
<td>381.04</td>
<td>CMS GEM</td>
</tr>
<tr>
<td>H65.115</td>
<td>381.05</td>
<td>CMS GEM</td>
</tr>
<tr>
<td>H65.115</td>
<td>381.06</td>
<td>CMS GEM</td>
</tr>
</tbody>
</table>

When building or generating a CSV file, keep the following factors in mind: If you include decimal points in the codes, the system will strip them out during processing, so they are not necessary. The system automatically knows which digits belong before and after the decimal point. If you are using a spreadsheet, do not include a header row. The system may try to process the header as a set of codes.
Working with Custom Comparison Files

Once you have a custom file (in CSV format), you are ready to use it in Claims Edit System. Implementing a custom file follows this process:

- Import the comparison file.
- Set up a claim route (to link your comparison file with ruleset for analysis).

To import a comparison file:

1. Follow the steps to [access the Code Repository](#).
2. Select the **ICD-10 to ICD-9 Diagnosis Comparison** icon.
3. Select the **Import** button. A dialog displays asking you to enter the name of the file you want to import.
4. Enter information in the dialog box as follows:
   - **Comparison File Name**
     - Enter a unique name for the file (to distinguish it from other comparison files in the system). If you enter a name that is already used by another file, the system will overwrite the existing file with this new one.
   - **Version Date**
     - Using the calendar tool, select the desired version date.
5. When finished, select **Next**. The system displays a browsing utility.
6. Select the **Browse** button and select the file you want to import.
7. Select the **Begin Import** button. The system then imports the file. It will show up in the list of files.

To set up a corresponding claim route:

1. Go into the **Claim Routes** screen. (Refer to the [Claim Routes](#) section for details.)
2. Under **Destination Ruleset**, select from the dropdown menu. (Refer to the [Managing Rulesets](#) section for details.)

Among the system rulesets, the Medicare ruleset is the only one containing rules that look across claim history for diagnosis codes. Therefore, you should use a Medicare ruleset as the destination unless you want to build your own custom ruleset instead. If you do create a custom ruleset, remember to include the following rules among those you add to your ruleset:
(DCM) ICD-10 to ICD-9 Diagnosis Comparison

(mEV) Medicare Multiple Evaluation and Management Codes

(mFP) Medicare Global Follow-Up by Provider

Any other rules you have created that look across claim history for diagnosis codes

3. Under Routing Parameters, find the Diagnosis Comparison File field and select your custom file from the dropdown list.

4. Define the other settings for this claim route as appropriate.

5. Select Save when finished.

User-defined Tables

During claims analysis, the system uses various forms of data (such as that found in the Code Repository). However, sometimes unique policies require the use of data that doesn’t exist in the system. In that case, you need the ability to create your own data sets, which (supported by custom rules) can then be used to analyze claims.

With user-defined tables, you can create data sets — like contracted fee schedules or relationship data structures — to evaluate claims against multiple code relationships based on your unique policies.

Accessing User-defined Tables

To create a new user-defined table:

1. Follow the steps in the Accessing the Code Repository section.

2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.

3. Select the Add Table button.

4. On the ManageTable screen:
   a. Select the Change button (to activate fields).
   b. In the Name field, enter a unique name for your table.
   c. In the Description field, enter a brief description showing the purpose of the table.

5. Select the Save button.
6. Add the desired columns for the table.
   a. Select the Add Column button.
   b. In the Name field, enter a name for the column.
   c. In the Data Type dropdown field, select the desired data type to be used. You can select Alphanumeric, Numeric, Date, Phone Number, Zip Code, Decimal Number or True/False.
   d. In the Length field, enter the maximum number of characters that can be entered for data in this column.
   e. In the Description field, enter a brief description showing the purpose of the column.
   f. Select Save to create the column.
   g. Repeat this process to create as many columns as you need to complete the table.

7. If you add a column that you then want to remove:
   a. Select a checkbox next to the column you want to remove. The Delete Column button then becomes accessible.
   b. Select the Delete Column button. The system asks you to confirm the action.
   c. Select OK to confirm. The system removes the column from the table.

To open an existing user-defined table:
1. Follow the steps in the Accessing the Code Repository section.
2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.
3. Enter the applicable search criteria in the Selection Criteria section at the top of the screen.

To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria. (NOTE: Wildcards do not work in strictly numeric fields; they work only in alpha or alphanumeric fields.)

4. Select Find. The system then lists all existing tables.
5. In the list, select the checkbox next to the table you want to open.
Before you continue, check the Usage column for any table you want to open. This column tells you whether or not the table already contains data, and/or it is used in a rule. You cannot edit any table that is currently in use.

6. Select the Edit Table button. A screen opens where you can manage the data on the table. (Refer to the Managing data on user-defined tables section.)

To delete user-defined tables:

1. Follow the steps in the Accessing the Code Repository section.
2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.
3. Enter the applicable search criteria in the Selection Criteria section at the top of the screen.

Note

To aid your search, remember that the wildcard character % indicates that you want to search for "any number of characters." For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria. (NOTE: Wildcards do not work in strictly numeric fields; they work only in alpha or alphanumeric fields.)

4. Select Find. The system then lists all existing tables.
5. In the list, select the checkbox next to each table you want to delete.

Important!

Before you continue, check the Usage column for any table you want to delete. This column tells you whether or not the table already contains data, and/or it is used in a rule.

6. Select the Delete Table button. The system displays a dialog asking you to confirm the deletion.
7. Select OK to confirm the deletion. The system then deletes the table(s) selected.
Managing data on user-defined tables

To populate a user-defined table with imported data:

1. Using a program that supports the creation of Comma-Separated Value files (CSV), create a CSV data file to import:
   a. On the first row (or “header”), enter the exact column names matching those of the user-defined table to which you will import data in Claims Edit System. This will become the comma-delimited header row when you generate the CSV file. (If the column names do not match exactly, you will receive an error during the import.)
   b. Below the header rows (or in the individual records), enter the corresponding data. Each row/record will become a comma-delimited row when you generate the CSV file.
   c. When finished, select Save As and chose the CSV format. Save the file to a location where you can find and import it in Claims Edit System.

2. In Claims Edit System, follow the steps in the Accessing the Code Repository section.

3. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.

4. Select the checkbox next to the desired table (or create a new table as described above). Ensure that the table you select contains columns that match the data you plan to import (i.e., the same data type, the same field length, etc.).

5. Select the Edit Data button.

6. On the Manage Table Data screen, select the Import UDT button.

7. On the Upload UDT screen, define the following fields:
   a. In the CSV File Location field, select the Browse button to locate and select the file you want to import.
   b. In the Data Handling field, select one of the following options:
      - Append - Choose this option when you want to keep any data that already exists on the table. With this option, the import adds the new data to the table below the existing data.
      - Replace All - Choose this option when you want to remove any data that already exists on the table and replace it with the new data from the import file.

8. Select the Begin Import button. The system then imports the data to your table.
To manually populate a user-defined table with data:

1. Follow the steps in the Accessing the Code Repository section.
2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.
3. Open the desired table (or create a new table) as described above.
4. On the Manage Table Data screen, select the Add button.
5. In the Add dialog, enter the following for each column field:
   a. Enter the desired data in each named field.
   b. Enter the effective date that applies in each Effective Date field.
   c. Enter the expiration date that applies (if any) in each Expiration Date field.
7. Indicate whether this item should apply to the entire enterprise (refer to the Enterprises section for details), or specific rulesets within the enterprise.
8. When finished, select Complete Override.

To search for data records on a user-defined table:

1. Follow the steps to Access the Code Repository.
2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.
3. Select to open the desired table from the list.
4. On the Manage Table Data screen, enter the desired selection criteria to refine the search.
5. Select the Find button. The system then displays all table rows (i.e., records) that match the criteria.

To edit an individual data record on a user-defined table:

1. Follow the steps to access the Code Repository.
2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.
3. Select to open the desired table from those on the list.
4. On the Manage Table Data screen, select the checkbox next to the data record you want to edit.
5. Select the Edit button. The system then opens a dialog where you can edit the following for each field in the record:
a. In each named field, revise the entry for the desired data.

b. In each Effective Date field, revise the entry for the effective date that applies.

c. In eachExpiration Date field, revise the entry for the expiration date that applies (if any).

6. When finished, select Save.

**To delete individual data records from a user-defined table:**

1. Follow the steps to [access the Code Repository](#).

2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.

3. Select to open the desired table from those on the list.

4. On the Manage Table Data screen, select the checkbox next the data records you want to delete.

5. Select the Delete button. The system asks you to confirm the action.

6. After you confirm, the system removes those data records from the table. Once the data is removed, it no longer exists in the system, and the only way to get it back is to re-enter the data.

**To purge data from a user-defined table:**

1. Follow the steps in the [Accessing the Code Repository](#) section.

2. Select the User-Defined Tables icon. The system displays the User-Defined Table Browse screen.

3. Select to open the desired table from those on the list.

4. On the Manage Table Data screen, select the Purge All button. The system asks you to confirm the action.

5. After you confirm, the system removes all data records from the table. Once the data is removed, it no longer exists in the system, and the only way to get it back is to re-enter the data.
Local Coverage Determination (LCD)

LCD Overview

What are LCDs?

LCD stands for Local Coverage Determination. CMS (The Centers for Medicare & Medicaid Services) uses LCDs to determine coverage for Medicare policies that are local (rather than national) in scope.

| Note | LCDs used to be called LMRPs (Local Medical Review Policies). The difference is, LMRPs contained lists of codes plus a guidelines section. These two sections have been broken up into LCDs (lists of codes) and Articles (guidelines). |

To develop LCD policies, CMS works with independent contractors. Three kinds of contractors develop LCD policies:

- **Carrier** - A contractor that publishes only LCD Part B policies.
- **Fi (Fiscal Intermediary)** - A contractor that publishes only LCD Part A policies.
- **MAC (Medicare Administrative Contractor)** - A new class of Medicare contractor that covers both Part A and Part B for a larger (multi-state) jurisdiction. MACs will eventually replace Part A Fiscal Intermediaries and Part B Carriers.

| Note | **Quick Definition**: The CMS describes Part A and Part B as follows:  
**Part A** - Policies that cover payment for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.  
**Part B** - Policies that cover payment for doctors’ services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. |

Each contractor (Carrier, Fi, or MAC) is responsible to publish LCDs for a specified geographic area. These LCDs must be consistent with national policies (they can’t contradict national policies, although they can be more detailed and specific), and must be developed according to scientific evidence and clinical practice. Each contractor’s Medical Director develops these policies, adhering to federal guidelines. LCDs are published in various journals and are placed on the contractor’s website.

If a contractor develops an LCD, it applies only within the area it services. No contractor is bound by the policies or decisions of other contractors. Although separate contractors may come to a similar decision on any particular issue, CMS does not require them to do so.
Contractors develop LCDs to establish clinical circumstances under which a procedure or service is appropriate. The objective of an LCD is to establish automated review in the absence of a National Coverage Decision (NCD) or other coverage provision in an interpretive manual.

**How LCDs work in Claims Edit System**

**To work with LCDs in Claims Edit System:**

1. *Subscribe:* Before you can begin using LCD data, you must subscribe (through Optum) to receive regular LCD updates for a given jurisdiction (i.e., geographic areas covered by a contractor). Once you subscribe, Optum will notify you of updates to the data whenever such updates become available. (For information about how to subscribe, contact your Optum customer representative.)

   **Important!** As new MACs come online, they replace existing Carriers and/or Fiscal Intermediaries. Therefore, subscribers to older Carriers/FIs should always check to verify if they have been replaced by a new MAC. This is important because it is not likely that outgoing Carriers/FIs will update their policies, which means that the PDF file showing the retired policies will not say that these policies are retired.

2. *Download:* After you subscribe, you will receive a username and password, which you can use to log in at [http://optum.force.com/CustomerPortal](http://optum.force.com/CustomerPortal). There, you can access a file server that stores LCD data for each state in your subscription. (Refer to the **Loading LCD data** section.)

3. *Load:* After you download the LCD data files, you must load the data into the system. (Refer to the **Loading LCD data** section.)

4. *Customize (if necessary):* Once you load your LCD data, the system will begin using it during claims analysis. There is no need to modify the system to make it work. However, there may be cases where you want to customize some of the LCD data. When this is the case, you can use any of the following functions to help you:
   - Viewing LCD policies
   - Customizing LCD policies
   - Viewing LCD procedure codes
   - Creating custom LCD contractors (carrier, FI, MAC)
   - Working with LCD rules
Downloading Optum LCD data

Optum updates LCD clients with changes provided by each jurisdiction (i.e., geographic areas) on a regular basis. This allows you to load updated LCD data into the system and compare the update against your current LCD data.

To download LCD data:

1. On your hard drive, create a folder in which to store LCD data. (Optum recommends C:\LCDDATA.) You should use the same directory each time you download.

2. Open Internet Explorer.


4. Enter your Username and Password, and then select Login.

5. On the upper-left side of the screen, select the Products tab. The screen loads a list of all products for which you have a subscription.

6. Find LCD 4.X - 5.x on the list.

7. Select LCD 4.X - 5.x to expand this item and display a list of available contractors.

8. When you find the desired contractor, select it, and then select the Content Search link. This will retrieve a list of matching carrier extracts.

9. For each data file you want to download, select the checkbox next to the file.

10. After you select the desired files, select the Download button at the top of the list.

11. A dialog displays, asking you to confirm that you want to save the downloaded file. Select Save.

12. When the Save As dialog displays, indicate where you want to save the data file (example: C:\LCDDATA), then select the Save button.

13. After you finish downloading each desired data file, log out of the Customer Portal and close your browser. You can then proceed to load the data.
Loading LCD Data

It is required that LCD data is loaded during downtimes or periods when claims will not be processed in the system.

After you download LCD data, you must load the data into the system.

If you are loading LCD data for the first time, you can skip ahead to the instructions below. However, if you are loading an update to LCD data previously loaded on your system, you should check the LCD change report before loading the new data.

To check the LCD change report:

1. Find the folder where you downloaded the new LCD data. (Refer to the Downloading LCD data section.)
2. Open the .zip file you downloaded. Inside this file you will find the following file:
   - changes.htm
3. Copy this file to a location on your hard drive.

Once you are ready to load the new LCD data, there are two ways you can do so: a) you can load a single LCD data file, or b) you can load multiple files in a batch.

To load a single/multiple LCD data File(s):

Note: It is also possible to bulk load a set of LCD carrier data files using a command-line utility. For further details, refer to the Command-Line Tools section of the CM/CES Technical Configuration and Tools Guide.

1. From the Control Panel menu for an enterprise, select the LCD Data icon.
2. Select the Load LCD icon to display the Load LCD screen.
3. The controls for selecting and loading LCD data files are beneath the Selection Criteria panel as shown below. Select the Browse button to open a file browser.
4. Navigate to the folder where LCD data files are stored on your local workstation, select one or more files and then select the **Open** button. (The SHIFT and CTRL keys can be helpful when selecting multiple files.) Selected files are added to the status table as shown below.

<table>
<thead>
<tr>
<th>Filename</th>
<th>Size</th>
<th>Uploaded</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>B_20190113_5.X.zip</td>
<td>25.7 MB</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

5. Select the **Begin Import** button to begin the data import process. Each file in the list is first uploaded to the application server, and then the LCD data for that file is loaded into the database. Progress and overall status information is updated in the table under the Uploaded and Status columns.

<table>
<thead>
<tr>
<th>Filename</th>
<th>Size</th>
<th>Uploaded</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>B_20190113_5.X.zip</td>
<td>25.7 MB</td>
<td>59%</td>
<td>Uploading...</td>
</tr>
</tbody>
</table>

6. When the data load completes, the Status is shown as “Complete.” Note that the newly loaded file will not be included in the table of LCD carriers at the bottom of the screen until after the **Refresh** button has been selected. This also clears the information in the status table above. The following information is displayed for each LCD carrier:

- **Carrier**
  Indicates the name of the contractor that publishes the LCD data.

- **Carrier Num**
  Indicates the identification number of the contractor that publishes the LCD data.

- **LCD Version Date**
  Indicates the date on which the LCD data was published (in yyyymmdd format).

**Note**

It is possible to load multiple versions of the same LCD extract. Where multiple versions exist, each version has a different LCD version date; this is how to tell the difference between versions. Also, notice that only one version of the extract has a status of **In Use**, which means that only that version will be used during claims processing.

- **Date Imported**
  Indicates the date on which the LCD file was loaded in the system.

- **Status**
Indicates the status of the LCD data extract for a given LCD contractor. The following status settings are valid.

- **Pending** - This is the default status for a newly imported file. Pending files are not yet active in the live analysis environment.
- **In Use** - Indicates the data has been made active in the live analysis environment.
- **Inactive** - Indicates the data has been disabled from being used in the live analysis environment.

For information about how to change the status of an LCD file, refer to the Changing FI/MAC Status section (below).

### Changing FI/MAC status

The **Status** column on this screen indicates whether the data you imported for an LCD contractor is active (i.e., being used for live analysis). For each contractor, only one version of the same LCD data extract can be active at a time. Therefore, when you activate one contractor (with the same Carrier Number), the system automatically changes the status of that extract to **In Use**, and at the same time changes all other extracts for that contractor to **Inactive**. (Refer to the explanations of each status above.)

### To activate an FI/MAC policy (or version):

1. On the **Load LCD** screen, select the checkbox next to each FI/MAC (or version) you want to activate. You can select more than one FI/MAC at a time, but you cannot select multiple versions of the same FI/MAC.
2. Select the **Activate** button. The system then activates the FI/MAC and changes the status of corresponding versions (toggling between **In Use** and **Inactive**). Pending only displays when you first import a new file. For live claims processing, the system will only use **In Use** FI/MACs.

### Removing LCD data

### To remove an LCD:

1. On the **Load LCD** screen, select the checkbox next to an **Inactive FI/MAC**. (You cannot delete a policy that is **In Use**.)
2. Select the **Remove** button. The system then asks you to confirm the deletion.
3. Select **OK** to confirm the change. The system then removes the LCD data file.
Viewing LCD Policies

Claims Edit System gives you the ability to reference a list of LCD policies in the system and view the related CMS policy in PDF or HTML format.

To view LCD policies:

1. Open the LCD Data module from the Enterprise entry-level screen.
2. Select the Policies icon at the LCD Data screen.
3. Using this screen, you can display a list of the LCD policies in the system. You can display all policies by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow down the list, you can use the following criteria to do so:

   **Policy ID**
   
   Use this option to find a policy with a specific Policy ID (a unique identification number assigned by the CMS).

   **Carrier**
   
   Use this option to find policies associated with a specific carrier or other contractor.

   **Status**
   
   Use this option to find all policies set to a specific load status (i.e., the status of the LCD data file with which the policy is associated). The following options are available:
   
   - **Pending** - This is the default status for a newly imported file. Pending files are not yet active in the live analysis environment.
   - **In Use** - Indicates the data has been made active in the live analysis environment.
   - **Inactive** - Indicates the data has been disabled from being used in the live analysis environment.

   **Effective Date**
   
   Use this option to find all policies that are effective within a specific date range.

   **Expiration Date**
   
   Use this option to find all policies that expire within a specific date range.
Note
To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria.

4. After you define the desired Selection Criteria, select the Find button. The system then displays a list of corresponding policies.

Note
In some cases, you might see items listed with the same (i.e., duplicate) CPT codes, but different expiration dates. This occurs when a policy has changes that must take effect after a certain date, but not beforehand.

In the list that displays, there are two kinds of policies:

- **System Policies** - These are the standard policies that entered the system when you loaded LCD data. (Refer to the [Loading LCD data](#) section.) System policies appear in the list with a darker color.

- **Custom Policies** - These are custom policies you created for your system. (Refer to the [Customizing LCD policies](#) section.) Custom policies appear in the list with a lighter color. When a custom policy exists with the same ID number as a system policy, it is considered an “override,” meaning that the system will use the custom copy rather than the original system policy.

<table>
<thead>
<tr>
<th>Policy ID</th>
<th>Type</th>
<th>Carrier</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>System</td>
<td>0</td>
<td>08/31/1992</td>
</tr>
<tr>
<td>10.1</td>
<td>Custom</td>
<td>0</td>
<td>08/31/1992</td>
</tr>
</tbody>
</table>

5. In the Policy ID column, place the cursor over the ID number for the policy you want to view. The system will underline the item (as shown below).

6. Select the underlined item. The system then opens a screen showing information on the selected item.

7. Near the upper portion of this screen, there are two links called View Policy PDF and View Policy HTML.

Select either of these links and the system displays the entire Policy.
Customizing LCD Policies

In Claims Edit System, you can customize LCD policies in either of the following ways:

- You can create a new (custom) policy from scratch.
- You can go into a system policy and make changes. However, when you do this, the system does not actually modify the base system policy. Instead, it makes a second copy of the policy, using the same Policy ID number. Claims Edit System recognizes the new copy as an override to the system; it will use the copy rather than the original.

Creating New LCD policies

You can create a new LCD policy from scratch.

To create a new policy:

1. Open the LCD Data module from the Enterprise entry-level screen.
2. Select the Policies icon at the LCD Data screen. The Policies screen then displays.
3. Select the New Policy button.
4. Enter the desired settings in each of the fields. (Refer to the Viewing LCD policies section for details about the fields.)
5. When finished, select Save Changes to exit.

When creating a new policy, keep the following in mind:

- For LCD/NCD policies, the value in the Policy ID field cannot be the same as an original system policy - the system does not allow duplicate IDs.
- When you make a change to the Policy ID field, be aware that it is tied to the claim flag message. Therefore, any change you make to the Policy ID field will be reflected in the claim flag message.
- When adding a new diagnosis code (refer to the Attributes of LCD sub-policies section), the system will display an error if you try to leave the subset blank. Therefore, you should enter a value of zero (0) rather than leaving the subset blank.
Modifying (overriding) a system LCD policy

To override a system policy:

1. Open the LCD Data module from the Enterprise entry-level screen.
2. Select the Policies icon at the LCD Data screen. The Policies screen then displays.
3. Using this screen, you can display a list of the LCD policies in the system. You can display all policies by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow down the list, you can enter search criteria and then select Find.
4. Once the list of policies displays, find a policy and place the cursor over the Policy ID number. The system will underline the item (as shown below).

5. Select the underlined item. The system then opens a screen showing information on the selected item.

Important! Be sure to select a policy with the LCD Status for the carrier set to In Use. Otherwise you will not be able to save any changes you make to the policy. (Refer to the Changing FI/MAC status section for instructions on how to activate data.)

6. To modify the policy, edit the information in any of the following fields (leaving the existing settings as you deem appropriate):

   Policy Title
   
   Enter a descriptive title for the policy.

   Description
   
   Enter a description for the policy.

   Clause
   
   Select one of the following options for the policy:
   
   • Policy Title
   • Description
- Status
- Effective/Expiration Dates

**Effective Date**

Enter the date on which the policy becomes effective.

**Expiration Date**

Enter the date on which the policy expires.

| Note | You can modify the same policy several times if you use different effective and expiration dates. However, you should be careful not to allow multiple versions to overlap dates. |

**Status**

Select one of the following options for the policy:

- **Enabled** - Indicates the policy is active in the live analysis environment.
- **Disabled** - Indicates the policy exists, but the system does not use it in the live analysis environment.

7. After you make changes to any of these fields, select **Save Changes**. In addition to these changes, you can also customize the sub-policies associated with the policy.

**Customizing sub-policies**

There are two tabs in the lower portion of the screen:

- **Sub-Policies** - This tab displays by default. It lists all sub-policies associated with the main policy.
- **Procedures** - This tab displays all procedure codes associated with the policy.

**To modify an existing sub-policy:**

1. With the **Sub-Policies** tab selected, go to the **Identifier** column and select a policy number. The system then opens the sub-policy for editing.
2. Edit the attributes for the sub-policy. (Refer to the [Attributes of LCD sub-policies](#) section for details.)
3. When finished, select **Continue to Policy**. The system returns you to the main policy screen.
4. Select **Save Changes**.
To add a new sub-policy:

1. With the Sub-Policies tab selected, select the Add button. A dialog box displays.
2. From the dropdown box under the Type column, select the type of sub-policy you are creating.
3. From the dropdown box under the Edit Action column, select the edit action type for the policy you are creating.
4. When finished, select Save. The system then opens the sub-policy screen.

Adding Procedures to the Sub-Policy

Before you can exit the sub-policy screen, you must add at least one procedure to the sub-policy. To do this:

a. Make sure the Procedure tab is selected (it should be by default).

b. Select the Add button. A dialog box then displays in which you can define the following settings:
   
   **Code**

   Enter the desired procedure code.

   **Gender**

   If a specific gender applies to this procedure code, select the gender.

   **Minimum Age**

   If a minimum age applies to this procedure code, enter the age.

   **Min. Age Type**

   If you entered a minimum age, indicate whether that age is in days, months or years.

   **Maximum Age**

   If a maximum age applies to this procedure code, enter the age.

   **Max. Age Type**

   If you entered a maximum age, indicate whether that age is in days, months or years.

   **Broad Diagnostic**

   Indicate whether the procedure is broad diagnostic (i.e., it is a procedure that can have a broader application than the one restricted by this LCD policy).
Support

This field lists one of the following options for the relationship:

- Yes - Indicates a "supporting" relationship. This means that the system expects the procedure on the claim to match the procedure code entered here. In other words, the system will throw a flag when the claim contains a procedure code other than the one entered here.

- No - Indicates a "non-supporting" relationship. This means that the system expects the procedure on the claim to be different from the procedure code entered here. In other words, the system will throw a flag if the procedure code entered here is found on the claim.

Effective Date

Enter the date on which this procedure's relationship to the policy becomes effective.

Expiration Date

Enter the date on which this procedure's relationship to the policy expires.

c. When finished, select Save.
d. Continue this process for any other procedures you want to add.

Adding Other Attributes to the Sub-Policy

After you add procedure(s) to the sub-policy, you can go on to define other attributes. (Refer to the Attributes of LCD sub-policies section for details.) When finished, select Return to Policy.

To remove a sub-policy:

1. Select the checkbox next to each sub-policy you want to remove.
2. Select the Remove button.

How the system stores overrides

When you save modifications to a system policy, the system does not store those modifications in the original policy. Instead, the system creates a separate copy of the policy known as an "override."

![Image of Policy ID, Type, Carrier, Effective Date, Expiration Date, Extract/Change Date columns with data entries for Original Policy and Override Policy]
If you open (or edit) an override policy, it appears to have all of its own settings. However, most of these settings are actually inherited from the original system policy (with which it shares the same Policy ID and Carrier numbers). Only those settings that you have modified are actually stored in the new policy.

For each override policy you create, it is important to understand which attributes are inherited and which are not. This is because all inherited attributes are subject to change the next time you download an LCD data update (as illustrated below).

In other words, if an override policy inherits an attribute from a system policy and if that system policy changes during an LCD update, then the override policy might inherit those changes. However, the following conditions must exist for the inheritance to occur:

- The Policy ID and Carrier of the original policy must remain the same after the update.
- You must activate the updated policy after loading the update. (Refer to the Loading LCD data section.)
Because of this relationship between original policies and override copies, you must take steps to maintain your customized policies each time you load a new LCD extract.

To maintain customized policies when loading a new LCD extract:

1. Find the folder where you downloaded the new LCD data. (Refer to the Downloading LCD data section.)
2. Open the .zip file you downloaded. Inside this file you will find the following file:
   - changes.htm
3. Copy this file to a location on your hard drive.
4. Using a browser, open the file named changes.htm. This file will break down each of the system policies that have been changed for this release.
5. Compare your customized policies with those in the change report file and make adjustments as needed.

Keep in mind that the change report only shows items that have changed since the most recent update. Therefore, if you skipped an update (i.e., failed to download/load it), the report will not show items that changed during the update you missed.

Editing procedures from the Policy screen

By using the Procedures tab, you can also edit the settings for any procedures associated with the policy.

To edit a procedure:

1. Select the underlined procedure code you want to edit.
2. Modify the procedure settings as desired. (Refer to the Viewing LCD procedure codes section for details about these settings.)
3. When finished, select Save Changes to exit.

Attributes of LCD Sub-policies

When you edit or create an LCD policy, you can add sub-policies to the policy you are working with (refer to the Customizing LCD policies section). For each sub-policy you add, you can define specific attributes.
To define an attribute for a sub-policy:

1. Before you can define an attribute, you must first create the sub-policy. (Refer to the Customizing LCD policies section.) Once you create the sub-policy, the system displays a screen where you can define settings.

2. From the Sub-Policies screen, select the Add Attribute button.

3. From the dialog box that displays, select the type of attribute you want to define, then select Save. The system then adds a new tab to the sub-policy.

4. Select the Add button.

5. Enter the desired settings for the new attribute. (Refer to the Detailed settings for each attribute section below for details.)

6. Select the Save button.

7. Repeat this process for each attribute you want to define.

To delete an attribute:

If you want to remove an attribute, select the red X next to the corresponding tab. The system will then remove the attribute from the sub-policy.

Detailed settings for each attribute

The following settings are available for each attribute type:

Diagnosis

Diagnosis Code

Enter the first (or beginning) diagnosis code in the range of codes that apply.
Ending Diagnosis Code

Enter the last (or ending) diagnosis code in the range of codes that apply.

Code Type

Indicate whether the code is an ICD-9 code or an ICD-10 code.

Gender

If a specific gender applies to this range of diagnosis codes, select the gender.

Minimum Age

If a minimum age applies to this range of diagnosis codes, enter the age.

Min. Age Type

If you entered a minimum age, indicate whether that age is in days, months or years.

Maximum Age

If a maximum age applies to this range of diagnosis codes, enter the age.

Max. Age Type

If you entered a maximum age, indicate whether that age is in days, months or years.

Subset

Indicates whether the range of diagnosis codes should be billed in a specific group of diagnosis codes. There can be an unlimited number of subsets.

[Sequence/Group]

These two fields work together, and the significance of each field depends on the settings you make in the other:

- If you set the Ordered field to Yes, the Sequence/Group becomes a sequential grouping number (within the corresponding subset). This means the system considers all diagnosis codes with the same Sequence/Group number as belonging to the same sequential group. (Those with a number 1 are part of the “Primary” group, those with number 2 are part of the “Secondary” group, and those with number 3 are part of the “Tertiary” group.) The system then checks for two things:
  a. It checks to verify that at least one code from each group appears on the claim.
  b. It checks to verify that the sequencing is honored (i.e., no secondary or tertiary codes appear before a primary code, etc.).
The system only allows you to enter a number 0-3 in the Sequence/Group field.

- If you set the **Ordered** field to **No**, the **Sequence/Group** becomes a non-sequential grouping number (within the corresponding subset). In other words, the system considers all diagnosis codes with the same **Sequence/Group** number as belonging to the same group, but sequence doesn’t matter. Thus, the system checks to verify that at least one code from each group appears on the claim, regardless of where it appears.

- If you leave the **Ordered** field blank, the **Sequence/Group** must also be left blank. This indicates the diagnosis code has a “standalone” relationship (i.e., is not considered with other diagnosis codes, but must be present).

**Ordered**

Indicate the order (sequence) of a diagnosis code.

**Support**

In this field, select one of the following options:

- **Yes** - Indicates a “supporting” relationship. This means that the system expects the diagnosis on the claim to match the diagnosis codes listed in the range. In other words, the system will throw a flag when the claim contains any diagnosis code other than the ones in this list.

- **No** - Indicates a “non-supporting” relationship. This means that the system expects the diagnosis on the claim to be different from the diagnosis codes listed in the range. In other words, the system will throw a flag if any of the diagnosis codes listed are found on the claim.

**Effective Date**

Indicate the effective date (if any) that applies.

**Expiration Date**

Indicate the expiration date (if any) that applies.

**Implementation Date**

Indicate the implementation date of the diagnosis code.

**Status**

Select one of the following options:
- **Enabled** - Indicates these settings have been made active in the live analysis environment.
- **Disabled** - Indicates these settings have been disabled from being used in the live analysis environment.

**Modifier**

*Modifier*

Enter the modifier that applies.

**Required**

In this field, select one of the following options:

- **Yes** - Indicates the modifier you enter here is required. This means the system expects the modifier on the claim to match the modifier listed here. In other words, the system will throw a flag when the claim contains any modifier other than the one listed here.
- **No** - Indicates the modifier you enter here is not allowed. This means the system expects the modifier on the claim to be different from the modifier listed here. In other words, the system will throw a flag when this modifier is found on the claim.
- **Optional** - Indicates the system will accept a modifier on the claim to match the modifier listed here, but does not require this match.

**Effective Date**

Indicate the effective date (if any) that applies.

**Expiration Date**

Indicate the expiration date (if any) that applies.

**Implementation Date**

Indicate the implementation date of the diagnosis code.

**Status**

Select one of the following options:

- **Enabled** - Indicates these settings have been made active in the live analysis environment.
- **Disabled** - Indicates these settings are inactive in the live analysis environment.
Place of Service (POS)

Place of Service

Enter the place of service code that applies.

Required

In this field, select one of the following options:

- **Yes** - Indicates the place of service code you enter here is required. This means the system expects the code on the claim to match the code listed here. In other words, the system will throw a flag when the claim contains any place of service code other than the one listed here.

- **No** - Indicates that the place of service code you enter here is not allowed. This means the system expects the code on the claim to be different from the code listed here, and will throw a flag when this code is found on the claim.

- **Optional** - Indicates the system will accept a place of service code on the claim to match the modifier listed here, but does not require this match.

Effective Date

Indicate the effective date (if any) that applies.

Expiration Date

Indicate the expiration date (if any) that applies.

Implementation Date

Indicate the implementation date of the diagnosis code.

Status

Select one of the following options:

- **Enabled** - Indicates these settings have been made active in the live analysis environment.

- **Disabled** - Indicates these settings are inactive in the live analysis environment.

Frequency

Under this tab, there are two sections:

**Header Section**

The upper section contains settings for the Frequency attribute as a whole. It contains the following fields:
**Frequency Type**

Indicate what type of restriction should apply (for example, less than the allowed amount, greater than the allowed amount, equal to the allowed amount, etc.).

**Number Allowed**

Enter the allowed amount that applies (described above).

**Duration**

Indicate how many increments of time (refer to the Span section, below) apply to the allowed amount (refer to the Allowed section, above).

**Span**

Indicate the time span during which the maximum setting applies (refer to the Allowed and Duration sections, above). Available settings are Days, Weeks, Months, Years or Lifetime.

**Accounting**

For a given procedure, the system can calculate maximum frequency in two different ways:

a. The frequency count can increase only when the procedure itself occurs (within the limited timeframe).

b. The frequency count can increase each time any procedure belonging to the same “group” occurs (within the limited timeframe).

The Accounting field indicates which of these methods apply. Select from the following options in this field:

- Individual - This means that the frequency setting applies to each individual code exclusively.
- Group - This means that the frequency setting applies to the entire code group collectively.

**Group Members**

Enter the other procedure codes that belong to the same group (if the Group accounting is used).

**Effective Date**

Indicate the effective date (if any) that applies.

**Expiration Date**

Indicate the expiration date (if any) that applies.

**Implementation Date**
Indicate the implementation date of the diagnosis code.

**Status**

Select one of the following options:

- Enabled - Indicates these settings have been made active in the live analysis environment.
- Disabled - Indicates these settings are inactive in the live analysis environment.

**Codes Section**

Once you have defined the main (header) settings for the frequency attribute, a lower section displays where you can add ranges of procedure codes.

If you add any procedure codes to the *Frequency* tab, make sure the codes are also listed under the Procedure tab (even if you have to add them there). If you add any code on this tab that is not also listed under the *Procedure* tab, it will not trigger the frequency flag as desired.

You can add codes to this section using the following fields:

**Beginning Code**

Enter the first (or beginning) procedure code in the range of codes that apply.

**Ending Code**

Enter the last (or ending) procedure code in the range of codes that apply.

**Effective Date**

Indicate the effective date (if any) that applies.

**Expiration Date**

Indicate the expiration date (if any) that applies.

**Status**

Select one of the following options:

- Enabled - Indicates these settings have been made active in the live analysis environment.
- Disabled - Indicates these settings are inactive in the live analysis environment.
**Code-to-Code**

*Beg. Code*

Enter the first (or beginning) procedure code in the range of codes that apply.

*End. Code*

Enter the last (or ending) procedure code in the range of codes that apply.

*Effective Date*

Indicate the effective date (if any) that applies.

*Expiration Date*

Indicate the expiration date (if any) that applies.

*Implementation Date*

Indicate the implementation date of the diagnosis code.

*Status*

Select one of the following options:

- Enabled - Indicates these settings have been made active in the live analysis environment.
- Disabled - Indicates these settings are inactive in the live analysis environment.

**Specialty**

*Specialty*

Enter the specialty code that applies.

*Allowed*

Select one of the following options:

- Yes - This means the specialty code is allowed for the procedure (i.e., expected by the system for this sub-policy).
- No - This means the specialty code is not allowed for the procedure (i.e., not expected by the system for this sub-policy).

*Effective Date*
Indicate the effective date (if any) that applies.

Expiration Date

Indicate the expiration date (if any) that applies.

Implementation Date

Indicate the implementation date of the diagnosis code.

Status

Select one of the following options:

- Enabled - Indicates these settings have been made active in the live analysis environment.
- Disabled - Indicates these settings are inactive in the live analysis environment.

Expiring or Disabling LCD Policies

To effectively manage your LCD data, you may want to make certain policies inactive so that they do not conflict with other policies.

Expiring policies

By expiring a policy, you limit the number of claims that can apply to that policy by setting an expiration date.

To expire an LCD policy:

1. Open the LCD Data module from the Enterprise entry-level screen.
2. Select the Policies icon at the LCD Data screen.
3. Enter the desired Selection Criteria and select the Find button.
4. In the Policy ID column of the list, place the cursor over the ID number for the policy you want to open, and then select the underlined number. The system opens the policy for editing.
5. Go to the Expiration Date field and set the date on which you want the policy to expire. The system will apply the policy only to claims dated on or before the date you set here.

**Note**  
Keep in mind the Effective Date when selecting an Expiration Date. You cannot set the policy to expire on any date prior to the effective date.

6. Select Save Changes when finished.
Disabling policies

When you disable a policy, it continues to reside in the system (much like an expired policy). However, no claims will apply to that policy, regardless of the date on the claim.

To disable an LCD policy:

1. Open the LCD Data module from the Enterprise entry-level screen.
2. Select the Policies icon at the LCD Data screen.
3. Enter the desired Selection Criteria and select the Find button. The system then displays a list of policies matching the criteria.
4. In the Policy ID column of the list, place the cursor over the ID number for the policy you want to open, and then select the underlined number.
5. Go to the Status field and select Disabled.
6. Select Save Changes when finished.

Viewing LCD Procedure Codes

Claims Edit System gives you the ability to view a list of the main LCD procedure codes and their relationships.

To view LCD procedure codes:

1. Open the LCD Data module from the Enterprise entry-level screen.
2. Select the Procedures icon on the LCD Data screen.
3. Using this screen, you can display a list of the main LCD procedures in the system. You can display all LCD procedures by leaving the Selection Criteria alone (default options), then selecting the Find button. However, if you want to narrow down the list, use the following criteria:

   Code
   
   Use this option to find a specific procedure code.

   Policy #
   
   Use this option to find procedures associated with a specific LCD policy. Enter the CMS ID number in this field (a unique identification number assigned by CMS).

   Carrier
Use this option to find a procedure associated with a specific carrier or other contractor.

**Status**

Use this option to find all procedures with a specific load status (i.e., the status of the LCD data file with which the procedure is associated). The following options are available:

- **Pending** - This is the default status for a newly imported file. Pending files are not yet active in the live analysis environment.
- **In Use** - Indicates the data has been made active in the live analysis environment.
- **Inactive** - Indicates the data has been disabled from being used in the live analysis environment.

**Procedure Type**

Use this option to find custom procedures vs. system procedures.

| Note | To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria. |

4. After you define the **Selection Criteria**, select the **Find** button.

5. In the **Code** column, place the cursor over the procedure code you want to view. The system will underline the item.

6. Select the underlined item. The system displays a screen showing detailed information about the LCD policies surrounding the procedure code.

![Diagram of relationship tabs and diagnostic model](image)

The information on this screen displays in list form. The specific list information displayed depends upon which tabs you select. (Selected tabs appear light blue while non-selected tabs appear gray.) There are two types of tabs on this screen:
Relationship Tabs - On the left side of the screen, the system displays one tab for each procedure code relationship that is part of LCD policies. You can select these tabs to toggle between relationships, and the system will change the information displayed on the list (to the right) accordingly.

On this screen, you may see tabs for any of the following types of relationships:

- Medical Necessity (Med Nec) - A relationship where the procedure code is deemed “Medically Necessary” if certain diagnosis codes are also used. (“Medical Necessity” means a procedure is reasonable, necessary, and/or appropriate based on clinical standards of care.)
- Code-to-Code (C2C) - A relationship where the procedure code has other (additional) procedure codes associated with it in the LCD policies.
- Procedure Modifier (Proc Mod) - A relationship where the procedure code has specific modifier associations that affect medical necessity.
- Procedure Frequency (Proc Frequ) - A relationship where the procedure code has maximum frequency restrictions associated with it. (By “Maximum Frequency,” we mean that there are limits on the number of times a procedure can be billed within a given time period.)
- Procedure Place of Service (Proc POS) - A relationship where the procedure has Place of Service (POS) restrictions associated with it in LCD policies.
- Procedure Age/Gender (Proc Age/Gender) - A relationship where the procedure has restrictions (based on patient age and/or gender) associated with it in LCD policies.
- Procedure Modifier Frequency (Proc Mod Frequ) - A relationship where the procedure code has specific modifier associations, which have maximum frequency restrictions associated with them.

About Edit Action Types

Each Relationship tab has a specific “action” (e.g., pay, profile, etc.). These are the specific edit actions associated with the relationship.

While most policies state that a claim can be paid if it meets the requirements of the policy, some policies specify that the claim line should be denied or that documentation should be requested or reviewed.

The edit action type identifies the appropriate action to be taken when a claim line matches the requirements of an NCD or LCD policy.

The following edit actions are possible for a given relationship:

- Pay
- Pend – Request Documentation
About Overrides

You will notice an **override** button on the currently-selected Relationship tab. This button allows you to go into the selected relationship and modify the settings. When you do this, the system records your changes as an override to the original relationship settings.

**List Tabs** - Along the top of this screen, the system displays a set of tabs that control what kind of information will display on the list below it. The system displays one tab for each type of list that applies. For example, if there is an LCD relationship between diagnosis codes and the procedure code, then a *Diagnosis* tab displays to let you see a list of these diagnosis codes. Similarly, if there is an LCD relationship between modifiers and the procedure code, then a *Modifier* tab displays to let you see them.

The following list tabs may appear on this screen:

<table>
<thead>
<tr>
<th>Note</th>
<th>The system will rarely (if ever) display all of the following tabs on the same screen. Rather, the system displays only those tabs that apply to the selected procedure code (usually only one or two tabs).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Diagnosis</em></td>
</tr>
<tr>
<td></td>
<td><em>Modifier</em></td>
</tr>
<tr>
<td></td>
<td><em>Place of Service (POS)</em></td>
</tr>
<tr>
<td></td>
<td><em>Code-to-Code (C2C)</em></td>
</tr>
<tr>
<td></td>
<td><em>Age/Gender</em></td>
</tr>
<tr>
<td></td>
<td><em>Frequency</em></td>
</tr>
<tr>
<td></td>
<td><em>Provider Specialty</em></td>
</tr>
</tbody>
</table>

**LCD Procedure List Tabs**

When you open an LCD procedure (refer to the Viewing LCD procedure codes section), the system displays lists containing information about the procedure’s LCD relationships. The specific list displayed depends upon
which tabs you select. The following are descriptions for each tab that may display on this screen.

Note
The system will rarely (if ever) display all of the following tabs on the same screen. Rather, the system displays only those tabs that apply to the selected procedure code (usually only one or two tabs).

**Diagnosis tab**

This tab displays if the procedure has LCD relationships that involve diagnosis codes.

Under this tab, the following information displays for each diagnosis code listed:

*Diagnosis*

Displays the range of diagnosis codes that apply to the relationship.

*Code Type*

Displays the code type for the listed diagnosis code (e.g., ICD-9, ICD-10).

*Gender*

Displays the gender requirement for the listed diagnosis code.

*Min Age*

Displays the minimum age requirement for the listed diagnosis code.

*Max Age*

Displays the maximum age requirement for the listed diagnosis code.

*Implementation Date*

Indicates the implementation date of the diagnosis code.

*Subset*

Indicates whether the diagnosis code should be billed in a specific group of diagnosis codes. There can be an unlimited number of subsets.

*Sequence/Group Ordered*
If Ordered = Yes, the code(s) is sequenced and the value in the Sequence/Group Ordered column designates the position in which the codes must exist (e.g., Primary, Secondary, Tertiary). If Ordered = No, the value in the Sequence/Group Ordered column designates a grouping. For example, if there were primary and secondary groups, one code from the primary group would have to be present on the line as well as one code from the secondary group, but the codes do not have to be in a specific order on the claim line.

Support

This field lists one of the following options for the relationship:

- Yes - Indicates a “supporting” relationship. This means that the system expects the diagnosis on the claim to match the diagnosis codes listed in the range. In other words, the system will throw a flag when the claim contains any diagnosis code other than the ones in this list.
- No - Indicates a “non-supporting” relationship. This means that the system expects the diagnosis on the claim to be different from the diagnosis codes listed in the range. In other words, the system will throw a flag if any of the diagnosis codes listed are found on the claim.

Effective Date

Indicate the effective date (if any) that applies.

Expiration Date

Indicate the expiration date (if any) that applies.

Implementation Date

Indicate the implementation date of the diagnosis code.

Origin

Indicates the Enterprise level where the relationship was created. (Refer to the Enterprise hierarchy section for details.)

Status

Indicates whether the relationship is used during claims analysis (enabled) or is ignored (disabled).

Modifier Tab

This tab displays if the procedure has LCD relationships that involve modifiers.

Under this tab, the following information displays for each modifier listed:

Modifier
Displays the modifier that applies to the relationship.

*Required*

This field lists one of the following options for the relationship:

- **Yes** - Indicates the modifier you enter here is required. This means the system expects the modifier on the claim to match the modifier listed here. In other words, the system will throw a flag when the claim contains any modifier other than the one listed here.

- **No** - Indicates the modifier you enter here is not allowed. This means the system expects the modifier on the claim to be different from the modifier listed here. In other words, the system will throw a flag when this modifier is found on the claim.

- **Optional** - Indicates the system will accept a modifier on the claim to match the modifier listed here, but does not require this match.

*Effective Date*

Indicate the effective date (if any) that applies.

*Expiration Date*

Indicate the expiration date (if any) that applies.

*Implementation Date*

Indicate the implementation date of the diagnosis code.

*Origin*

Indicates the Enterprise level where the relationship was created. (Refer to the [Enterprise hierarchy](#) section for details.)

*Status*

Indicates whether the relationship is used during claims analysis (enabled) or ignored (disabled).

**Place of Service (POS) tab**

This tab displays if the procedure has LCD relationships that involve Place of Service (POS) codes.

Under this tab, the following information displays:

*Place of Service*

Displays each POS code that has an LCD relationship with the procedure.

*Allowed*
This field lists one of the following options for the relationship:

- Yes - This means the POS code is allowed on the claim, and the system expects it to appear on the claim. Therefore, the system will throw a flag if the POS code is missing.
- No - This means the POS code is not allowed on the claim, and the system does not expect it to appear on the claim. Therefore, the system will throw a flag if the POS code appears on the claim.

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Origin**

Indicates the Enterprise level where the relationship was created. (Refer to the [Enterprise hierarchy](#) section for details.)

**Implementation Date**

Indicates the implementation date of the diagnosis code.

**Status**

Indicates whether the relationship is used during claims analysis (enabled) or is ignored (disabled).

**Effective Date**

Indicate the effective date (if any) that applies.

**Expiration Date**

Indicate the expiration date (if any) that applies.

**Implementation Date**

Indicate the implementation date of the diagnosis code.

**Code/Code Tab**

Many procedures have additional procedures (code-to-code relationships) associated with them. This tab displays if the selected procedure has these kinds of LCD relationships.

Under this tab, the following information displays:

**Code**
Displays the procedure code (or range of codes) that must be billed with the main procedure.

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Origin**

Indicates the Enterprise level where the relationship was created. (Refer to the [Enterprise hierarchy](#) section for details.)

**Implementation Date**

Indicates the implementation date of the diagnosis code.

**Status**

Indicates whether the relationship is used during claims analysis (enabled) or is ignored (disabled).

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Implementation Date**

Indicates the implementation date of the diagnosis code.

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Implementation Date**

Indicates the implementation date of the diagnosis code.

**Age/Gender Tab**

This tab displays if the procedure has LCD relationships that involve age or gender restrictions.
Under this tab, the following information displays for each modifier listed:

**Attribute**

Indicates whether each item is an age relationship or a gender relationship.

**Value**

Displays a description of the age or gender restriction that applies.

**Required By Diagnosis**

Lists one of the following options for the relationship:

- Yes - This means the diagnosis specifies the age/gender relationship instead of the procedure.
- No - This means the procedure specifies the age/gender relationship.

**Origin**

Indicates the Enterprise level where the relationship was created. (Refer to the Enterprise hierarchy section for details.)

**Implementation Date**

Indicates the implementation date of the diagnosis code.

**Status**

Indicates whether the relationship is used during claims analysis (enabled) or is ignored (disabled).

### Frequency Tab

Many procedures have maximum frequency restrictions associated with them. (By “Maximum Frequency,” we mean that there are limits on the number of times a procedure can be billed within a given time period.) This tab displays if the selected procedure has these kinds of LCD relationships.

Under this tab, there are two sections:

**Header Section**

The upper section contains settings for the Frequency relationship as a whole. It contains the following fields:

**Type**

Indicates what type of restriction applies (i.e., less than the allowed amount, greater than the allowed amount, equal to the allowed amount, etc.).
Allowed
Displays the allowed amount that applies to the restriction (described above).

Duration
Indicates how many increments of time (refer to Span, below) apply to the allowed amount (refer to Allowed, above).

Span
Indicates the time span during which the maximum setting applies (refer to Allowed and Duration, above).
Available settings are Lifetime, Year, Semi-annual, Quarterly, Monthly, and Weekly.

Accounting
For a given procedure, the system can calculate maximum frequency in two different ways:

a. The frequency count can increase only when the procedure itself occurs (within the limited timeframe).

b. The frequency count can increase each time any procedure belonging to the same “group” occurs (within the limited timeframe).

The Accounting field indicates which of these methods apply. The following options may appear in this field:

- Individual - This means that the frequency setting applies to each individual code exclusively.
- Group - This means that the frequency setting applies to the entire code group collectively.

Effective Date
Indicates the effective date (if any) that applies.

Expiration Date
Indicates the expiration date (if any) that applies.

Origin
Indicates the Enterprise level where the relationship was created. (Refer to the Enterprise hierarchy section for details.)

Implementation Date
Indicates the implementation date of the diagnosis code.

Status
Indicates whether the relationship is used during claims analysis (enabled) or is ignored (disabled).

**Codes Section**

The lower section contains settings for any other procedure codes that apply in a frequency relationship to the main procedure code.

**Important!**

Any codes listed under the *Frequency* tab must also be listed under the *Procedure* tab. Otherwise the system will not trigger the frequency flag as desired.

This section contains the following columns:

**Code Range**

Lists the range of procedure codes that apply.

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Origin**

Indicates the Enterprise level where each code range was entered. (Refer to the *Enterprise hierarchy* section for details.)

**Status**

Indicates whether a given code range is used during claims analysis (enabled) or is ignored (disabled).

**Provider Specialty**

This tab displays if the procedure has LCD relationships that involve Provider Specialty.

Under this tab, the following information displays:

**Specialty**

Displays the specialty code that applies to the relationship.

**Allowed**
This field lists one of the following options for the relationship:

- **Yes** - This means the specialty code is allowed for the procedure (i.e., expected by the system).
- **No** - This means the specialty code is not allowed for the procedure (i.e., not expected by the system).

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Origin**

Indicates the Enterprise level where the relationship was created. (Refer to the Enterprise hierarchy section for details.)

**Implementation Date**

Indicates the implementation date of the diagnosis code.

**Status**

Indicates whether the relationship is used during claims analysis (enabled) or is ignored (disabled).

**Effective Date**

Indicates the effective date (if any) that applies.

**Expiration Date**

Indicates the expiration date (if any) that applies.

**Effective Date**

Indicates the effective date (if any) that applies.
Indicates the effective date (if any) that applies.

Expiration Date
Indicates the expiration date (if any) that applies.

Effective Date
Indicates the effective date (if any) that applies.

Expiration Date
Indicates the expiration date (if any) that applies.

Creating Custom Carriers
To develop LCD policies, CMS works with independent contractors (also known as carriers).

By default, the system maintains information about carriers as part of the LCD data you load (refer to the Loading LCD data section). You can work with these standard carriers as they exist in your system, creating custom policies and overrides as needed (refer to the Customizing LCD policies section). However, there may be cases where you want to create custom carriers for certain custom policies. When this is the case, you can create custom carriers as follows:

To create a custom carrier:
1. Open the LCD Data module from the Enterprise entry-level screen.
2. Open the module to Load LCD. A screen displays listing the LCD carriers that exist on your system.
3. Select the Create Custom Carrier button. A dialog displays where you can enter the following information:

Carrier
Enter the name of your custom contractor.

Carrier Description
Enter a description of your custom contractor.

4. When you finish, select the Save button. The system then creates your custom contractor, with a default status set to In Use. You can distinguish custom contractors because they appear in the list highlighted in a lighter color than the system contractors do.
The system lists all contractors in alphabetical order. Therefore, you may need to scroll down to find your custom contractor in the list.

**To remove a custom carrier:**

1. From the list of carriers, select the checkbox next to the item(s) you want to remove.
2. At the top of the list, select the **Remove** button.
3. The system displays a prompt asking you to confirm that you want to continue with the removal. Select **OK**. The system then removes the designated carriers.

**Working with LCD Rules**

Claims Edit System contains a special rule to process LCDs. This rule is part of the system’s *Medicare Professional* ruleset, and it raises several flags during claims analysis. To understand how the LCD rule raises these flags, you can look at the rule logic in the *Rules Management* module.

*Beginning with the 2017 Q3A KB, there are two versions of the PE LCD Rule in DDR (LCD Rule and LCD Rule Excludes Broad Diagnostic).*

To understand the logic of the LCD rule (or any other rule), you must be a qualified rule developer that is familiar with the system rules and rules management. Before you try to adjust the system of rules, make yourself familiar with the Rules Management section and all supporting documents.

**To access and view an ILOG LCD rule:**

1. Open the **Rules** module from the *Enterprise* entry-level screen.
2. Select **Manage Rules**. The system displays the Rules Management screen.
3. From the list of rules displayed, select an **LCD Rule**.

**Note**

The system lists all contractors in alphabetical order. Therefore, you may need to scroll down to find your custom contractor in the list.
Note  If you cannot see a list of rulesets to choose from, select the Find button. The system will then display a list of all rulesets in the system.

4. Once you open the desired rule, the system displays the basic settings for that rule. The logic for this rule displays in the Rule Logic section of this screen (toward the bottom).

Customizing LCD rules

If you find that the LCD Rule does not meet your needs, you can customize the system. Again, it is very important that only qualified rule developers attempt to adjust the system of rules.

For additional information about how this works, refer to the Managing rules section.

Note that these instructions for customizing LCD rules and routing claims to LCD rules are specific to ILOG, though the routing portion applies if the user is using the static DDR UI.

Routing claims to LCD rules

When a claim enters the Claims Edit System, it does not automatically run against every rule in the system. Rather, claims are assigned to run against specific sets of rules that work together in analyzing a specific type of claim. (Refer to the Managing rulesets section and the Claim routes section for details about how this works.)

The LCD rule is part of the Medicare system ruleset. However, by default, the system does not use the Medicare ruleset, but only routes claims to the commercial ruleset. Therefore, if you want to use the LCD rule, you must create a separate claim route to the Medicare ruleset. (Refer to the Claim routes section for details about this process.) Similarly, if you create any custom LCD rules, you must establish claim routes to any custom rulesets you have created. Otherwise, the system cannot use those rules during analysis.

DDR PE LCD Rule

DDR PE LCD Rule Key Considerations

Optum recommends that users begin using the DDR PE LCD rules instead of the ILOG LCD rules. The DDR LCD rule contains the most current NCD/LCD claims editing functionality.

LCD Rule vs. LCD Rule Excludes Broad Diagnostic

Starting with the CM_KB_2017_Q3A_5.0-5.4 KnowledgeBase, the application includes two versions of the PE LCD Rule: the LCD Rule and LCD Rule - Excludes Broad Diagnostic. The LCD Rules ignore the diagnosis code requirements on an Action Group (AG) if it has the Broad Diagnostic designation; any diagnosis
code meets the diagnosis code requirement. The LCD Rule Excludes Broad Diagnostic rules enforce the Action Group’s (AG’s) diagnosis code requirements; only the listed diagnosis codes meet the diagnosis code requirements for the AG. Use only one of these rules.

For Static DDR, the Medicare PE and Medicare DME PE system rulesets contain both rules. When using the Medicare system rulesets, copy the ruleset and disable or remove the rule you are not using. When using a custom Medicare Ruleset, add the appropriate rule for use.

For Dynamic DDR, make the appropriate rule active and disable or ignore the rule not in use.

Starting with the 2017 Q4A KnowledgeBase, users have the ability to create LCD policy-level overrides to force Broad Diagnostic and Excludes Broad Diagnostic behavior on specific LCD policies. This functionality also exists for the release of the FE LCD Rule in the 2018 Q2A KnowledgeBase.

For more information regarding policy-level overrides and the difference in the LCD Rule and the LCD Rule – Excludes Broad Diagnostic, refer to the LCD rules section.

**LCD caching in DDR**

The DDR PE LCD Rule makes use of cached LCD data. A system configuration option in the Dynamic DDR UI called Memory Management must be enabled to use this functionality.

To use the DDR LCD rules in either Static or Dynamic rulesets, Memory Management must be enabled; otherwise an error message is generated indicating LCD Cache is disabled.

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**Important!** Memory Management must be enabled for DDR LCD to function correctly. However, note that this must be done only when no claims are being processed. Optum recommends to wait a few minutes after enabling Memory Management to allow internal memory caches to be fully built.

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**Important!** Enabling cached LCD data/memory management uses additional system resources. Optum recommends that systems meet the current minimum hardware requirements in order to avoid any system resource issues (minimum 16 GB of RAM).
To enable memory management (for static UI):

2. Select the link in the upper right-hand corner called Dynamic DDR Rulesets to launch the Dynamic DDR rulesets UI.
3. In the upper left-hand corner, select Configuration > Memory.
4. Select Load Medicare’s Local Coverage Determination (LCD) data.

To enable memory management (for dynamic UI):

2. In the upper left-hand corner select Configuration > Memory and select Load Medicare’s Local Coverage Determination (LCD) data.

NCD carrier versus LCD carrier

If the NCD carrier is loaded and in use, it will automatically be included in analysis along with the LCD carrier assigned to a route. If the NCD carrier is assigned to a route, only the NCD policies are used for rule analysis.

Policies with no diagnosis code requirements

Some policies and/or action groups (AGs) may not list any diagnosis code requirements and function similarly to Broad Diagnostic, i.e., any diagnosis code on the line will satisfy the diagnosis requirement.

Diagnosis code flags

Diagnosis code flags have either sequenced (e.g., LBP, LBS LBT) or non-sequenced (e.g., LBI) requirements. With sequenced diagnosis code requirements, the codes must be listed in a specific order on the claim line to satisfy the policy requirements. With non-sequenced diagnosis code requirements, the codes must be present on the claim line, but a specific order is not required. The non-sequenced flag (LBI) is given higher priority than sequenced flags.

Action groups that contain non-sequenced codes apply the LBI flag when the diagnosis code requirements are not met.

Action groups that contain both non-sequenced and sequenced codes apply the LBI flag when the diagnosis code requirements are not met. The LBI flag is considered higher priority than the sequenced flags.

Action groups that contain sequenced codes apply the sequenced diagnosis flags. If none of the primary diagnosis requirements are met, the claim line receives the LBP flag only. If at least one primary diagnosis...
requirement is met, but no secondary diagnosis requirements are met, the LBS flag is applied to the line. If a tertiary diagnosis requirement exists and at least one primary requirement is met, but the tertiary requirement is not met, the LBT flag will be applied to the line.

**Assigning an LCD carrier in the Dynamic DDR user interface**

Assigning an LCD carrier in the Dynamic DDR user interface is done in the DDR ruleset’s routing configuration.

**To assign the LCD carrier:**

1. Navigate to the appropriate enterprise.
2. Open the Dynamic DDR UI by selecting **Rules > Manage Data-Driven Rulesets** from the menus.
3. Select the ruleset that includes the DDR LCD Rule.
4. Select **Route Properties**.
5. Select **Add a Property**.
6. Create a Condition Expression. This sets the conditions that must be met in order to route a claim to the DDR ruleset containing the DDR LCD and NCD Rule. In the **Then** statement of your Condition Expression, select **Set LCD and NCD Carrier**.
7. Select the appropriate LCD carrier and NCD carrier from the dropdown menu. Note that only LCD and NCD carriers that are **In Use** will be available to select from the dropdown menu.

| Note | When multiple LCD and NCD carriers are loaded, the NCD carrier can now be selected in addition to the LCD carrier. When creating a new route property using set LCD/NCD options, “Select” will be displayed by default. If both LCD and NCD route property values are set to “None,” the Save button will not be enabled. |
**LCD Rules**

<table>
<thead>
<tr>
<th>Rule name</th>
<th>Rule description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LCD Rule</td>
<td>LCD Rule</td>
</tr>
<tr>
<td>LCD Rule Excludes Broad Diagnostic*</td>
<td>LCD Rule without Broad Diagnostic designation</td>
</tr>
<tr>
<td>*Exists in PE only</td>
<td></td>
</tr>
</tbody>
</table>

**Note**

The release of the DDR FE LCD Rule in the 2018 Q2A KnowledgeBase includes only the standard LCD rule.

If you need the Excludes Broad Diagnostic functionality, this can be configured by using a Broad Diagnostic Policy-Level Override.

**Why are there two PE LCD rules?**

There are LCD policies containing procedure codes that can be submitted with a broad range of diagnosis, but the particular policy or article is limited to a specific condition. Procedure codes within a policy may have additional coverage for conditions that are not addressed within a policy. When these policies exist, procedure codes may be marked as broad diagnostic to prevent invalid edits for conditions that are not addressed in a policy or article.

For example, LCD policy A55326, Zika Virus Testing by PCR and ELISA Methods, contains a list of specific diagnosis codes within the policy. CPT code 87801 is a specific code for infectious agent detection by nucleic acid (DNA or RNA), used for Zika virus testing. The diagnosis editing is developed only to CPT code 87801 in Optum’s database. CPT 87801 (Infectious agent detection by nucleic acid [DNA or RNA], multiple organisms) can be utilized for organisms other than the Zika virus. Therefore, it has been designated as broad diagnostic in the application.
Marking a procedure code as broad diagnostic indicates the procedure code is not limited to the coverage in the policy.

Some clients choose to follow the broad diagnostic and do not limit the procedure codes to only the diagnosis codes in the policy. In the example above, the LBI would not be expected from this article for CPT 87801 when billed with a diagnosis not in the policy.

Some clients choose to limit the procedure codes to only the diagnosis specified in the policy. In the example, the LBI would flag if a diagnosis was submitted that is not listed in the policy.

Optum provides two LCD rules to allow clients to select the approach that works best for them.

**What rule should I use?**

**LCD Rule**

This rule allows policies with procedure codes marked as broad diagnostic to cleanly pass without limitation of the specified diagnosis in the policy.

**LCD Rule – Excludes Broad Diagnostic**

This rule restricts procedure codes to the published diagnosis codes for the policy and edits based on the diagnosis codes listed.

Clients should select the appropriate rule for their ruleset(s) and remove or disable the rule not used.

**DDR LCD Rule Broad Diagnostic Policy-Level Overrides**

Starting with the October 2017 KnowledgeBase, users are able to create LCD Policy-level overrides.
As noted above, if the standard LCD Rule is used and a policy is considered broad diagnostic, any diagnosis code on the line will always satisfy the diagnosis code requirement of the policy. On the other hand, if the LCD Rule - Excludes Broad Diagnostic is used, the rule will always restrict the diagnosis codes that satisfy the policy to those specifically listed in the policy.

Broad Diagnostic Policy-level overrides allow users to make selective overrides at the policy level rather than having to use the default “all or nothing” approach of the LCD Rule and the LCD Rule – Excludes Broad Diagnostic. This functionality allows users to force behavior in two ways:

1. Force Broad Diagnostic - Policies that are not considered broad diagnostic can be forced to behave as if they are broad diagnostic. This means diagnosis codes other than those specifically listed for the policy will satisfy the diagnosis code requirements of the policy.

2. Force Excludes Broad Diagnostic - Policies that are considered broad diagnostic can be forced to behave as if they are not broad diagnostic. This means that only the diagnosis codes listed in the policy will meet the policy’s diagnosis code requirement.

The policy-level override functionality is accomplished by adding the Carrier Number and LCD Policy Number to one of two system association lists. These lists are delivered in the KnowledgeBase extracts. The system lists are named as follows:

3. DDR LCD Force Broad DX for Carrier/Policy – Adding the Carrier Number and LCD Policy Number to this list forces Broad Diagnostic behavior for the given policy.

4. DDR LCD Force Excludes Broad DX for Carrier/Policy – Adding the Carrier Number and LCD Policy Number to this list forces Excludes Broad Diagnostic behavior for the given policy.

Users can add up to five overrides at a time using the Add button. Users can also import a comma-separated list if overriding more than five policies.

In the following example, policies L11111 and L22222 for carrier 01234 have been overridden to force Excludes Broad Diagnostic behavior. When used with the standard LCD Rule, this override will force Excludes Broad Diagnostic behavior on only these two policies. All other broad diagnostic policies will continue to function as normal, meaning that any diagnosis code on the line would satisfy the diagnosis code requirement of Broad Diagnostic policies.
Note: Unless overridden using a policy-level override, using the Excludes Broad Diagnostic rule applies to all policies.

**LCD Implementation Date Versus Effective Date Functionality**

Beginning with 5.3.1 SP2-CU09 and 5.4 SP1-CU03, a new field called *Implementation Date* appears on the LCD data screens. Implementation Date is used when LCD policy data is delivered retroactively.

For example, CMS could change a policy’s requirements on 7/1/2019 with a backdated effective date of 1/1/2019. In this case, the Effective Date for the change would be dated 1/1/2019, and the Implementation Date would be dated 7/1/2019.

Before the inclusion of Implementation Date, a claim with a date of service of 1/1/2019 would yield different editing results depending on whether it was analyzed before or after the update was implemented. The Implementation Date versus Effective Date functionality allows users to choose whether to use the Effective Date or the Implementation Date for editing with the DDR PE LCD Rule.

**Note** Effective Date will always be populated for LCD Data, but Implementation Date will only be populated when it differs from the Effective Date.
Requirements for using LCD Implementation Date

- This functionality is only supported in the DDR PE LCD Rule when using the panel-based DDR UI.
- This functionality is only available in PE for the 2017 Q3A and later KBs and in FE in the 2018 Q2A and later KBs.
- This functionality is only available in the 5.3.1 SP2-CU09 and 5.4 SP1-CU03 and later.

To allow for the greatest level of configurability, the option to use Implementation Date is configured as a Rule-set Route Property in the Dynamic DDR UI. The default setting is No, meaning the rule will use Effective Date by default unless the Implementation Date functionality is turned on.

To enable Implementation Date functionality:

1. Navigate to Rules > Manage Data Driven Rulesets.
2. Select the appropriate ruleset, then Route Properties.
3. Select Add a Property. Define the Statement as necessary, then select Set a route property > LCD Implementation Date > Yes.

LCD Data Overview

Within the Claims Edit System application, the primary data components for LCD include:

1. The LCD policy
2. The Procedure Code
3. The Edit Action Group (Sub-Policy)

4. The relationship attributes at the Edit Action Group level (e.g., Diagnosis, Modifier, Gender, etc.)

Based on the relationships that exist for the Edit Action Group for a given Procedure Code in an LCD policy, there are two primary workflows:

1. Edit Action Group relationship requirements are met – refer to the Compliance Workflow section below.
2. Edit Action Group relationship requirements are not met – refer to the Non-Compliance Workflow section below.

**Compliance Workflow**

IGNORE, DENY, PAY, PROFILE or PEND REVIEW Action Groups requirements are met.

**LCD Process Flow for Met Scenarios**

Edit Action Groups (AGs) are analyzed in a specific priority order. This ensures the expected rule behavior is supported by the existing data structure.

The following flags use this format: PE flag/FE flag. The priority order in the rule is:

1. IGNORE AGs – If IGNORE AGs requirements are met, all other AGs within the same policy will be ignored and the line is clean.
2. DENY AGs – If DENY AGs requirements are met, the claim line will receive an LDY/LCDY and analysis stops.
3. PAY AGs – If PAY AGs requirements are met, the claim line will be clean and analysis stops.
4. PROFILE AGs – If PROFILE AGs requirements are met, the claim line receives an LPF/LCPF and analysis stops.
5. PEND REVIEW AGs – If PEND REVIEW AGs requirements are met, the claim line receives an LRD/LCRD and analysis stops.

**Examples of Compliance Workflow - Met Scenarios**

| Note | The following examples are custom policies added with example data to demonstrate the flow of the LCD rule when there are multiple action groups present. They do not reflect actual CMS policies. These examples are for illustrative purposes and represent only a small portion of possible claim scenarios. |
Compliance Scenario 1 - IGNORE Action Group Met

All other AGs in the same policy will be ignored and the line is clean.

In this example, IGNORE and DENY AGs exist for procedure code 11111. The IGNORE AG includes diagnosis codes 996 and 997. The DENY AG includes diagnosis codes 997 and 998. The claim line has a diagnosis code of 997, which is listed in both the IGNORE and DENY AGs, so both AG requirements are met.

Because the IGNORE AG takes priority, all other AGs (in this case the DENY AG) are ignored and the line is clean.

IGNORE Action Group Example

![Diagram of IGNORE Action Group Example]

DENY Action Group Example

![Diagram of DENY Action Group Example]

Claim Example

![Claim Example]

Compliance Scenario 2 - DENY and PAY Action Groups Met

Claim line will receive an LDY/LCDY and analysis stops.
In this example, IGNORE, DENY, and PAY AGs exist for procedure code 11111. The IGNORE AG includes diagnosis codes 996 and 997. The DENY AG includes diagnosis codes 994, 997 and 998. The PAY AG includes diagnosis codes 994 and 999. The claim line contains diagnosis code 994, which is in the DENY AG and the PAY AG. The DENY AG and PAY AG are met, but since the DENY AG takes priority, the LDY flag is applied to the claim line and analysis stops.

**IGNORE Action Group Example**

**DENY Action Group Example**

**PAY Action Group Example**

**Claim Example**
Compliance Scenario 3 - Pend Review Action Group Met

Claim line receives an LRD/LCRD and analysis stops.

In this example, PEND REVIEW AGs exist for procedure code 22222. DENY, PROFILE and PAY AGs also exist, but the claim line matches the criteria for the PEND REVIEW AGs only. The PEND REVIEW AGs for both policies includes diagnosis code 995. The claim line has a diagnosis code of 995. Both policies’ PEND REVIEW AG requirements are met since diagnosis code 995 is on the claim line; therefore, the LRD flag is applied to the line and both policy IDs are included in the flag message.

PEND REVIEW Action Group Example

![Diagnosis Code Table]

PEND REVIEW Action Group Example

Claim Example

![Claim Line Example]

Non-Compliance Workflow

PAY, PROFILE, and PEND REVIEW Action Groups are not met.

LCD Process Flow for Not-Met Scenarios

If none of the AG relationships is met 100% and at least one PAY, PROFILE or PEND REVIEW Action Group exists, analysis enters the Non-Compliance workflow. These edits are intended to identify which requirements are not being met to satisfy a policy requirement.
Non-Compliance workflows include logic for PAY, PROFILE, and PEND REVIEW AGs. Non-Compliance workflows do not include logic for IGNORE and DENY AGs; it is not necessary to identify how to meet a DENY AG requirement, which would result in an LDY flag. Similar to the Compliance scenarios, the relationship flags fire in a specified priority order.

Claims are analyzed against the LCD rule to determine appropriate flags based on the following priority order:

<table>
<thead>
<tr>
<th>Order</th>
<th>LCD Rule</th>
<th>PE Flag/FE Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diagnoses</td>
<td>LBI, LBP, LBS, LBT/ LCI, LCP, LCS, LCT</td>
</tr>
<tr>
<td>2</td>
<td>Modifier</td>
<td>LBM/LCM</td>
</tr>
<tr>
<td>3</td>
<td>Code to Code</td>
<td>BCC/LCC</td>
</tr>
<tr>
<td>4</td>
<td>Gender</td>
<td>BSX/LCG</td>
</tr>
<tr>
<td>5</td>
<td>Age</td>
<td>BAG/LCAG</td>
</tr>
<tr>
<td>6</td>
<td>Frequency</td>
<td>BFR/LCFR</td>
</tr>
<tr>
<td>7</td>
<td>Place of Service (PE only)</td>
<td>BPO/NA</td>
</tr>
<tr>
<td>8</td>
<td>Provider (PE only)</td>
<td>BSP/NA</td>
</tr>
<tr>
<td>9</td>
<td>Type of Bill (FE only)</td>
<td>NA/LTOB</td>
</tr>
<tr>
<td>10</td>
<td>Revenue Code (FE only)</td>
<td>NA/LRC</td>
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<tr>
<td>11</td>
<td>Condition Code (FE only)</td>
<td>NA/LCON</td>
</tr>
<tr>
<td>12</td>
<td>Value Code (FE only)</td>
<td>NA/LVC</td>
</tr>
</tbody>
</table>

**Examples of Non-Compliance Workflow – Not-Met Scenarios**

**Non-Compliance Scenario 1 - Diagnosis Requirements Not Met**

In this example, three PAY AGs and one PROFILE AG exist under two separate policies.

The claim line includes diagnosis code A111, which is not a supported diagnosis code in any of the AGs. Therefore, the claim enters the Non-Compliance Workflow.

Because the claim line does not contain a supported code as listed in any of the policies’ AGs, an LBI flag is applied to the line and both policy IDs are included in the flag message.
# PAY Action Group Example – Policy R779988

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Diagnosis</th>
<th>Code Type</th>
<th>Gender</th>
<th>Min. Age</th>
<th>Max. Age</th>
<th>Subset Sequence/Group</th>
<th>Ordered</th>
<th>Support</th>
<th>Effective Date</th>
<th>Expiration Date</th>
<th>Origin</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>R377 ICD-10</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Professional Main Enterprise</td>
<td>Enabled</td>
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<tr>
<td></td>
<td>R388 ICD-10</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Professional Main Enterprise</td>
<td>Enabled</td>
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<tr>
<td></td>
<td>R399 ICD-10</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Professional Main Enterprise</td>
<td>Enabled</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# PROFILE Action Group Example – Policy R779988

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Diagnosis</th>
<th>Code Type</th>
<th>Gender</th>
<th>Min. Age</th>
<th>Max. Age</th>
<th>Subset Sequence/Group</th>
<th>Ordered</th>
<th>Support</th>
<th>Effective Date</th>
<th>Expiration Date</th>
<th>Origin</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>R377 ICD-10</td>
<td>Yes</td>
<td>01/01/2017</td>
<td>Professional Main Enterprise</td>
<td>Enabled</td>
<td></td>
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# PAY Action Group Example 1 – Policy R889977

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<th>Diagnosis</th>
<th>Code Type</th>
<th>Gender</th>
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<th>Max. Age</th>
<th>Subset Sequence/Group</th>
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# PAY Action Group Example 2 – Policy R889977

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<th>Code Type</th>
<th>Gender</th>
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</table>
Claim Example

Non-Compliance Scenario 2 - Modifier and Place of Service Requirements Not Met

In this example, PAY and PROFILE AGs exist under a single policy.

Both AGs have diagnosis, modifier and place of service requirements. The claim line includes diagnosis code R555, which is supported in both policies, but the claim line does not contain a supported modifier or place of service code. Since the modifier flag (LBM/LCM) is considered higher priority than the place of service flag (BPO), the LBM flag is applied to the line.

PROFILE Action Group Example
PAY Action Group Example

Claim Example

Non-Compliance Scenario 3 - Place of Service Requirements Not Met

In this example, PAY and PROFILE AGs exist under a single policy.

Both AGs have diagnosis, modifier and place of service requirements. The claim line includes diagnosis code R555 and modifier R1, both of which are listed as supported in their respective lists. However, the claim line does not contain a supported place of service code. Since the policy contains a place of service requirement that is not met, the BPO flag is applied to the line.
PROFILE Action Group Example

PAY Action Group Example

Claim Example

LCD vs NCD Priority

From a data perspective, LCD supersedes NCD in most circumstances. Exceptions are:
● Meeting an NCD DENY AG (LDY/LCDY)
● Scenarios when an LCD policy is silent on a diagnosis code that is supported in an NCD policy

Excluded Diagnosis code example:

Claim Line: Procedure = 99999; Diagnosis code = 999; Place of Service = 11

<table>
<thead>
<tr>
<th>NCD for Procedure 99999</th>
<th>LCD for Procedure 99999</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCD Policy 1 PAY Action Group Diagnosis code: 999</td>
<td>LCD Policy 1 PAY Action Group Diagnosis code: 888, 777, 666</td>
</tr>
</tbody>
</table>

In the above scenario, diagnosis code 999 is on the claim line. Diagnosis code 999 is not included in the list of supported codes under the LCD policy. This would normally result in an LBI/LCI flag because the diagnosis requirements of the LCD policy are not being met. However, since diagnosis code 999 is supported in the corresponding NCD policy, the LBI/LCI flag is suppressed and the line is considered clean.

Note: With the DDR version of the LCD rule, if an LCD policy and an NCD policy both trigger the same edit, both policy IDs are listed in the flag message. The ILOG version of the LCD rule will only list the NCD policy ID.

Working with Claims

Claims Edit System

Claims Overview

The Claims Edit System is a state-of-the-art system that analyzes medical claims for potential inappropriate coding. The system reviews claims quickly, analyzing each claim against thousands of government, industry, and corporate rules, regulations, and policies governing health care claims. This efficient analysis enables you to pay claims that are coded correctly, or “clean” claims.

If there are exceptions on a claim, the system makes it easier to review or deny the claim automatically, according to your organization’s preference. Claim analysis means that the system looks at each piece of data on the claim itself and checks for inappropriate coding, omissions, and questionable coding relationships. If claims have been filed for any patient in the past, the system can also check the database for problems between the current claim and that patient’s historical claims.

For more information about flags in Claims Edit System, refer to the Managing Flags section.
To provide this complex review, the system combines an advanced rules engine with Optum’s proprietary Claims Editing KnowledgeBase™ and displays the results. Optum updates the KnowledgeBase regularly with the latest information, including procedure code (CPT codes and HCPCS codes) and diagnosis codes (ICD-9-CM\(^1\) or ICD-10-CM\(^2\)). At any given time, the KnowledgeBase contains three years of information to help you identify coding changes and ensure that your payment policies are always current.

Typically, claims without any errors are quickly cleared for payment. Claims with errors are flagged with either a deny flag or a review flag. Deny flags typically mark the claim for rejection. Those claims with review flags are sent back to the host system for processing based on your organization’s workflow processes. Also, a claims adjuster can review the claim interactively, in real time, using the Claims Edit System interface.

Claims Edit System can be set up to process individual or large batches of claims either before your host system (pre-processing) or in the middle of your process (in-line). Most clients choose to have Claims Edit System process claims in-line between verification and claim pricing. However, pre-processing claims before they are even sent to your system is an option.

In-line processing works well if your host system is working at or under its capacity and is able to handle all incoming claims, regardless of any issues on them. By setting up Claims Edit System to process claims that have already been verified, you can take advantage of the information contained within the edits to help you establish and adhere to your pricing and payment policies. Once Claims Edit System has finished analyzing the claims it receives from your host system, exported files containing clean and denied claims can be automatically sent back to your host system.

Pre-processing claims before sending them to your host system works well if you need to increase throughput by having Claims Edit System eliminate “dirty” claims (i.e., those with inappropriate coding or other issues on them). In this configuration, only “clean” claims are sent on for further processing by your host system. The host system then runs its own series of tests on those claims, denying incorrect ones according to your organization’s policies and procedures.

This topic explains the main components of a claim. Here you can learn how to modify claims, find and access existing claims, and analyze and review claim results.

This section includes:

\(^1\)International Classification of Diseases (ICD), Ninth revision (–9), Clinical Modification (–CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval.

\(^2\)International Classification of Diseases (ICD), Tenth revision (–10), Clinical Modification (–CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval. These codes allow more specific reporting of diseases and patient conditions.
Types of Claims

The Claims Edit System Professional module accepts Professional claims using some of the same information as the Physician Claim: CMS-1500 form. This is a standard claim form used by providers and can provide you with an idea of the types of information that may appear on a claim in the system. Some of this information may also be necessary if you are entering a claim yourself. The Claims Edit System interface contains some additional fields used in claims processing as well as some consolidated information to aid your online review.

In order for the system to edit a claim successfully, the claim must meet the following conditions when it is submitted to you:

- The claim must represent services by a single provider.
- The claim must represent services by that single provider to a single patient.

Claims Edit System cannot successfully apply its rules to facility billing claims when a single date of entry is used for all services on the claim. Physician/Clinic owned laboratory and radiology practices must post services for the date(s) of services are actually rendered for the system to work correctly.

Accessing Claims

Most claims are entered automatically in batch mode, directly from one computer to another. You can also enter and analyze individual claims manually through the Claims Edit System interface.

1. Log in to the Claims Edit System interface. (For more information about logging in and creating users, refer to the Security section.) The system displays the Main Menu.

2. Select the Professional icon to access your existing claims. For more information about how to add claims to your system, refer to the Modifying Claims section.

3. Choose the appropriate Enterprise if you have more than one to choose from. You must be at the lowest level in the Enterprise tree to access claims. Refer to the Defining enterprises section for more information.

   The system displays the Professional screen.
4. Select **Claims**.

The system displays the Claims screen where you can choose to add a new claim or find an existing one. For more information about entering a new claim or finding an existing claim, refer to the [Modifying claims](#) section.

### Modifying Claims in Claims Edit System

You can use Claims Edit System to view, enter, modify, and analyze claims using a browser.

You can enter the majority of your claims automatically in batch mode, directly from one computer to another.

You can also choose to manually enter claims through the interface.

Claims are entered for live data analysis from the host system or directly from the Claims Edit System interface.

| Note | If you add or modify a claim, your changes may not be applied to your host system. If you need to have these changes in your system, consider making them in that system and then sending the claims into Claims Edit System in a batch for analysis. |

This section covers:

- [Entering a new claim](#)
- [Saving a claim](#)
- [Searching for an existing claim](#)
- [Editing a claim](#)
- [Copying a claim](#)
- [Deleting a claim](#)

### Entering a new claim

When you make a change to the system (such as changing the behavior of a rule or adding an override), you can enter claims to test this change.

| Note | When you create test claims, it is recommended that you use the same business data (providers, accounts, etc.) that you use on your live claims. |

A claim consists of a header (which contains data for the entire claim) and one or more claim lines or billing lines (which describe the various items being billed).
When you enter a claim through the interface, you first enter the header information and then one or more claim lines.

The claim header section has four vital pieces of data: the Claim ID, Patient ID, Account ID and Plan ID. This header information is vital to claim analysis. If there are any problems in the header information, a flag is issued by the rules engine and processing for the claim stops.

*Claim ID*

This is a unique identifier used to keep the claim separate from other claims in the system.

*Patient ID*

This is used to compare the claim with history (previous claims) for that patient. When the system analyzes the claim, the Patient ID is also used to add the current claim into the history file for that patient.

*Account ID and Plan ID*

The Account and Plan Identification numbers identify which ruleset, or group of rules, the system uses to analyze a claim.

To enter a claim:

1. Follow the steps to access a claim.
2. Select Add Claim. The system displays the Add/Edit Claim screen.
3. Enter the appropriate information at the header and line levels to create the claim you need. Lookups are available for your convenience in filling out the information in some fields.
4. Several blank lines are provided for you on a claim. Simply fill in as much data in as many lines as you need. If you need only two lines, fill them in and proceed to the Saving a Claim section below.

   The system saves your data and deletes any remaining unused or blank lines. For more about the specific information in each field, refer to the Claim Fields section.

   Find the information that you need in the lookup table and copy and paste it into the appropriate claim field. If necessary, you can add a new record to these tables. For more information about the data available to you and how to add records, select the applicable link above.

Saving a claim

After you enter both the header and the line information, you must either save or analyze the claim to store it in the database.
You can modify and re-save a claim as needed, but the Claim ID cannot be changed if you have saved or analyzed the claim.

You can save a partially completed claim or use the Analyze function to save a completed claim and send it through the system for analysis. If you choose save only, no results will be generated and the claim will have a status of NN (New, Needs Analysis). You can choose to save individual line information as you edit an existing claim and then save the entire claim as well as any new header information when you have completed your changes. If you choose to use the analyze functionality to save the claim, results are generated and saved for your review.

**To save a claim:**

1. Enter a new claim or access an existing one.
2. Create or modify the claim information as necessary. Lookups are available for your convenience in filling out the information in some fields.

| Note | If you decide that you do not want to save the claim information, you can use the Cancel button to exit the claim form you are editing. If you have already saved a portion of the claim, the Cancel button will eliminate only the changes you have made since the last save. |

3. To add a new set of blank lines, select the **Add Lines** button.

   The system saves your data and deletes any remaining unused or blank lines.

4. When you have entered all the information for the claim, select the **Save** button at the top of the claim to save the whole claim. The system saves the claim in its entirety.

You can also save your claim at the same time you analyze it by choosing either:

- **Test Analyze.** The claim is saved in the test environment, and it does not affect your live data, with the exception of business data (providers, accounts, and plans). It also does not affect any reports you run on the live environment. You can choose to run your reports against either live or test data or both. Refer to the **Report types** section for more information.

- **Live Analyze.** The claim is saved in the live environment, and it becomes part of your working database of live claims. Thus, it is included in any reports you run for the live environment.

For more information about live and test environments, refer to the **Analyzing claims** section.
Searching for an existing claim

Once a claim has been imported from the host system, or you enter and save it, you can find it in the system by searching for it using the Claim Browse Selection Criteria.

The search fields are:

**Status**

- **AC** – Analysis Failed, deny claim level (40000–44999)
- **AD** – Analyzed, needs documentation (15000–19999)
- **AF** – Analysis Failed, deny line level (30000–99999)
- **AI** – Analyzed, needs information or analysis incomplete (10000–14999)
- **AN** – Analyzed, needs no review (5000–9999)
- **AR** – Analyzed, needs review, Line Level (20000–29999)
- **NN** – New, needs analysis (0–4999)

The numerical values correspond to the error level.

**Environment**

You can filter claims by the type of environment they are stored in: Test, Live or All. For more information about live and test environments, refer to the Analyzing claims section.

**Current**

This field allows you to filter historical or current (the most recent) claims. If the claim displayed is the most recent, the system displays a “Y” for Yes. If there is a more recent claim in the system, it displays an “N” for No in the search results.

**Claim ID**

Enter a range of identification numbers or one specific ID in the To and From range boxes. This field contains the unique alphanumeric claim number that identifies each individual claim. The system returns a specific one.
**Batch ID**

Enter a range of identification numbers or a specific ID in the To and From range boxes. The system returns a specific one.

**Message Control ID**

Search claims by Message Control ID (also known as Interchange Control Number).

**Sender ID**

Search claims by Interchange Sender ID.

**Patient ID**

Enter a range of identification numbers or a specific ID in the To and range boxes. The system returns a specific one.

**BDOS**

Search claims by Beginning Date Of Service (BDOS). If a claim has multiple claim lines, if any claim line has a BDOS within the selected range, the claim will display.

**Entry Date**

This field contains the entry date for the claim. Enter a range of dates or a specific date in the To and From range boxes. The system returns a specific set of claims within those dates.

**Last Analysis**

Search by the date the claim was analyzed. You can also enter time (24-hour format) as part of the search criteria.

**Billing Specialty**

Search claims by specialty.

| Note | The system sorts claim results alphanumerically. Letters are displayed before numbers and 0 is displayed before 1. For example, claim # 1J678 is displayed before 11780 and 1J00345 before 1J100034. Keep this in mind when entering ranges of claim numbers. |
To find an existing claim:

| Note | Some of the fields provide From and To ranges for you. If you want to use only one value (date, ID, or data), enter that information in both the From and To fields. Otherwise, enter the beginning value in the From field and the ending value in the To field. Some fields have lookups that access the list or table containing that information (e.g., the link on the Account ID opens the list of valid Accounts). You can copy and paste the information you want into the applicable search field(s). |

1. Follow the steps to access a claim.
2. Select Claim Browse. The system displays the Claim Browse screen.
3. Add the applicable search criteria to access an existing claim.

| Note | To aid your search, remember that the wildcard character % indicates that you want to search for “any number of characters.” For example, if you were to enter A%, it would indicate searching for all items starting with the letter A, followed by any number of characters. Thus, you can use the wildcard character to search for multiple items matching a broader criteria. |

4. Select Find.

The system displays the list of claims that meet the search criteria you entered.

| Note | The claim results will be sorted alphanumerically. This means that letters will be displayed before numbers and zeros before ones. For example, claim # 1J678 will be displayed before 11780 and 1J00345 before 1J100034. Keep this in mind when entering ranges of claim numbers. |

The fields displayed are:

- Row ID
- Claim ID
- Environment
- Current
- Status
- Patient ID
Last Analysis

Batch ID

5. Find the claim you want in the list or perform another lookup.

Note

After your search is complete, the search area is collapsed automatically to provide more room on the screen for results. However, you can perform another lookup from this screen if you want. Select on the show link next to the Selection Criteria heading under Browse Claims to expand the fields. Enter new information to perform another search. By default, previous search criteria information is not retained; new search criteria will have to be re-entered.

6. You have the ability to:

- Select a single claim to view results, edit, delete (test claims only), or generate a worksheet.
- Select multiple claims to delete by marking the checkboxes beside the claims. You can select all the claims in your list by marking the box at the very top of the list, to the left of the Row ID heading.
- Select an individual Claim ID to view the results for that individual claim.

Editing a claim

You can modify or change the data on only one claim at a time. You can also change the information on the header and edit or delete individual lines on the claim. You can also choose to analyze the claim in test or live environments, which will modify the data in the applicable environment.

If changes need to be made to a claim to fix a coding relationship, those changes can be handled either through the Claims Edit System interface or in your host system software. If you make changes in your host system, run the claim through Claims Edit System again to make sure that the new information is analyzed correctly.

To edit a claim:

1. Follow the steps to access a claim.
2. Select the box next to the claim you are interested in.
3. Select the Edit button at the top of the list. The system displays the Add/Edit Claim screen.
4. From here you can make the necessary changes to the claim.
   - If you need to make changes to a specific line, select in the claim line field and make your change. The display expands to allow you to look up valid dates and codes that already exist in your system.

   **Note**
   The Modifier and ICD fields can each hold multiple entries. In order to view these entries, you must scroll to the right. These codes are separated by commas with the most significant one listed first.

   • If you need to delete a specific line, select the checkbox to the left of the line and choose **Delete Line**.
   • You can also choose to analyze the claim again.

   **Important!**
   Even though you may have entered header and line information and saved a line, the entire claim is not saved until you select the **Save** button at the top of the claim or one of the **Analyze** buttons.

5. When you have finished making your changes, select **Save**.

**Copying a claim**

You can re-use or “copy” a claim by accessing the claim you want and changing the claim ID. Once you have done this, save the claim. It is now ready to be re-analyzed to test rule changes.

You can copy an individual claim from within the Claim Edit screen. This copy functionality allows you to reuse large portions of similar claims for analysis.

**To copy a claim:**

1. Follow the steps to **access a claim**.
2. Select the box next to the claim you are interested in or select a specific Claim ID.
3. Select the **Copy** button at the top of the list or the screen if you have accessed the claim. The system displays the copy of the claim with the Claim ID blank.
4. Change the appropriate information and save or analyze the claim.

**Deleting a claim**

For deleting claims, refer to the **Purging claims** section.
Professional Claim Fields

The CMS 1500 hard copy form (also known as the HCFA 1500 or 1500), or its 837P electronic equivalent, is the current industry standard for Professional claims submitted by health care providers. Claims Edit System accepts claims using some of the same information as the standard form.

This form can provide you with an idea of the types of information that might show on a claim in the system. Some of this information may also be necessary if you are entering a claim yourself. Additionally, the Claims Edit System interface contains some additional fields used in claims processing as well as some consolidated information to aid online claim review.

Like the standard form, the interface is divided into header and line sections. The header section consists of fields used to identify the patient and the applicable account and plan. The line section is made up of specific codes and information that describes the procedures and care rendered by the provider.

Each claim entering Claims Edit System from the host system may contain the following fields:

**Header Fields**

The claim header section contains information that is vital to claims analysis (for example, Claim ID, Patient ID, etc.). If there are any problems in the header information, a flag is issued by the rules engine, and processing for the claim may stop, depending on the severity of the flag.

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<td>Some fields may have lookups that access the list or table containing that information (i.e., the link on the Account ID opens the list of valid Accounts). You can copy and paste the information you want into the applicable field(s). Calendar lookups are also available when you see the calendar icon.</td>
</tr>
</tbody>
</table>

**Claim ID**

This alphanumeric text field is a unique identifier used to keep each claim separate from other claims in the system. It is assigned by the host system when a claim is entered. It can consist of any combination of numbers and letters (e.g., ABC20191001). It is editable until the claim is analyzed in the live environment and always editable in a test environment. This ID is required.

For more information about the test and live environments, refer to the Analyzing claims section.

**Alternate Claim ID**

If the Type of Bill codes indicate that the claim is changed, this alphanumeric text field represents the original ID.
**Tracking Number**

The use of this alphanumeric text field is agreed upon between "transaction intermediaries."

**Entry Date**

This field displays the date on which the claim was entered into the system. Claims Edit System automatically inserts the current date.

**Org ID**

This field requires the specific ID number assigned by Medicare for the insurance plan.

**Org Group**

This field is for routing and accounting purposes.

**Type of Bill**

The TOB is an applicable three-digit number that provides specific information about the bill for Medicare (or other payer) billing purposes (e.g., 131). This field is optional and is used for outpatient services billed by a facility. The first digit identifies the type of facility, the second digit identifies the type of care being billed, and the third digit indicates the sequence of the bill for a specific episode of care.

**Electronic Claim**

A checkmark here indicates the claim is electronic.

**Environment**

This field indicates whether the claim is part of the Live or Test environment. By default, all new claims you create in Claims Edit System are part of the Test environment.

**Patient ID**

The Patient ID is a unique field that identifies each individual for which a claim is submitted (e.g., 12325555544). Several of the checks Claims Edit System look at the patient; without a valid patient ID, these checks will not work. For example, when the system analyzes the claim, the Patient ID is used to add the current claim into the history file for that patient. This field is editable in both the Live and Test environments.

When you enter a valid patient ID (i.e., a patient record that exists in the Patient table), the Patient Name, Gender, and Birth Date are displayed.

**Patient Name**
This field identifies each patient in the standard format. You can change the name and other information when you save a claim or modify it in your host system and resend it for analysis.

**Gender**

This field identifies the gender of the patient: Male, Female or Unspecified.

**Patient’s DOB (Date of Birth)**

This field identifies a patient’s date of birth (e.g., 12/12/1990).

**Diagnosis Codes**

These are the diagnosis codes that apply to the procedure being billed.

**Provider ID**

The unique Provider Identification number is contained in this field (e.g., 12348). It can contain up to 80 characters.

This field has a lookup to allow you to access the Provider table in the [User-updated data](#) section. From the Provider table you can find the applicable provider and use the copy-and-paste functionality to move this information to the claim.

**Account ID, Plan ID**

These alphanumeric fields are assigned by the host system or manually entered at claim creation. These fields identify the account and specific insurance plan that belong to the patient.

Specific accounts or plans may have special custom rulesets assigned to them. If these fields are left blank, the default ruleset is used to analyze the claim instead of any specialized rulesets you create. The Account ID and Plan ID are editable in both the Test and Live environments (e.g., Account ID: APEX10 and Plan ID: PP123). For a list of valid accounts and plans, and to add new ones, refer to the [User-updated data](#) section. You can copy and paste the applicable IDs into the claim if necessary.

**Service Facility ID**

This field contains the facility identification number of the facility where the service was rendered.

**Service Facility Taxonomy**

This field contains the taxonomy code for the facility where the service was rendered.

**Service Facility Zip**

This field contains the postal ZIP Code of the facility where the service was rendered.

**Ambulance Zip**
This field contains the ambulance point of pick up ZIP Code.

Accident Indicator

This text field indicates the type of accident such as AA – Auto Accident, EM – Employment, OA – Other Accident.

Line Fields

Some fields may have lookups that access the list or table containing that information (e.g., the link on the Account ID opens the list of valid Accounts). You can copy and paste the information you want into the applicable field(s). Calendar lookups are also available when you see the calendar icon.

Line Status

Indicates the current state of the line (e.g., A). Select the dropdown arrow to select a line status code. The possible codes are:

- **A** = Active means this line is open and valid. This line will be included in analysis.
- **D** = Deleted means this line has been deleted and will not be included in any further analysis.
- **X** = Originally for PPS as a way to indicate a claim line that was already denied by the host system before being sent to CES. No longer used, as PPS is not used.
- **P** = Profile Only means this line is included in the analysis but does not return any edits back to your host system.

Line ID

This field indicates the line number, which identifies a unique transaction (e.g., 1). The system automatically fills in this field in numerical order when a claim is entered manually. When a claim is imported the host system may send an external line ID, which Claims Edit System then displays.

Beginning Date of Service (BDOS)/Ending Date of Service (EDOS)

The beginning and ending date of service must be entered using the MMDDYYYY format (e.g., 10/08/2019 and 10/15/2019). These columns default to the current date. The Calendar Lookup works for these fields.

Procedure Code
(Px) This code is required for analysis. Enter the CPT procedure code, Level II HCPCS code, or client-specific code for the line item (e.g., 81010). The Procedures list can be accessed by selecting the Procedure Code header link when adding or editing a claim. For more information, refer to the Code Repository (KnowledgeBase) section.

Modifiers

This is the two-digit CPT or HCPCS modifier code for a procedure. These codes add information to the basic procedure code that may alter or vary the service reported. An unlimited number of modifier codes can be entered on one claim line by separating them by commas (e.g., 50, 61). If there is more than one, the first modifier is the primary modifier.

Code Type

This column indicates whether the diagnosis codes (next column) is an ICD-9-CM\(^1\) code type or an ICD-10-CM\(^2\) code type.

Diagnosis Code

This column lists the diagnosis code(s) that apply to the procedure(s).

| Note | Claims Edit System assumes the code entered first is the primary diagnosis. In order for the NPD (Not a Primary Diagnosis) edit to function properly, the primary diagnosis needs to be the first code entered on a particular line. In the dropdown list, the primary diagnosis should be at the top of the list. Secondary codes are entered below the primary diagnosis. Type the code to the most specific digit, and include additional digits when appropriate. When entering fourth, fifth, sixth or seventh-digit codes, do not type a decimal point after the third digit; the decimal point is implied. The system allows an unlimited number of diagnosis codes on one claim line. However, your billing system may not. Be aware of how many codes your billing system can support. |

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\(^1\)International Classification of Diseases (ICD), Ninth revision (-9), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval.

\(^2\)International Classification of Diseases (ICD), Tenth revision (-10), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval. These codes allow more specific reporting of diseases and patient conditions.
Units

(Units or days) This field contains the total number of days of service, or total units of service, for anesthesia or other procedure (e.g., 1). This field automatically defaults to one.

Partial Units

This field is related to the Units field (above), to be used when the units are fractional. All entries in this field begin with a decimal point and are added (fractionally) to the number of whole units. (Example: Units =1, Partial Units =.500, total = 1.500.)

Total Charges

This field is used to summarize the total charges for each revenue code in a billing period. In addition to the Revenue Center code, a HCPCS procedure code that sums the total charges for the billing period for each HCPCS code can be used if the services require.

Place of Service

This is the two-digit place of service code for a procedure (e.g., 22). The POS (Place of Service) List allows you to look up POS records in the database. POS is used by several rules in order to determine the validity of billing and coding.

Revenue Code

This field is used for outpatient services billed by a facility. Revenue codes are four-digit codes that represent a specific accommodation, ancillary service or billing calculation (e.g., 0300). If applicable, enter the revenue code here.

Type of Service

Typically, a CMS (Centers for Medicare and Medicaid Services) Type of Service (TOS) code or a user-defined TOS code (e.g., 07).

Refer to the System lists and crosswalks section for more information about adding TOS codes.

NDC

This text field requires the NDC number used for reporting prescribed drugs and biologics as required by government regulation.

NDC Units

This text field requires the NDC count.

NDC Units of Measure
This dropdown option contains the units of NDC such as F2=international unit, GR=gram, MG=milligram, ML=milliliter, UN=unit.

Provider ID

The unique Provider Identification number is entered in this field (e.g., 1). This field can contain up to 80 characters. This field has a lookup to allow you to access the Provider table in the Business Data section. From the Provider table you can find the applicable provider and use the copy-and-paste functionality to move this information to the claim.

UPIN

This field contains the Universal Provider Identification Number.

Charge

The provider’s charge for the procedure is entered here. Type the entire amount and include the decimal point if entering cents (e.g., 25.37). If entering an even dollar amount, press the TAB key after typing the dollar amount and the system automatically adds a decimal point and ending zeros (37.00).

Billing Provider

This field requires your unique Billing Provider Identifier.

Billing Provider NPI

This field requires your unique National Provider Identifier (NPI).

Billing Specialty

This field requires the unique Billing Specialty Identifier assigned to each physician to identify his/her medical specialty.

Billing Department

This field lists the department that is associated with the Billing Provider.

Billing Provider Zip

This field can be used in conjunction with the overpayment detection functionality. (Refer to the Overpayment Detection section.) It contains the ZIP Code for the Billing Provider.

Billing Provider State

This field can be used in conjunction with the overpayment detection functionality. (Refer to the Overpayment Detection section.) It contains the abbreviation for the state where the Billing Provider practices.

Billing Provider Degree
This field can be used in conjunction with the overpayment detection functionality. (Refer to the Overpayment Detection section.) It contains an abbreviation of the degree held by the Billing Provider.

**Billing Provider CLIA**

This field enables timely and proper payment for services rendered as a provider, in compliance with the CLIA (Clinical Laboratory Improvement Amendments) program. It also allows payers to efficiently pay claims under these reimbursement policy guidelines. This is a 10-digit alphanumeric value.

**Servicing Physician**

This field requires your unique Servicing Provider Identifier.

**Servicing Provider NPI**

This field requires your unique National Provider Identifier (NPI).

**Servicing Specialty**

This field requires the unique Servicing Specialty Identifier (UPIN) assigned to each physician to identify his/her medical specialty.

**Servicing Department**

This field lists the department that is associated with the Servicing Provider.

**Servicing Provider Zip**

This field can be used in conjunction with the overpayment detection functionality. (Refer to the Overpayment Detection section.) It contains the ZIP Code for the Servicing Provider.

**Servicing Provider State**

This field can be used in conjunction with the overpayment detection functionality. (Refer to the Overpayment Detection section.) It contains the abbreviation for the state where the Servicing Provider practices.

**Servicing Provider Degree**

This field can be used in conjunction with the overpayment detection functionality. (Refer to the Overpayment Detection section.) It contains an abbreviation of the degree held by the Servicing Provider.

**Primary Payer**

A principal payer is selected by a letter or numeral specific to the type of payer designated to pay for medical expenses, i.e., 1 = Self Pay.

**Secondary Payer**
Same as Primary Payer but listed as a second choice.

**Servicing Provider CLIA ID**

This field enables timely and proper payment for services rendered as a provider, in compliance with the CLIA (Clinical Laboratory Improvement Amendments) program. It also allows payers to efficiently pay claims under these reimbursement policy guidelines. This is a 10-digit alphanumerical value.

**Specialty**

This field contains the provider’s specialty. Each specialty can be up to 50 characters.

**Pre-Authorization**

This field contains the pre-authorization code that has been given for the procedure (e.g., 2233A) to be performed.

**User Defined Fields**

These fields allow you to customize to meet your organization’s needs (e.g., ABC). They will only display if your administrator has set them up to contain custom information for your organization. For more information about how to set up these fields, refer to the User-Defined Fields section.

**Analyzing Claims**

The major function of Claims Edit System is to analyze claims.

The system looks at each piece of data on the claim and checks for inappropriate coding, omissions, and questionable coding relationships. If claims have been filed for the patient in the past, Claims Edit System can also check for problems between the current claim and the patient’s historical claims in the database.

For each claim that is analyzed, the entire claim and each line is reviewed for important coding issues such as:

- Unbundling detection
- Rejection of duplicate claims
- Detection of mutually exclusive services
- Patient diagnosis correlated with procedure appropriateness
- Validation of modifiers
- Place of service editing
- Surgical assistant appropriateness
Flagging when a maximum frequency-per-day limit is exceeded

Checking for age appropriateness of procedures

Checking for gender-specific procedures versus patient gender

Flagging of cosmetic procedures

Claims Edit System allows you to analyze claims through the interface. When the system analyzes a claim, it checks all of the data on the claim against a specific set of rules.

If there are inappropriate codes on the claim, the system raises a flag for each coding issue it finds.

When you live analyze a claim, the system uses live rules. However, when you test analyze, the system uses a different set of rules called test rules. The live rules are used to process production claims while the modified test rules are undergoing revisions and testing.

After you have tested the modified rules, you can make them live, changing the way claims are analyzed to meet your needs.

Among other things, rules can:

- Translate user-defined terms into values the system understands using crosswalks
- Check codes against each other and against history
- Judge coding relationships as valid or invalid according to the KnowledgeBase

If the rules find any of these conditions on a claim, a flag is raised to indicate that there is a problem with the claim, with a specific line of the claim, or both. You can also choose whether the claim analysis changes your live data.

For more information about rules, refer to the Managing rules section.

Understanding Live and Test Claims

Both live and test claims are entered and modified using the same screen (Add/Edit Claim) and the same methods. They both use the same sources for business data (providers, accounts, plans, etc.) which is treated as “live” data regardless of whether it is used on a test claim or a live claim.

When you create test claims, it is recommended that you use the same business data that you use on your live claims.

Even though the data for live claims and test claims is entered in exactly the same way, it is stored separately (except for business data) so that the test data does not affect your live reports. Refer to the Report types section for more information about how to run test versus live reports.
A live claim is a current and active claim that has been submitted by a client. If a live claim meets all of the conditions set up through the rules in Claims Edit System, it will be sent to the next step in the payment process. Most live claims are initially sent to Claims Edit System as part of a group, or batch, of claims.

**Important!** If you add or modify a claim, your changes may not be applied to your host system. If you need to have these changes in your system, consider making them in that system and then sending the claims to Claims Edit System in a batch for analysis.

When a batch of claims is sent electronically through the system, each one is automatically analyzed (using the live rules) for possible inappropriate codes. After the entire batch is analyzed, you can view the results. Additionally, you can enter individual claims meeting your test criteria through the new claim screen. Refer to the *Modifying claims* section for more information about adding claims.

Test claims are run through Claims Edit System to determine how it handles various combinations of data. For example, you might create a new message that will appear when certain CPT codes are detected. After creating this message, you can then run a few test claims to make sure the message is appearing.

**Note** If you analyze a claim and receive a CPT flag on every claim line, even though the CPT codes are all valid, this indicates that your system does not have a KnowledgeBase loaded (contact your system administrator).

**Analyzing a test claim**

The *Test Analyze* functionality marks the claim in the database as a test claim. When you use this functionality, the claim’s test data is stored separately (except business data, i.e., providers, accounts, etc.) from live data.

Be sure to choose the *Test Analyze* button when re-analyzing claims so that your test data does not affect your live data.

**To analyze a test claim:**

1. Follow the steps to add or access a claim. The system displays the Add/Edit Claim screen.
2. Make any changes necessary to the header and line information. Refer to the *Claims results* section for more information about claim fields.
3. Select the *Test Analyze* button. The system saves your changes to a new iteration of the claim. The original claim with its results is still available and unchanged.

The Claim Results screen displays to allow you to view the results of the corresponding analysis.
Analyzing a live claim

If you test a claim in the live environment, any changes will be made to the “live” data. Live Analyze uses the actual working rules and marks the claim as a live claim.

| Note | If you perform both a test analyze and a live analyze of the same claim, the system will end up with both a test version and a live version in the database. These two versions are processed independently and will not interfere with each other. |

To analyze a live claim:

1. Follow the steps to add or access a claim. The system displays the Add/Edit Claim screen.
2. Make any changes necessary to the header and line information. Refer to the Claim fields section for more information about claim fields.
3. Choose the Live Analyze button at the top of the claim.

   The system displays a confirmation warning to make sure you want to live analyze your claim and change your production data. If you select OK, the system saves your changes to a new iteration of the claim. The original claim with its results is available and unchanged.

   The Claim Results screen displays to allow you to view the results of the analysis.

| Note | After you have analyzed a claim, you can always select the Re-Analyze button to redo the analysis. |

Use Live History for Test Claims

This feature enables analysis of both test and live claims. Select the checkbox Use Live History for Test Claims before selecting Test Analyze or Re-Analyze to consider both test and live claims for analysis.

Claim Results

Clean claims (which have been screened by both Claims Edit System and your host system) are automatically sent to the billing system for payment, or “cleared.”

Claims with errors are flagged with either a Deny or a Review flag. “Dirty” claims, those with a Deny flag, are automatically denied.
Review of the remaining claims can either be handled automatically in the host software (when integrated with Claims Edit System) or manually by a reviewer through the Claims Edit System interface.

Whenever the rules find a potential problem, Claims Edit System raises a flag against the line of claims that contains the error. Some errors (such as missing patient information) are so significant that no further processing can be done and the claim is denied or rejected. Less drastic errors may raise a flag but continue to allow the rest of the claim to be processed.

You can create multiple sets of rules to meet the needs of your organization. The claim analysis feature allows you to ensure you are getting the results that you need. Refer to the Managing rulesets section for more information about rulesets.

Viewing claim results

Once the system raises flags for a given claim, the system can handle it in one of two ways: by returning recommendations or by applying edits.

To view results:

1. Follow the steps to access a claim.
2. If you are adding a new claim enter the appropriate data in the header and line fields on the Add/Edit Claim screen and then select one of the following:
   - Test Analyze - To check the claim against your test environments' rule setup and save the results in the test environment.
   - Live Analyze - To check the claim against your "real" rule setup and save the results in the live environment.
3. If you are searching for an existing claim, select the applicable Claim ID to view the analysis results for that claim. The system displays the Claim Results screen.

| Note | Some fields repeat in different sections of the display for your convenience in assessing the flags that may have been raised against the claim. |

4. Select the “plus” sign next to the applicable header to expand the results section that you want to view.
5. Select the “minus” sign next to the applicable header to collapse the results so that you can view those areas further down the claim.

Claim ID
This alphanumeric text field is a unique identifier used to keep each claim separate from other claims in the system. It is assigned by the host system when a claim is entered. It can consist of any combination of numbers and letters (e.g., ABC20190101). This ID is required. It is editable until the claim is analyzed in the live environment and always editable in a test environment.

For more information about the test and live environments, refer to the Analyzing claims section.

**Entry Date**

This is the date the claim was received by the Claims Edit System Facility module for analysis. This could represent the date that the batch was loaded or the date the claim was manually entered.

**Type of Bill**

The TOB is an applicable three-digit number that provides specific information about the bill for Medicare (or other payer) billing purposes (e.g., 131). This field is optional and is used for outpatient services billed by a facility. The first digit identifies the type of facility, the second digit identifies the type of care being billed, and the third digit indicates the sequence of the bill for a specific episode of care.

**Current Iteration**

This yes or no indicator lets you know whether or not this is a historical representation of the claim or if this is the most recent one.

**Claim Status (Error Level)**

This abbreviation represents the current claim’s status:

- AC - Analysis Failed, Deny Claim level (40000 - 44999)
- AD – Analyzed, needs documentation (15000 - 19999)
- AF – Analysis Failed, Deny Line level (30000 - 99999)
- AI – Analyzed, needs information or Analysis Incomplete (10000 - 14999)
- AN – Analyzed, needs no review (5000 - 9999)
- AR – Analyzed, needs review, line level (20000 - 29999)
- AZ – Analyzed, needs review, claim level (45000 - 49999)
- NN – New, needs analysis (0 - 4999)

The numerical values correspond to the error level.

[Other Claim Fields]
The Header section also displays several fields defined on the claim itself (i.e., Patient ID, Patient Name, etc.). For details about these fields, refer to the Claim fields section.

Original lines

In this section you can view the claim lines as they existed before the analysis was performed. This functionality helps make reviewing of the flags that were raised against claim data easier.

Refer to the Claim fields section for more information.

External Line ID

This is the number of the original line on the claim that was imported into Claims Edit System from the host system. This allows you to easily compare it to the original line to see the changes or determine if a line has been dropped from analysis (e.g., if the external line IDs go from 3 to 6, you know that lines 4 and 5 have been eliminated from further analysis).

When you have applied edit functionality turned on and a two-line claim gets a TRA flag that creates virtual line 3, and line 3 gets a TRA and REB which creates virtual line 4, the modified line results displays this as Line ID 4.

Beginning and Ending Date of Service

This is the information that was entered on the claim when it was created or loaded into the system.

Submitted Procedure Code

This field contains the procedure code(s) that were on the original claim line when it was created or received by the system for analysis. It is included here for your convenience in reviewing any flags that may have been raised for the line.

Modifiers

These CPT or HCPCS modifier codes pertain to the procedure submitted. These codes add information to the basic procedure code that may alter or vary the service reported. An unlimited number of modifier codes can be entered on one claim line by separating them with commas. If there is more than one, the first modifier is the primary modifier.

Diagnosis Codes

These codes were entered on the claim when it was created or loaded into the system. They correspond to the diagnosis given to the patient during their first visit or initial consultation. If there is more than one, they are separated by commas and the first one is the primary.

Units
This field displays the total number of days of service or total units of service for anesthesia. This field automatically defaults to 1 if no value is entered.

**POS**

This field contains the code corresponding to the location where the patient on this claims received care.

**Revenue Code**

This field contains the four-digit code that represents a specific accommodation, ancillary service or billing calculation.

**Type of Service (TOS)**

This code identifies the service that was performed (for example, 07 would be displayed for the Anesthesia service).

**Provider ID**

The unique identification number for the caregiver is displayed here.

**Submitted Charge**

The submitted amount, or cost, of the procedure is displayed here.

**Pre-Authorization**

The value in this field indicates whether the procedure has been pre-authorized (e.g., 2233A). If pre-authorization is not needed, this field will be blank.

**Status**

This abbreviation indicates the current state of the line (e.g., Active). The three possible codes follow:

- **A** = Active means this line is open and valid. This line will be included in analysis.
- **P** = Profile Only means this line is included in the analysis, but does not return any edits back to your host system.
- **D** = Deleted means this line has been deleted and will not be included in any further analysis.

**User-defined Fields**

These fields are provided for you to customize to meet your organization’s needs. They can contain codes and values to support your local policies and unique information.

**Analysis Results**

This section shows the line results. Only those fields that affect the results data are explained.
For an explanation of the fields that were presented for analysis, such as Patient ID or Patient Name, refer to the Claim fields section.

**Note**

If you analyze a claim and receive a CPT flag on every claim line, even though the CPT codes are all valid, this indicates that your system does not have a KnowledgeBase loaded. Your system administrator needs to add a KnowledgeBase.

**External Line ID**

This is the number of the result line generated from the analysis of an original line on the claim. This ID is provided so you can compare it to the ExternalLine ID in the Original Lines to view the changes or determine if a line has been dropped from analysis. For example, if the External Line ID and the Analysis Result Line ID do not match, you know that lines on the claim have been eliminated from further analysis.

When you have applied edit functionality turned on and a two-line claim gets a TRA flag that creates virtual line 3, and line 3 gets a TRA and REB which creates virtual line 4, the modified line results displays this as row 3 and Line ID 4. For more information, refer to the Applied Edits section.

**Flag Indicator**

This field indicates what kind of flag was raised. The options are:

- **I** = Interim Flag, any flag added in an interim pass that is removed in the final pass.
- **F** = Final Flag, any flag that a) drops a line and is not caused by a virtual line, b) adds a virtual line on an interim pass and is not dropped by the final pass, or c) fires on the final pass for the claim line.

**Important!**

Only final flags will be returned to your host system in the EMF format; Interim flags will not be sent back to your system.

**Flag**

This is the alphanumeric designation identifying all flags raised on the line. It is also referred to as a mnemonic. All flags on the line are returned in the EMF. They are displayed in the priority order used to set the line disposition with the highest priority flag displaying first.

**Flag Description**

This is the description of the flag on the line, providing you with a brief explanation of why the flag was raised.

**Flag Status**
This is an abbreviation for the disposition of the flag. Valid statuses are Review (R), Deny (D), Profile (P), and Off (O).

**Ruleset**

This field displays the name of the ruleset used in the analysis of this claim. This helps you assess whether or not changes need to be made to the ruleset to meet your analysis needs. Refer to the Manage Rulesets section for more information on modifying rulesets.

**Disclosure**

A link is displayed here if a disclosure, or rationale, statement is present in Claims Edit System that explains why the code relationship was flagged as inappropriate. Select the link to view the explanation of this edit for the line you are on.

For more information about managing code relationships and their associated disclosure statements, refer to the Code Relationships and Disclosure sections.

**Modified Lines**

The data fields here are the adjusted fields that appear in the Original Lines section (above) combined with results fields. You can view each modified claim line after the edits have been applied. Refer to the Applied Edits section for more information about how this functionality works.

The following data fields relate to the modifications:

**Internal Line ID**

This number identifies the claim line where the flag was triggered so that you can assess the data in the line, as necessary.

**Revenue Code**

This field contains the four-digit code that represents a specific accommodation, ancillary service or billing calculation.

**Adjusted Procedure Code**

This field displays the cross-walked codes that have been set up within the system to replace more generic submitted codes (e.g., any time a procedure code 50280 is submitted it will be crosswalked and replaced in this field with 00862). Additionally, if there is no crosswalk specified for a certain code, the submitted code will remain unchanged in this field.

**RVU (Relative Value Unit)**
A Relative Value Unit is a number assigned to Procedures to indicate the cost of completing these procedures relative to work, practice expense, and malpractice. On a claim, this value can be either a CMS (Medicare) RVU or an Optum RVU. Refer to the [RVU](#) section for more information.

**Disposition**

Recommend to the host system how to handle the claim line:

- **Pay** - This status indicates that the line is clean and ready for payment (no edits on the line).
- **Deny** - This status indicates that you should deny payment on the line based on edit(s) received.
- **Review** - This status indicates that flag(s) have been set for the line and you need to review the line manually and set the line to Pay or Deny, as appropriate.
- **Pay Add** - This status indicates a line should be added by the host system and then be paid.
- **Deny Add** - This status indicates a line should be added by the host system and then denied.
- **Review Add** - This status indicates a line needs to be added by the host system and you need to manually review flag(s) on the line and set the line to Pay or Deny, as appropriate.

For more information about disposition, refer to the [Applied Edits](#) section.

**Flag(s)**

This is the alphanumeric designation identifying the flag raised against the line. These flags will display in the priority order used to set the line disposition, with the highest priority displaying first.

**Mnemonic**

This is the alphanumeric designation identifying the flag raised against the line. These mnemonics will display in the priority order used to set the line disposition with the highest priority displaying first.

**Description**

This is the description of the edit itself, providing you with a brief explanation of why the flag was applied.

For original and added claim lines that are clean, no flag or flag description in the mnemonic field will be displayed. If the line is clean, no flag will be sent back in the EMF.

**Adjusted Charge**

The allowed charge, or cost, of the portion of the procedure listed on a specific line is displayed here.

**Beginning (BDOS) and Ending Date of Service (EDOS)**
This information is the same information that was entered on the claim when it was created or loaded into the system.

**Adjusted Modifiers**

These modifiers were entered on the claim when it was created or imported unless you have Applied Edits functionality turned on. If so, these modifiers may have been changed during analysis. They are included here for your convenience in reviewing any flag that may have been raised in connection with the modifiers.

**Service Date**

This is the date submitted as the Beginning of Service date, or the date that the patient began receiving care.

**Ending Service Date**

This is the date submitted as the Ending Service date, or the date that the patient finished receiving care.

**Modifiers**

This field contains the modifier codes, if any, that were submitted with the procedure.

**Adjusted Units**

This field displays the total number of days of service, or total units of service for anesthesia or other procedures. This field automatically defaults to one if no value is entered.

**Modified?**

This is a Yes or No indicator telling you whether this line has actually been changed.

**Applied Edit?**

This field indicates whether any edits have been applied on the claim line. It displays No if the modified line has not had any edits applied to the line received. It also displays No when a new (added) claim line is created or data is changed (edited) but no edits have been applied. It only displays Yes when some of the data on the line is changed by applied edits functionality.

**Reference Line ID**

This number corresponds to the new line created from an original line. If no additional lines are created the Reference Line ID is left blank. This field allows for unlimited values in case multiple lines are created from a single original line.

**Modeled from Line**
This number corresponds to original claim lines that were used to create the new lines. If a line is not added, Model From Line ID is left blank.

**Generating a Worksheet**

To see both the claim information and the analysis results, select Generate Worksheet. Doing this loads the worksheet report for the current claim using Acrobat Reader. The Worksheet Report is printable through the print menu in Acrobat Reader.

**Importing and Exporting Claims**

In most cases, claims data comes into Claims Edit System through an interface with your host adjudication system. However, in some cases clients may need to pass claims information to (and from) Claims Edit System without using a direct interface with the host system. When that is the case, you can use Import Claims to upload claims manually and then use Export Claims to return analysis results to the host system.

**To Import Claims Data Manually:**

1. Open the Claims module from the Enterprise entry-level screen.
2. Select the Import Claims icon at the Claims screen. The Import Claims Data screen then displays.
3. Using the File Type field, indicate the data type of the file you want to upload. At this time, the system will accept files formatted in any of the following formats:
   - 837p
4. At the File Location field, use the Browse button to select the file you want to upload.
5. Select the Next button. The system then uploads the file and lists it in the Import History.

**To Export Claims Analysis Results:**

1. Open the Claims module from the Enterprise entry-level screen.
2. Select the Export Claims icon at the Claims screen. The Export Claims Data screen then displays.
3. Enter a valid Batch ID and select Find. The system displays a list of results files with the matching ID.

<table>
<thead>
<tr>
<th>Batch ID</th>
<th>Date</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>080409A</td>
<td>08/04/09</td>
<td>ac</td>
</tr>
</tbody>
</table>

4. Select the Download button next to the batch file you want to export. The system will then create a CSV file (Comma Separated Values) containing the analysis results.

### Applied Edits

You can set up Claims Edit System to automatically apply changes to a claim during claims processing. This is known as Applied Edits.

#### How the System Works with Applied Edits Off

When Applied Edits are turned off, the system handles flags as *recommendations only*. The system does not make any changes to the claims during analysis, but merely raises flags to recommend changes. When analysis is complete, Claims Edit System then communicates these recommended changes back to the host system without changing the original claim data. Therefore, the host system must be able to interpret the results from Claims Edit System and then apply the recommended changes to each claim.
How the System Works with Applied Edits On

When your system has Applied Edits turned on, Claims Edit System not only generates flags (i.e., recommended changes), but it also executes special rules to create “modified” claim lines for these flags. The modified lines apply changes to the claim line that are needed due to the corresponding flag. Claims Edit System then transfers the modified claims to the host system.

About the Apply Edits Rules

The system uses the following rules to apply edits:

<table>
<thead>
<tr>
<th>Rule Name</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Edit - Set Pay Disposition</td>
<td>Applies the “Pay” status to lines as needed. This status indicates that the line is clean and ready for payment (no edits on the line).</td>
</tr>
<tr>
<td>Applied Edit - Set Deny Disposition</td>
<td>Applies the “Deny” status to lines as needed. This status indicates that you should deny payment on the line based on edit(s) received.</td>
</tr>
<tr>
<td>Applied Edit - Set Review Disposition</td>
<td>Applies the “Review” status to lines as needed. This status indicates that flag(s) have been set for the line and you need to review the line and manually set the line to Pay or Deny, as appropriate.</td>
</tr>
<tr>
<td>Applied Edit - Set Pay Add Disposition</td>
<td>Applies the “Pay Add” status to lines as needed. This status indicates a line should be added by the host system and then be paid.</td>
</tr>
</tbody>
</table>
Applied Edit - Set Deny Add Disposition
Applies the “Deny Add” status to lines as needed and ensures the line has the most severe flag it received in normal editing. This status indicates a line should be added by the host system and then be denied.

Applied Edit - Set Review Add Disposition
Applies the “Review Add” status to lines as needed and ensures the line has the most severe flag it received in normal editing. This status indicates a line needs to be added by the host system and you need to manually review flag(s) on the line and set the line to Pay or Deny, as appropriate.

Applied Edit - Modify Denied Lines
Sets the amount of denied lines to “0” and removes virtual lines that have been denied.

Applied Edit - M26
Changes the claim line to add the modifier 26, and then removes the M26 flag so the claim line goes back into the system clean.

Applied Edit - PCM
Changes the claim line to remove the modifier 26, and then removes the PCM flag so the claim line goes back into the system clean.

Applied Edit - mPC
Changes the claim line to remove both the 26 and TC modifiers, and then removes the mPC flag so the claim line goes back into the system clean.

The logic behind these rules works as follows:

1. During claims analysis, if the current line’s submitted units are not the same as its surviving units, the system splits the line into multiple lines with one unit each.

2. The system creates a copy of the current line – this will be the modified line sent back to the host system.

3. The system checks to see if there are any flags on the current line.
   a. If there are no flags, the system sets the line disposition of the modified line to “pay” and the rule stops.
   b. If there are flags, the system identifies the most severe flag on the current line (all flags having a status of “deny” or “review” which is placed on the line on the current line during its final pass). Flags TRA, M26, mPC, and PCM are excluded from this consideration. The rule then continues as with step 4 (below).

Important! Profile flags are excluded from Applied Edits.
4. If a flag has been identified in step 3, the system sets the disposition of this flag (e.g., Deny or Review) on the modified line.

5. If the M26 flag has been placed on the current line, the system reacts as follows:
   - It adds modifier 26 to the modified line and removes the M26 flag from the modified line. However...
   - If the M26 flag is set to profile status on your system, it does not add modifier 26 to the modified line and does not remove the M26 flag from the modified line.

6. If the PCM flag has been placed on the current line, the system reacts as follows:
   - It removes modifier 26 from the modified line and removes the PCM flag from the modified line. However...
   - If the PCM flag is set to profile status on your system, it does not remove modifier 26 from the modified line and does not remove the PCM flag from the modified line.

7. If the mPC flag has been placed on the current line, the system reacts as follows:
   - It removes the mPC flag from the modified line. However...
   - If the mPC flag is set to profile status on your system, it does not remove the PCM flag from the modified line.

8. If the current line is a virtual line, the system considers the following:
   - If the modified line’s disposition is “Review” or “Pay,” it changes the disposition to “Review-Add” or “Pay-Add” respectively.
   - If the modified line’s disposition is “Deny,” it removes the modified line from further consideration. (A virtual line indicates that the line has been added during rule processing. A denied virtual line adds no value to the host system, since it indicates that a line needs to be added to the claim and then denied.)

9. If the disposition of the modified line is “Deny,” the system sets the adjusted amount on the modified line to 0.

10. If the claim line has been partially denied (by the REB or MFD flag), the system sends back to the host system as many lines as there are units on the original line. Each line has a disposition similar to that of the flag that is placed on the line on that unit. In this case, the paid units are sent first. The first paid unit has a disposition of “Pay.” All other units have a “Pay-Add,” “Deny-Add,” or “Review-Add” disposition.

To receive the full benefit from the Applied Edits functionality, the interface to your host system must handle the additional “modified” claim lines from Claims Edit System (generated during analysis). Also, it must be able to handle the Pay, Deny, Deny Add, and Pay Add dispositions recommended in the results.

Additionally, if a Review or Review Add disposition is returned to your host system, it must then pend (or mark) the claim for manual review. Once you have reviewed the pended lines and determined how you want to
handle them, your system must release the claim from the review queue and complete its processing according to your organization’s procedures.

The system’s rule logic sets the line disposition to Pay, Deny or Review. You can view a line’s disposition in the modified line results of the claim. You can create customizations to have the system pay, deny or mark lines for review automatically. Also, if you want to add additional flags, you can copy an existing applied edit rule, add your flag(s) to it, and then define the behavior in your rule that will result in the flag being applied.

**Activating Applied Edits**

You must take two steps to activate applied edits in your system:

a. Activate applied edits at the system level

b. Activate the Apply Edits ruleset(s)

It is important to understand how these two levels of activation work together.

**System Level Activation**

When you activate applied edits at the “system” level (i.e., going into the system settings), the system changes the way it generates results during claims processing.

- **With Applied Edits Off** - The system generates results for individual claim lines - showing the flags generated for each line.

- **With Applied Edits On** - The system generates results with the following sections of information for each claim line flagged:
  - Original Claim Line - This section shows each claim line as it originally existed before analysis.
  - Claims Analysis Results - This section lists any flags that were raised on the claim.
  - Modified Claim Lines - This section shows each modified claim line after the Applied Edits were applied.

Thus, activating applied edits at the system level allows the system to generate modified lines and transmit them back to the host system. If applied edits are off, the system will only generate (and transmit) flagged claim lines.

| Important! | If you turn applied edits on and process claims, the system will generate modified lines for those claims. If you then turn applied edits off, the system will not generate modified lines for any claims coming through the system after you do so, but it will retain (and transmit) |

---
To turn on Applied Edits at the System level:

1. Go to the Main Menu (i.e., the menu that displays after you first log in to the system).
2. Open the System Settings module.
3. Open the Applied Edits module.
4. On the Applied Edits screen, set the Applied Edits field to ON.
5. Select Save.

Ruleset Level Activation

The Apply Edits ruleset contains the rules used to generate modified lines. If they are disabled, the system will not generate data for the modified lines - even if (at the system level) you have turned applied edits on. Therefore, if the rules are disabled, the system leaves the modified lines section on the claim results screen blank.

Another thing you must remember is that the Apply Edits ruleset is just that - a ruleset. In addition, in Claims Edit System, all rulesets are enterprise dependent. That means if you activate (or deactivate) a ruleset within one enterprise, it does not necessarily mean the same thing will happen in other enterprises. It all depends upon the inheritance structure. (Refer to the Defining enterprises section for more information.)

By default, the Apply Edits ruleset resides at the System Enterprise level. In addition, since the System Enterprise is a parent to all other enterprises, activating the Apply Edits ruleset within that enterprise means it will be inherited in all other enterprises. However, if you do not want to have applied edits active within all enterprises, you can choose to log in at specific "lower" enterprises and activate the Professional/Facility Apply Edits ruleset there. That way, you can activate applied edits in certain enterprises while leaving it inactive in others.

To activate the Apply Edits ruleset:

1. Open the Rules module from the Enterprise entry-level screen.
2. Open the module to Manage Rulesets.
3. Select the link to access the Professional/Facility Apply Edits ruleset. The system displays the list of rules belonging to the ruleset.
4. Look at the Status column to the right of the list of rules. If this column shows that the rules are *Enabled*, it means Applied Edits are already active in your system. However, if the rules are *Disabled*, you can activate them in the following manner:

5. Select the checkbox in the heading for the ruleset.

This causes all of the rules in the ruleset to become selected.

It is strongly recommended that you enable or disable all of the rules in the ruleset. Unless you know what you are doing, leaving some rules inactive while activating others individually may cause the applied edits to function improperly.

6. Select Change Status. The Status column changes to show that all of the rules are enabled.

7. Select the Save Changes button in the upper right portion of the screen.

Using Lookups

Several lookups and validation lists are available to assist you in creating or changing information on your claims. For example, if you are unsure about the provider identification number, you can select the Provider ID column header link and a list of Provider IDs will be displayed.

Claim Header Lookups that you might use on a claim or report include Patient ID, Account ID or Plan ID. Claim Line level lookups that you might use include Procedure Code, Modifiers or Diagnosis Codes.

To look up data from a claim (Selection Criteria):

1. Roll your pointer over the header field names to see the available lookups (for example, Claim ID).

2. Select the link above the field to access a table of valid entries for that field.
To look up data from a claim (data entry fields):

1. Roll your pointer over the header field names to see the available lookups.

<table>
<thead>
<tr>
<th>Lines</th>
<th>Add Lines</th>
<th>Delete Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line ID</td>
<td>Status</td>
<td>DDOS</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>04/18/2007</td>
</tr>
</tbody>
</table>

2. Select the column heading link to access a table of valid entries for that field (e.g., Procedure Code).
3. Find the information that you need in the lookup table and copy and paste it into the appropriate claim field.

To look up data for a report:

1. Roll your pointer over the Report Criteria field names to view the available lookups.

<table>
<thead>
<tr>
<th>Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim ID:</td>
</tr>
<tr>
<td>Import Date:</td>
</tr>
<tr>
<td>Service Date:</td>
</tr>
<tr>
<td>Batch ID:</td>
</tr>
<tr>
<td>Provider:</td>
</tr>
<tr>
<td>Patient:</td>
</tr>
</tbody>
</table>

2. Select the field name link to access a table of valid entries for that field (e.g., Claim ID).
3. Find the information that you need in the lookup table and copy and paste it into the appropriate criteria field.

If necessary, you can add a new record to these tables. For more information about adding new codes or finding and modifying existing ones, refer to the Working with codes section.

Calendar Lookup

The Calendar Lookup function allows you to graphically select and insert a date into Claims Edit System date fields. Dates selected with the calendar are automatically entered in the correct format. This feature is especially helpful if the date you need is in the current month. If you need a birth date from many years ago, it may be easier to simply type the date.
Dates are entered in the system in the format mm/dd/yyyy (e.g., February 8, 2020 would be entered 02/08/2020).

To use the Calendar Lookup:

1. Select the Calendar Lookup icon. The system displays a calendar window with the current date highlighted.
2. If you need to access another month, select the dropdown menu to select the desired month.
3. If you need another year, select the dropdown menu to select the desired year.
4. Once the calendar displays the correct month and year, select one of the days in the month to insert that date into your chosen field.
Claims Edit System Reports

Report Types

The reports in Claims Edit System are organized in specific categories. These are Operational Reports, Trends and Policies Reports, Maintenance Reports, and Customization Reports. The section for each category contains reports you can use to analyze your claims processing tasks, workload, procedures, system settings, and resources.

Report categories

**Operational Reports** help claims managers and claims reviewers (adjudicators) observe claims analysis activity across the system. These reports allow you to identify operational discrepancies and make process changes. They can be run on a regular basis and as needed.

**Management Reports** focus on the efficiency and improvement of your overall use of Claims Edit System and aid claims managers and organizational leaders in making decisions for the organization. These reports show the overall use and efficiency of Claims Edit System. They give you a view of how many flags are raised over time and how much your organization is saving by implementing effective claim analysis. These reports can be run on a regular basis and as needed.

**Trends and Policy Reports** extract information from the database and show how often claims with certain diagnoses and procedures are submitted for processing and are being used by providers, which allows you to analyze their billing practices. These reports also show trends in provider billing, which allows you to analyze your reimbursement policies and decide how to configure your system to address billing trends effectively. These reports can be run on a regular basis and as needed.

Maintenance Reports allow you to see what changes have been made to the default codes and relationships sent to you in the KnowledgeBase. You can use these reports, in conjunction with effective Enterprise management, to target specific areas in your organization needing changes. Making changes that apply to your organization as a whole or to just a part of it is known as defining the scope of a change. These reports can be run on a regular basis and as needed.

**Customization Reports** help you identify any customizations or changes that have been implemented in your system since you began using Claims Edit System. These reports allow you to keep your customizations up to date.

Report results vary depending on the type. These reports are made up of both submitted values (such as claim header and line fields) and analysis values (such as flags in analysis results and total adjusted charges).
For more information about the fields and values that are submitted on incoming claims, refer to the Claim Fields section. For more information about the fields and values that are generated as the claim is processed, refer to the Claim Results section.

Working with Reports

Claims Edit System provides you with a number of report sections and specific reports within them to help you manage your claims analysis. This section provides steps to access and run reports. For more information about each report, refer to the following sections:

- Operational
- Management
- Trends & Policy
- Maintenance

Note: You can only generate reports with data that is available in the enterprise(s) you have access to. Refer to the Enterprises and Security sections.

Generating Reports

There are two ways to generate reports: immediately or scheduled.

To generate an immediate report:

1. Open the Reports module from the Enterprise entry-level screen. The system displays the Reports screen where you can choose which report you want to run.

2. Select the link of the Report Name in the appropriate section. A screen displays any scheduled jobs for that report.


4. Enter filtering criteria to create your report. For more information on each field, refer to the Reports Fields section.

5. Select OK to create the report.

   The system generates the report. You can print using HTML or PDF or export to CSV format. Once you have generated the report, you can use the Back button to return to the Reports selection screen. For more information, refer to the Claim Fields section or the Claim Results section.
To schedule a report:

1. Open the Reports module from the Enterprise entry-level screen. The system displays the Reports screen where you can choose the specific report you want to run.

2. Select the link of the Report Name in the appropriate section. The screen displays any scheduled jobs for that report.

3. Select Add Job.

4. Enter a name in the Job Name field.

5. Select the desired report format: HTML, CSV or PDF.

6. Define any filtering criteria (refer to the Report Filtering Criteria section).

7. In the Scheduler Frequency area, define settings:

   Select one of the following options:

   - Daily
   - Weekly
   - Monthly

   Every X Days
   
   Indicate the report frequency (i.e., enter "3" to run every three days).

   At X Hours
   
   Enter the exact time of day when the report should run (i.e., 14:00 hour = 2:00 pm).

8. When finished, select Save Job.

Report Filtering Criteria

The following settings are available when scheduling reports to generate later (refer to the Scheduling Reports section). All reports except for the KnowledgeBase Customization Report use the following criteria.

Note

The following is a global list of potential report settings; none of the reports will contain all of them. Each report varies regarding the specific criteria that are available.
Criteria for Most Reports

Claim ID

The Claim Identification numbers are unique numbers assigned by your host system on imported claims, or numbers you assign each test claim. To filter the report for records with specific Claim ID numbers, enter the range of desired ID numbers.

Import Date

The Import Date option refers to the day claims were imported into Claims Edit System. To filter the report for records with claims imported within a specific date range, enter the date range. There is a Calendar Lookup available for this field.

Service Date

The Service Date option is for the beginning date of service listed on claims. To filter the report by service dates, enter the date range. There is a Calendar Lookup available for this field.

Batch ID

The system automatically assigns a Batch ID to each batch of claims. When entering test claims manually or importing individual claims real time, the assigned Batch ID consists of the date and user name (login name). For example, the Batch ID 20191014-User 1 indicates the claim was entered or imported on October 14, 2019, by User 1. All the claims manually entered or imported individually for a given day will have the same Batch ID.

When claims are imported in a group, or batch, they are assigned a different Batch ID. The imported claims’ Batch IDs consist of the date and the batch number. For example, Batch ID 20191029-0001 indicates the batch was imported on October 29, 2019 in batch 0001. To filter the report for records with specific Batch ID numbers, enter the range of desired ID numbers.

Provider ID

The Provider ID refers to the provider identification number assigned by the host system. To filter the report for records with specific Provider ID numbers on the claim, enter the range of desired ID numbers.

Group By

Select a radio button to determine how the information will be organized on the report (for example, grouped by Provider ID, Patient ID, Environment Type, etc.). Options vary depending on the report. Refer to the Reports Fields section.

Analysis Type
Select a radio button to filter the report by either of the following options:

- **Most Recent** - Organizes the report with most recent analyses first.
- **First Time** - Organizes the report with first-time analyses first.

**Environment**

Select a radio button to filter the report by either of the following options:

- **Live** - Live claims analysis.
- **Test** - Test claims analysis.

**Data Inclusion/Flag Types**

For some reports this setting is listed as **Data Inclusion**, while others list it as **Flag Types**. Select the checkbox for each of the following that you want to include on the report:

- **Profile** - Includes items with profile flags.
- **Review** - Includes items with review flags.

**Line Status**

Select the checkbox for each of the following items you want for the report:

- **Active** - Include items with a current claim-line status of **Active** (i.e., the claim line is open, valid, and will generate edits during claims analysis).
- **Profile** - Include items with a current claim-line status of **Profile** (i.e., the claim line will be included in claims analysis, but will not generate any edits).

**Error Level/Claim Status**

For some reports this setting is listed as **Error Level**, while others list it as **Claim Status**. In this area, select the checkbox for each of the following that you want to include on the report:

- **AD** (Analyzed, Needs Documentation) - Include items where the analysis returns a status of AD. (The corresponding error level value for AD = 15000 - 19999).
- **AF** (Analysis Failed, Deny Line Level) - Include items where the analysis returns a status of AF. (The corresponding error level value for AF = 30000 - 99999.)
- **AI** (Analyzed; Analyzed, Needs Information; or Analysis Incomplete) - Include items where the analysis returns a status of AI. (The corresponding error level value for AI = 10000-14999.)
• AN (Analyzed, Needs No Review) - Include items where the analysis returns a status of AN. (The corresponding error level value for AN = 5000 - 9999.)

• AR (Analyzed, Needs Review) - Include items where the analysis returns a status of AR. (The corresponding error level value for AR = (20000-29999.)

• AZ (Analyzed, Needs Review Claim Level) - Include items where the analysis returns a status of AZ. (The corresponding error level value for AZ = 45000-49999.)

Flags

To filter the report for records with specific flags, enter the flags here (separated by commas).

Account

This field refers to the alphanumeric identifier for the patient’s account.

Plan

This field refers to the alphanumeric identifier for the patient’s specific insurance plan.

Place of Service

This is the two-digit place of service code for the procedure associated with a given claim line. To filter the report for records with specific place-of-service codes, enter the codes here (separated by commas).

Code Type

Select the checkbox for each of the following that you want in the report:

- ICD-10 - Select this option to include items with 3-to-7-digit ICD-10-CM diagnosis codes.
- ICD-9 - Select this option to include items with 3-to-5-digit ICD-9-CM diagnosis codes.

Criteria for the KnowledgeBase Customization Report

The KnowledgeBase Customization Report is different from most other reports. Rather than reporting on claims analysis, this shows all of the areas where KnowledgeBase overrides have occurred, identifying where any changes were made and by whom. The following settings are available:

Override Modification Date

To filter the report to show KnowledgeBase modifications made on a specific date, enter a date range in this field.

User ID
To filter the report to show KnowledgeBase modifications made by a specific user, enter the desired user ID in this field.

**Ruleset**

Select the checkbox for each ruleset you want to include in the report. It will list all rulesets that exist on your system.

**Modules**

Select the checkbox for each data module you want to include in the report. It will list all data modules (i.e., all sub-modules apply to the Procedure, Diagnosis, and Modifier screens).

### Operational Reports

The Operational Reports help claims managers and claims reviewers (adjudicators) observe claims analysis activity across the system. These reports focus on claims analysis and provide details on what happened with your claims. They help you to identify operational discrepancies and make changes to your processes where needed. They can be run on a regular basis and as needed.

The following Operational Reports are available:

**Edit Error Report**

The Edit Error Report lists all claims and the summary of the claim detail that received a flag, the detail of each line that receives an edit (both claim header and line details) and the results of the analysis of the line (flags and savings).

Only lines that receive edits are visible in this report, unless you select to report on clean lines. This report is also useful when you want to see “profiled” items that will not otherwise affect the claim.

| Note | The previously used Claim Detail report has been merged into the current Edit Error Report functionality. These new reports provide the same information as the Claim Detail report as well as additional information and customization options. These enhanced reports help make claims information more specific and meaningful. |

**Worksheet Report**

The Worksheet Report provides help for troubleshooting claim errors or issues and provides a view of the details and analysis results of a specific claim. It also gives insight on how to improve claims processing. The Worksheet Report shows analysis details for the selected claim(s) header and line details, flags and savings, and descriptions for all codes found on the claim(s), including Procedure, Diagnosis, and Modifier codes. It
includes all lines on a claim regardless of whether they received an edit. A single claim Worksheet can be pulled from the claim results screen or the reports menu. This report runs against the most current claims analysis. For more information, refer to the Claim Results section.

Management Reports

In the Management section, the reports focus on the efficiency and improvement of your overall usage of Claims Edit System. These reports are provided for claims managers and organizational leaders to use in making decisions for the organization as a whole.

Management reports are usually run by a member of management to show the overall use and efficiency of Claims Edit System. These reports give you a view of how many flags are raised over time, and how much your organization is saving by implementing effective Claims Edit System claim analysis. These reports can be run on a regular basis and as needed.

The following maintenance reports are available:

Edit Summary Report

The Edit Summary report shows all flags generated during analysis, and provides a summary of claim lines that triggered the flags, activity of a flag that hit for an Account or Plan over a period of time, the total lines that hit and the percentage of lines that received the edit.

This report lists each edit returned on claims, in alphabetical order, by flag. The system generates this report from the analysis of all processed claims. Once you generate your report, you may see multiple flags of the same type per line. This is generally because the claims may have several codes submitted together on one line, and if there is an inappropriate code relationship on this line, you may see several flags.

In order to get data for a single date, you should know that dates in the Import Date filter are searched from midnight (beginning) of day one to midnight (end) of day two and requires entering both dates. To get data for a single day, enter dates for two days in the From/To fields (the desired day in the From field and the day following in the To field).

Edit Summary By Provider Report

The Edit Summary By Provider report shows the claims submitted by providers and the claims’ status. The status includes the number of claims that a provider has submitted and the associated charges. It also shows the adjusted amount paid of that provider’s claims as well as the total savings realized on the original charges submitted.
Savings Summary Report

The **Savings Summary** report calculates the savings that have been generated from analysis of claims within the Claims Edit System Professional module. This report gives you a synopsis of the savings you are receiving by each account and plan. The system generates this report from the analysis of all processed claims. The system derives the savings by account and plan from a comparison of the submitted charge versus the adjusted charge.

Claim Counter Report

The **Claim Counter** report helps you track the number of claims your system has processed during a specific period time. To verify that everything was imported into the system correctly, run this report on Profiled, Deleted and Active lines. This can then be used to compare the information on this report with the information in your adjudication system.

Rule(s) in Ruleset(s) Report

The Rule(s) in Ruleset(s) report helps you identify ruleset mapping in the system (i.e., which rules belong to which rulesets). This can be very beneficial as you manage your custom rules.

**Trends and Policy Reports**

The Trends and Policy section of the interface contains reports that come directly from the database and allow you to see what is being submitted and how the system is handling it.

These reports allow you to analyze the billing trends within your provider data.

| Note | Since the Trends and Policy reports are returned to you as comma-delimited files pulled directly from the database, they provide you with more analytical value than static reports that are already formatted a certain way. If you choose to do so, you can run these reports and then export them to pivot tables or an external report program for further analysis and processing. |

The following maintenance reports are available:

**Diagnosis Drill Down Report**

The **Diagnosis Drill Down** report shows activity for a specific Diagnosis (Dx) code on your claims.

This report shows the impact of a billed diagnosis code. It lists each provider that has submitted claims with your chosen code(s). It also provides information about how many claims submitted have that diagnosis on
them and how many lines the code is applied to across the claim or range of claims you choose. Additionally, this report includes subtotals and totals of monetary charges associated with the selected diagnosis code(s). This report can be run for a particular provider or range of providers.

**Diagnosis Frequency Report**

The *Diagnosis Frequency* report shows the most commonly billed diagnosis codes per provider, plan, and/or account. The top five procedure codes are identified along with the dollar amount. This report can help when updating encounter/charge forms and can be used when adding new information to the forms. This report does not include the associated procedure.

**Procedure Drill Down Report**

The *Procedure Drill Down* report shows activity for a specific procedure code on your claims.

This report shows the impact of a billed procedure code. It lists each provider that has submitted claims with your chosen code(s). It also provides information about how many claims submitted have those procedures on them, and how many lines the code is applied to across the claim or range of claims you choose. Additionally, this report includes subtotals and totals of monetary charges associated with the selected CPT or Level II HCPCS code(s). The report can be run for a particular provider or range of providers.

**Procedure Frequency Report**

The *Procedure Frequency* report tells you which procedure codes are used most commonly by a provider, plan, and/or account as well as the submitted charges and number of claims containing the procedures. The top five procedure codes are identified along with the dollar amount.

This report does not include the associated diagnosis; use the *Frequency by Diagnosis and Procedure* report to see this.

**Procedure Frequency by Procedure Report**

The *Procedure Frequency by Procedure* report tells you how often a specific procedure is billed together with other associated procedures by a given provider. It also tells you how many claims have been received containing a procedure and the associated charges submitted by that provider. A report on a global surgical code displays all the other procedures billed with that code and how often these combinations are billed by a provider.
Customization Reports

**Claim Route Customization Report**

The *Claim Route Customization* report helps you track modifications made to the related claim routes on your system. When you run this report, it will show you customizations made to the claim route name, destination ruleset, routing parameters and routing fields.

**Rules Customization Report**

The *Rules Customization* report helps you track modifications made to the related rules on your system. When you run this report, it will show you details about rule customizations (such as new rules created, rules changed, and rules deleted).

**Ruleset Customization Report**

The *Ruleset Customization* report helps you track modifications made to the related rulesets on your system. When you run this report, it will show you details about rule customizations (such as new rulesets created, priority order changed, rules selected, flags added, etc.).

**Report Fields**

The fields and checkboxes described in this section are available to you to configure your reports. Various fields allow you to enter specific values or ranges of data. The flexibility provided with these fields and selections allows you to drill down into your organization’s data and perform effective analysis.

Certain list option fields on the Parameter screen such as Accounts, Plans, Flags, Users, Revenue Code, and Places of Service default to [ALL]. The [ALL] option displays when the Parameter screen first appears. If the default value [ALL] is used to generate the report, the system will look for all values and display any records accordingly. If the [ALL] is removed without entering any value (a blank field), it will only search for entries that are null or blank.

**To indicate specific options on which to filter:**

- Type in the field parameter in a comma-delimited format with no space between the options (e.g., plan1,-plan2,plan3).

Other Parameter screen options such as Claim ID, Import Date, and Batch ID that request From: and To: data behave as ranges and only require a single value, not a range of values. Therefore, they may not contain a comma-delimited list.
Important! If some of the data in the fields on your report is shortened or cut off, it means that this data exceeded the maximum field length accepted by the system. If a field contains data that is too long, the system may truncate the data to fit that field for processing. For more information about the claim fields and the lengths that the system accepts, refer to the Claims Edit System IMF/EMF Specification.

Some fields and ranges are specific to certain reports, due to the nature of the reports. The fields that are specific to certain reports are noted.

Common Report Fields or Ranges

These fields are available for Claims Edit System reports. For a single date or ID, enter the same date or ID in the From and To fields.

| Note | Some of the fields provide From and To ranges for you. If you want to use only one value (date, ID or data), enter that information in both the From and To fields. Otherwise, enter the beginning value in the From field and the ending value in the To field. Some fields have lookups that access the list or table containing that information. You can copy and paste the information you want into the applicable search field(s). |
| Claim ID | The Claim ID From and To fields allow you to run a report on the unique claim identifiers assigned by the host system when claims are entered. It is alphanumeric and can consist of any combination of numbers and letters (e.g., ABC20190101). |
| Import Date | The Import Date From and To fields allow you to run a report on claims that have been received by the system on specific dates. Import Date uses the Entry Date to filter claim data. This Entry Date typically comes from your adjudication system. However, if the Entry Date is not supplied by your system, Claims Edit System will automatically fill in the Entry Date with the date the claim was imported or manually entered into the CES system. |

Important! To get data for a single date, be aware that dates in the Import Date filter are searched from midnight (beginning) of day one to midnight (end) of day two and requires entering both dates. To get data for a single
Important! day, enter dates for two days in the From/To fields (the desired day in the From field and the day following in the To field).

Service Date

The Service Date From and To fields allow you to run a report on claims that have been submitted for medical services or care received on specific dates.

Important! To get data for a single date, you should know that dates in the Service Date filter are searched from midnight (beginning) of day one to midnight (end) of day two and requires entering both dates. To get data for a single day, enter dates for two days in the From/To fields (the desired day in the From field and the day following in the To field).

Batch ID

The Batch ID From and To fields allow you to run a report on the Batch ID that is assigned by the host system when a group of claims is entered. It is alphanumeric and can consist of any combination of numbers and letters (e.g., ABC20190101).

Provider ID

The Provider ID From and To fields allow you to run a report on claims that have been submitted for a certain provider or range of provider names or IDs. For a single provider, enter the same Provider ID in both From and To fields. For a range of providers, enter the beginning Provider ID in the From field and ending Provider ID in the To field.

Patient ID

The Patient ID From and To fields allow you to run a report on claims that have been submitted for a certain patient or range of patient names or IDs. For a single patient, enter the same Patient ID in both From and To fields. For a range of patients, enter the beginning Patient ID in the From field and ending Patient ID in the To field.

Diagnosis Code

The Diagnosis Code From and To fields are available to use within the applicable Trends & Policy Reports. The Diagnosis Code field is included for the Diagnosis Reports. These fields allow you to run a report on claims that have been submitted for a certain diagnosis code or range of codes.

Procedure Code
The Procedure Code From and To fields are available to use within the applicable Trends & Policy Reports. The Procedure Code field is included for the Procedure reports. These fields allow you to run a report on claims that have been submitted for a certain CPT procedure code, Level II HCPCS code, or client-specific code or range of codes.

Data Inclusion/Flag Types/Line Status

These options are available for selection in selected reports.

Profile Line
Select this checkbox if you want your report to contain information from claim lines with a Profiled status.

Active Line
Select this checkbox if you want your report to contain information from claim lines with an Active status.

Note
Most users want to report on Active lines, but reports on Profiled lines are useful if you want to re-evaluate your editing.

Flag Status

These options are available for selection on Claims Edit System Professional reports.

Profile
This option allows you to include the claims corresponding with the rest of the report criteria you have entered that have received a Profile flag, or flags, during processing.

Review
This option allows you to include the claims corresponding with the rest of the report criteria you have entered that have received a Review flag, or flags, during processing. These are the claims or lines on the claims that need to be reviewed.

Deny
This option allows you to include the claims corresponding with the rest of the report criteria you have entered that have received a Deny flag, or flags, during processing. These are the claims or lines on the claims that will be dropped from further editing.

Interim
Choose from the *Interim Only* or *Exclude Interim* options to include or exclude the claims corresponding with the rest of the report criteria you have entered that have received an Interim (or temporary) flag(s) during processing.

**Environment**

These options are available for selection on all Claims Edit System reports.

*Live*

Choosing Live allows you to include the information, corresponding to the rest of the report criteria you have entered, from the claims in your live environment.

*Test*

Choosing Test allows you to include the information, corresponding to the rest of the report criteria you have entered, from the claims in your test environment.

Refer to the [Analyzing Claims](#) section for more information about these environments.

**Analysis Type**

This option allows you two choices by which to analyze a claim. You can select your analysis based on either *First Time* or *Most Recent*.

*First Time Analysis* - Limits report filtering results to the first time a claim was processed.

*Most Recent Analysis* - Typically the default option; report filtering results are limited to the last time a claim was processed.

**Group By**

This field allows you to group the items on your report by specific criteria. The specific options will vary, depending on which report you are running.

The following grouping options are available for the specified report:

- **Edit Error Report** - Claim, Provider, Patient, Plan, and Account ID
- **Diagnosis Frequency Report** - Account ID, Plan ID, and Provider
- **Procedure Frequency Report** - Account ID, Plan ID, and Provider

**Date Range**

The Date Range fields (From and To) are the date range of customizations that will be returned. Date Range returns a report for all customizations that occurred during the specified date span. If a customization
occurred outside the specified date range but does not have an expiration date, these customizations will be
returned also since they are current.

A maximum of three years’ worth of customizations are allowed for the report. If less data is wanted, the
report parameters allow the date range to be narrowed.

**Rule**

This option is available on some reports that deal with rules and/or rulesets. To use this option, enter the name
of a specific rule or use wildcard search characters to broaden the criteria.

**Rule Category**

This option is available on some reports that deal with rules and/or rulesets. To use this option, indicate what
type of rule you want to search for (i.e., custom, system, etc.).

**Additional Data**

These options are available for selection on Claims Edit System reports. Where available, the [ALL] option
searches under all available options for that particular field.

**Account ID**

The Account ID *From* and *To* fields allow you to run a report on a single account or range of accounts by
the Account ID.

**Accounts**

Populate this field with the list of desired Accounts or use the default [ALL]. This option allows you to
include the accounts associated with the other data you have entered in the report fields.

**Plans**

Populate this field with the list of desired Plans or use the default [ALL]. This option allows you to include
the plans associated with the other data you have entered in the report fields.

**Flags**

Populate this field with a list of Flag mnemonics included in rules or use the default option [ALL]. This
option allows you to include any flags that were raised in conjunction with the other data you have entered
in the report fields. Refer to the Manage Flags section for more information.

**User ID/Users**
Populate the User ID/Users field with a list of users who have manually entered claims into the system or use the default [ALL]. From this list, you can include only those claims that were entered by a specific user. Refer to the Defining User Records section for information about how users become registered with the system. Refer to the Modifying Claims section for information about how these users can manually enter claims in the system.

Place of Service

Populate this field with a numeric character Place of Service code (00-99). Each code identifies a specific site where services can be rendered. If you have specific places of service where certain services are performed, you can enter them here or use the default [ALL].


Error Level

Select an option that allows you to include specific claim statuses associated with the other data you have entered in the report fields or use the default [ALL]. Refer to the Claim Results section for more information about Claim Status.

Scope

The Scope field displays a list of all the types of rulesets on any given claim line that are available from within the enterprise.

Modules

The Modules field displays a list of all modules that can be shown on a code’s relationship. For KnowledgeBase Customization Reports, this list is the available modules that allow customizations. The default selection is [ALL]. When a module with a drill-down is selected, the additional drill-down choices are displayed.

Enterprises

The Enterprises field displays a list of all enterprises created in the application. It helps in filtering a report for a particular enterprise.

User ID/Users

The User ID/Users field displays a list of all users that have access to make changes to the KnowledgeBase. The default for this data selection is [ALL]. If a user is selected, only customizations made by that user are returned in the report.

Ruleset
The Ruleset field displays a list of the available rulesets. Select the desired ruleset. The default selection is [ALL].

Claim Statuses

This option prints the status of a claim using one or all of the following codes. The default selection is [ALL].

- AD = Analyzed, Needs Documentation
- AF = Analysis Failed
- AI = Analyzed, Needs Information
- AN = Analyzed, Needs No Review
- AR = Analyzed, Needs Review
- NN = New, Needs Analysis

Ranges - KnowledgeBase Customization Report

This field is available only on the KnowledgeBase Customization report, described in the Maintenance Reports section.

Note

This report does not include the codes or code relationships in the KnowledgeBase that are either still effective or have expired in the date range you enter. It includes only those changes that have been made on or within the date(s) you enter.

Audit Date

This field allows you to run a report that contains all the changes made on a specific date or within a range of dates.

Report Viewer

The Report Viewer icons are found at the top left of the screen when any report type is selected. However, these icons are active and can only be accessed after a report has been generated, after field values have been entered in the Parameter screen and OK has been selected.

Toggle table of contents icon - Toggles the screen view of the selected reports based on Claim ID number. The screen is split to show a list of provider Claim ID numbers on the left with a +
(plus) sign next to them, and the report on the right. By selecting a plus sign adjacent to the provider ID, a list of diagnosis codes for that provider is displayed.

**Run report** icon - Generate another report using the *Parameter* screen. Enables running the same report again using different criteria while retaining the previous selection criteria.

**Export data** icon - Opens the *Export Data* screen for exporting report data in .csv format.

### Available result sets

This dropdown list is based on search set criteria from the SQL database. From this list, multiple result sets can be generated. Various data set elements can be accessed, viewed, and analyzed based on the selection from the dropdown list. Use this list to decide what data you would like to view.

The **Available Columns** list of data is determined by the element selection made from the **Available result sets** dropdown list. You will notice that when multiple element selections are available, the **Available Columns** options will vary based upon the element that is selected.

### Available Columns/Selected Columns

Use the right and left arrow buttons to move the desired column names from and to the **Available Columns** list and the **Selected columns** list. The right double-arrow button moves all items in the **Available Columns** list to the **Selected Columns** list with a single selection.
To select individual Available Columns items, highlight the desired item and use the right single-arrow button to move the item to the Selected Columns list. Hold down the Ctrl key to select and highlight multiple items individually and move them as a group to the Selected Columns list using the single-arrow button.

Items can be reordered in the Selected Columns list by selecting an item and using the up or down arrow buttons to change the order of the item in the list.

Output encoding

UTF-8 (8-bit Unicode Transformation Format) is a variable-length character encoding format for Unicode. It is used to represent any character in the Unicode standard. UTF-8 uses groups of bytes to represent the Unicode standard for the alphabets of many of the world’s languages, allowing foreign language symbols to be interpreted. For most purposes for the Export Data screen, the default UTF-8 selection will be the selection of choice and will serve most users’ purposes.

Separator

Select the desired separator from the dropdown list that will be used between column types for the exported data. Upon export, the selected separator will be used between column (data) items. Different separators are used for different applications; it will be necessary to determine which separator(s) can be used for your particular application. The most common separator type is comma-separated values for .csv files.

Note

As an example, Microsoft® Office Excel spreadsheet-type applications use the comma (,) separator to place each data item in separate columns when the export file is saved as a .csv file. Separator types other than a comma, however, will save all column items in the .csv file to a single merged cell, not to individual cell columns. The application you use to read the exported data file will determine what separator character to use to separate data items into their respective fields.

Export column’s data type

When the .csv file is exported, the column name’s data type is added below the column name in the spreadsheet; for example, STRING, as shown in the following figure:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Modified From Claim</td>
<td>Provider Id</td>
</tr>
<tr>
<td>2</td>
<td>STRING</td>
<td>STRING</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When OK is selected in the Export Data screen, the default export file name is exportdata.csv using the Save As option. The file name, however, can be changed to any desired name and saved to any desired location. File output of the .csv file, when opened, will typically display in a spreadsheet format.
**Export report** icon - Opens the Export Report screen for exporting the report data to Microsoft Word, PowerPoint, Adobe PDF, PostScript, or Microsoft Excel formats.

**Print report** icon - Opens the Print Report screen for sending the specified report to be printed in HTML or PDF formats. All or specified pages may be printed.

### Reporting – Panel-based UI

**Prerequisites**

<table>
<thead>
<tr>
<th>Database type</th>
<th>Application version</th>
<th>KnowledgeBase version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oracle</td>
<td>Claims Manager/Claims Edit System 5.4 SP1-CU05 or later</td>
<td>KnowledgeBase 2019 Q3A+</td>
</tr>
<tr>
<td>MS SQL Server</td>
<td>Claims Manager/Claims Edit System 5.4 SP2 or later</td>
<td>KnowledgeBase 2019 Q3A+</td>
</tr>
</tbody>
</table>
Overview

All reports are specific to data for a selected enterprise and can be accessed from the Reports tab on the Enterprise panel for the selected enterprise. The Reports tab itself contains a dashboard of high-level charts that show key indicators of the performance/value of the system. Several categories of reports appear as subtabs under the Reports tab and include the following:

- **Summary Reports** - These reports produce high-level summary information based on claim detail. The data produced by these reports is what is displayed on the Report Dashboard, so by configuring these summary reports, the information on the dashboard can be customized. The following report templates are available:

<table>
<thead>
<tr>
<th>Report name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Edit Summary</td>
<td>Reports the total number or total value of claims that received edits versus those that were clean.</td>
</tr>
<tr>
<td>Flag Edit Summary</td>
<td>Reports the most frequently occurring flags/edits that occurred.</td>
</tr>
<tr>
<td>Flag Status Summary</td>
<td>Reports the number of claims that had a particular flag status after being analyzed (Deny, Review, Profile, or Clean).</td>
</tr>
</tbody>
</table>

- **Detail Reports** - These reports include detail information from individual claims or claim lines or from rules. The following report templates are available:

<table>
<thead>
<tr>
<th>Report name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dropped flags</td>
<td>Reports each flag that was dropped from a claim due to a drop flag rule.</td>
</tr>
<tr>
<td>Rules that did not add edits</td>
<td>Reports all rules that did not add any edits during the specified period. This report is useful for finding which rules are providing little value and could possibly be removed from rulesets.</td>
</tr>
</tbody>
</table>

- **Custom Reports** - This subtab allows custom reports using claim data to be defined by the user. Once a report is defined, it becomes a template from which separate reports can be generated by changing the filter values (time range, flag status, patient ID, type of bill, etc.). This provides a great deal of flexibility for clients to create reports with the specific claim data that they are interested in.
- **KB Customization** - The KB Customization Report is the only report that is currently included in this category.

<table>
<thead>
<tr>
<th>Report name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KB Customization Report</td>
<td>Produces a report of all KnowledgeBase overrides that have been added and which will affect claim editing.</td>
</tr>
</tbody>
</table>

**Report dashboard**

The dashboard is used to display a graphical summary of the latest data generated by the Summary reports. The information displayed in these graphs can be customized by changing the filter values for each of the Summary reports.

![Report dashboard screenshot]

*Claim Edit Summary* - A pie chart showing the percentage of claims to which edits were applied for the most recent time period (configurable).

*Flag Status Summary* - A bar chart showing the count of claims with Deny, Review, and Profile edits and the count of “Clean” claims (no edits) for the most recent period. The chart can also be configured to show the total dollar amount associated with each of these categories.
Flag Edit Summary - A pie chart showing the relative volume of the most frequent edits (flags) that were applied to claims for the last day.

Standard Report Features

Most of the reports that are described in later sections make use of standard features for defining, scheduling, and generating the report and for maintaining various instances of the report.

- Various filters are available for each report that allow you to select the specific detail that is to be included in the report.
- Some reports allow you to select the column in the report and the order in which they appear on the report. These are described in the following sections.
- If the report is to be run on a regular basis, it can be indicated by selecting a checkbox and then selecting the desired run schedule.
- When reports are generated, they are added to a Report Data Archive tab where they can be viewed later.
- Archived reports can be automatically deleted after a specified number of days. This ensures that report data (which can be large) does not pile up and unnecessarily consume hard disk space.

Report Category Subtab

Different categories of reports are grouped together by a subtab under the Reports tab. The panel for each subtab contains a list of reports that have been defined by use based on available report templates.

There is an Add a report button at the top of the screen that, when selected, displays a list of report templates upon which to base a specific report. An example for the Summary Reports category is shown below.

Report Properties tab

After selecting the desired template, a Properties panel displays where a name can be given for the report and for setting the various parameters for the report.
**Days to keep** - All reports allow you to specify the number of days the report should be kept before it is automatically deleted. This is especially helpful for reports that are automatically run on a daily or weekly basis as it prevents the hard disk from becoming filled with old data that is no longer pertinent. A value from 1 to 9999 is allowed.

**Filters** - Most report templates have a defined set of filters that can be applied to the report data. In the example in the figure above this includes Environment (Live or Test), Flag status (Deny, Review, Profile), Flags (# of top hitting edits), Time period and Analysis type (Most recent, First time). The specific filters that are available vary for each report template.

**Scheduling** - Select the **Run on a recurring schedule** checkbox in order to run the report on a periodic basis. A choice list will then become available with options for Daily, Weekly, Monthly and Quarterly. Based on the option selected the appropriate fields are displayed to more precisely choose when the report is to be generated.

**Save or Cancel** - These buttons are available in the left-hand pane of the panel to either save the report that has been defined or to cancel without saving.

**Delete Report** - After saving a report, the Cancel button is replaced by a **Delete Report** button that can be used to delete the report definition. This does not affect any archived reports that were generated before the report was deleted.
**Run Report** - After the report definition has been saved, it will appear in the list of defined reports for the report category subtab. The Run Report button will also become active and it can be selected to immediately start generating the report.

**Report Data Archive tab**

When a report begins data generation, it immediately appears in the list of reports in the Report Data Archive tab with a status of “Running.” When the report generation completes, the status changes to “Completed” and additional data (Row Count, Query Duration and Remaining Days) are added to the row.

**Viewing Report Data** - To view the data in the report, simply select the row in the Report Data Archive panel. A Report Run panel opens to the right. The Properties tab shows information about this specific report (start and end times for report generation, etc.). The Report Data tab is used for browsing through the data that was generated.

**Manually Deleting Report Data** - A Delete Report Run button is included at the bottom left-hand corner of the panel that can be selected to manually delete the report data.

**Exporting Report Data** - The Tools icon at the upper-right of the Report Data panel provides a way to export the data in the report to a CSV (comma-separated value) file that can be imported into a spreadsheet for further manipulation. Most databases also allow CSV data to be easily imported into a database table where it can be queried.

![Export listing to spreadsheet](image)

**Summary Reports**

The Summary Reports subtab includes pre-defined templates for the following three reports that were previously described for the Report Dashboard. The filters for these reports are also predefined, but the filter values can be changed to produce different reports.

**Claims Edit Summary Report**

The Claim Edit Summary report provides a high-level report of claim analysis results. For a given time period, it provides the total number of claims analyzed and the breakdown of clean versus claims that had edits. The output can be changed to the dollar value of claims instead of the count of claims.
## Filter options | Description
---|---
Environment | Live or Test
Grouped by | Count or Submitted Charge
Time Period | Day: Today, Yesterday, Previous 7 or 30 days
| Week: This week, Previous week
| Month: This month, Previous month, Previous 6 months
| Quarter: This quarter, Previous quarter
| Custom: Date range from calendar
Analysis type | Most recent analysis or First time analysis

Sample output:

![Sample output image]

### Flag Edit Summary Report

The *Flag Edit Summary* report provides a summary of the top flags for a specified flag status. For a given period, the most frequently occurring edits are listed ordered from most frequent to least frequent along with the number of times each edit occurred.

## Filter options | Description
---|---
Environment | Live or Test
Flag status | Review, Profile, or All
Flags | Top 5, 10, 15, or 20
Time Period | Day: Today, Yesterday, Previous 7 or 30 days
| Week: This week, Previous week
Filter options | Description
-------------|-------------------
Month: | This month, Previous month, Previous 6 months
Quarter: | This quarter, Previous quarter
Custom: | Date range from calendar

Analysis type | Most recent analysis or First time analysis

Sample output:

Flag Status Summary Report

The Flag Status Summary Report provides a summary of claims analyzed within a specified period. One row is shown for each of the possible flag status values (Deny, Review, Profile, and Clean/No Edits). A detailed description of the report columns is included below.

- The total value of claim lines or claims with edits of that status.
- The percent of the total claim value for that amount.

<table>
<thead>
<tr>
<th>Filter options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Live or Test</td>
</tr>
<tr>
<td>Time Period</td>
<td>Day: Today, Yesterday, Previous 7 or 30 days Week: This week, Previous week</td>
</tr>
</tbody>
</table>
Filter options | Description
--- | ---
Month | This month, Previous month, Previous 6 months
Quarter | This quarter, Previous quarter
Custom | Date range from calendar

Analysis type | Most recent analysis or First time analysis

Sample output:

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Count(%)</th>
<th>Submitted Charge($)</th>
<th>Submitted Charge(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>293</td>
<td>70.8</td>
<td>42187</td>
<td>2.6</td>
</tr>
<tr>
<td>Profile</td>
<td>2</td>
<td>0.5</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Clean</td>
<td>119</td>
<td>28.7</td>
<td>1600838</td>
<td>97.4</td>
</tr>
</tbody>
</table>

Column name | Description
--- | ---
Status | Deny, Review, Profile, and Clean.

Count | Number of edits with the associated flag status.
- A claim where two lines have edits will add 2 to the overall total.
- A claim line with multiple edits will add 1 to the overall total for the most severe edit on the line. For example, a Deny edit would be more severe than a Review edit, so the Deny would be included in the total and the Review edit would not.
- A claim that has both a claim-level edit and line-level edit will only include the claim-level edit in the total.
<table>
<thead>
<tr>
<th>Column name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count (%)</td>
<td>The percentage of all claims having an edit of that status at either the claim or claim line level.</td>
</tr>
<tr>
<td>Submitted Charge</td>
<td>The total value (sum of submitted charges) of claim lines or claims with edits of that status. <em>Note: If the claim has claim-level and line-level edits, the submitted charges on the claim lines will be summed.</em></td>
</tr>
<tr>
<td>Submitted Charge (%)</td>
<td>The percent of the total submitted charges made up of the submitted charge amount for this status.</td>
</tr>
</tbody>
</table>

**Detail Reports**

The **Detail Reports** subtab includes pre-defined templates for two reports that provide detailed information for specific edits or rules. The filters for these reports are predefined, but the filter values can be changed to produce different reports.

**Dropped Flags**

The **Dropped Flags** report is useful for identifying claims and claim lines where an edit that had been applied was removed from the claim (dropped) by a “Drop Flag” rule. It can be used for auditing purposes to ensure that drop flag rules are functioning appropriately.

<table>
<thead>
<tr>
<th>Filter options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Live or Test</td>
</tr>
<tr>
<td>Flag status</td>
<td>Review, Profile, or All</td>
</tr>
<tr>
<td>Time Period</td>
<td>Day: Today, Yesterday, Previous 7 or 30 days</td>
</tr>
<tr>
<td></td>
<td>Week: This week, Previous week</td>
</tr>
<tr>
<td></td>
<td>Month: This month, Previous month, Previous 6 months</td>
</tr>
<tr>
<td></td>
<td>Quarter: This quarter, Previous quarter</td>
</tr>
<tr>
<td></td>
<td>Custom: Date range from calendar</td>
</tr>
</tbody>
</table>

Sample output:
### Column name
<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Edit Scope</strong></td>
</tr>
<tr>
<td><strong>Claim ID</strong></td>
</tr>
<tr>
<td><strong>Claim Line ID</strong></td>
</tr>
<tr>
<td><strong>Dropped Edit Mnemonic</strong></td>
</tr>
<tr>
<td><strong>Drop Flag Rule Name</strong></td>
</tr>
<tr>
<td><strong>Other Edits</strong></td>
</tr>
<tr>
<td><strong>Submitted Charge ($)</strong></td>
</tr>
<tr>
<td><strong>Analysis Date</strong></td>
</tr>
</tbody>
</table>

### Rules That Did Not Add Edits

The *Rules That Did Not Add Edits* report identifies rules that have not applied any edits within a specified period. This is particularly helpful when migrating ILOG rules to DDR because if the rule is never or only rarely applying an edit, it may not be worth the effort to migrate it to DDR. It also allows ineffective rules to be removed from rulesets so as to improve the performance of claim editing (fewer rules means less time to analyze each claim).

### Filter options
<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rule Engine</strong></td>
</tr>
</tbody>
</table>
## Filter options

<table>
<thead>
<tr>
<th><strong>Rule type</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All, Custom or System</td>
<td></td>
</tr>
</tbody>
</table>

**Time Period**

- Day: Today, Yesterday, Previous 7 or 30 days
- Week: This week, Previous week
- Month: This month, Previous month, Previous 6 months
- Quarter: This quarter, Previous quarter
- Custom: Date range from calendar

### Rulesets

This is a multi-select choice list where each option relates to a specific ruleset (e.g., Commercial Professional, Medicaid Professional, Medicare Professional, etc.). “All” and “None” are also options.

### Sample output:

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Rule Name</th>
<th>Flag Mnemonic</th>
<th>Origin Enterprise</th>
<th>Rule Engine</th>
<th>Rule Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>10117</td>
<td>Varistin Injection - Review</td>
<td>SHEV</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10029</td>
<td>TX and CSHON - Injection JR...</td>
<td>sMN</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10116</td>
<td>TX and CSHON - Melotaste...</td>
<td>sLOH</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10130</td>
<td>THMP - Hemostatic - Sterile</td>
<td>sSHEV</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10123</td>
<td>Thrombin Injection - Diagnosis</td>
<td>sMN</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10118</td>
<td>Shaving Tissue - Bundled</td>
<td>sSLOH</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10117</td>
<td>Shaving Tissue</td>
<td>sLOH</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
<tr>
<td>10130</td>
<td>Shaving Amo and/or Foot</td>
<td>sSHEV</td>
<td>DDR</td>
<td>DDR</td>
<td>System</td>
</tr>
</tbody>
</table>

### Column name

<table>
<thead>
<tr>
<th><strong>Column name</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule ID</td>
<td>The ID (DDR pattern ID or ILOG flag) of a rule that has not fired any edits within the specified period.</td>
</tr>
<tr>
<td>Rule Name</td>
<td>The name of the rule.</td>
</tr>
<tr>
<td>Flag Mnemonic</td>
<td>The flag or edit mnemonic that can be applied by the rule.</td>
</tr>
<tr>
<td>Origin Enterprise</td>
<td>The name of the enterprise where the custom rule was created. This column applies only to ILOG rules and is always blank for data-driven rules.</td>
</tr>
<tr>
<td>Column name</td>
<td>Description</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Rules Engine</td>
<td>ILOG or DDR.</td>
</tr>
<tr>
<td>Rule Type</td>
<td>System or Custom.</td>
</tr>
</tbody>
</table>

**Custom Reports**

The **Custom Reports** subtab allows you to create reports with the specific claim detail that is needed. After a report has been generated, the data can also be exported to a CSV file that can be imported either into a different database table or into a spreadsheet for further manipulation.

The **Properties** panel is considerably more complex than other reports because it allows you to create a report template rather than using a pre-defined (hard-coded) template. This provides a great deal of flexibility.

![Custom Report Example](image)

After naming the custom report and making the desired setting for standard filters (Scheduling, Days to keep, and Analysis type), add the desired report columns by first selecting the **Show Report Columns** button to display the slide-out tray at the right of the screen. (The button will be relabeled as the **Hide Report Columns** button.)
Select the checkbox next to the claim or claim line field and that field will be added to the report in the *Report layout* box. You can select items in this box and use the **Move Up** and **Move Down** buttons to adjust the sequence in which the column will appear on the report.

In a similar manner, you can add filters to the *Filter data* box. Note that you must also assign values to each filter in order for the **Save** button to become enabled. You should save the report before running it for the first time.

**Note**
When manually generating reports, you can change the filter values before each generation of the report without needing to first save the report (which would change the template for all subsequent reports, particularly those that are scheduled). The same is true with regard to adding more columns to the report. If the template is saved, reports from that point on will include the new columns (but older reports in the Report Archive tab will not).

Sample output:

![Sample Report Image]

**Note**
The columns included on each custom report are selected by the user when the report template is defined. The above is just one of many possible examples.

**Note**
Claim ID hyperlinks will only be available if the user has “View Claims” privileges.

**KB Customization Report**

The KB Customization Report lists all overrides that have been made to the KnowledgeBase data for the current enterprise. These overrides will affect claim processing, so this report is useful for periodic auditing of overrides that to reconfirm that the reason behind the override is understood and is still applicable. From time
to time, new system data is added in KnowledgeBase updates that may eliminate the need for overrides (because they now exist in the system KB data). This is another reason for periodic monitoring of overrides.

This report presents filter options somewhat differently from other reports. There is an explicit Report Filters block with the following options:

<table>
<thead>
<tr>
<th>Filter options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modules</td>
<td>This is a multi-select choice list where each option relates to a specific KnowledgeBase table (e.g., Primary Procedures, Procedure Anesthesia, Diagnosis Code, Diagnosis Inappropriate Gender, etc.). “All” and “None” are also options.</td>
</tr>
<tr>
<td>Effective date</td>
<td>The default value is “no date chosen.” If a date value is entered, only those overrides that are effective on or after the specified date will be included in the report.</td>
</tr>
<tr>
<td>Expiration date</td>
<td>The default value is “no date chosen.” If a date value is entered, only those overrides that expire on or before the specified date will be included in the report.</td>
</tr>
<tr>
<td>Status</td>
<td>Override status: All, Enabled, or Disabled</td>
</tr>
<tr>
<td>Rulesets</td>
<td>This is a multi-select choice list where each option relates to a specific rulesets (e.g., Commercial Professional, Medicaid Professional, Medicare Professional, etc.). “All” and “None” are also options. Uncheck if enterprise wide overrides are not required.</td>
</tr>
</tbody>
</table>

Sample output:

<table>
<thead>
<tr>
<th>Column name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module Name</td>
<td>The KnowledgeBase data module name. Specific database tables are associated with each module.</td>
</tr>
<tr>
<td>Primary Code</td>
<td>Primary code (procedure, diagnosis, modifier, etc.)</td>
</tr>
<tr>
<td>State</td>
<td>Original or Overridden.</td>
</tr>
<tr>
<td>Column name</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ruleset</td>
<td>The name of the ruleset to which the override applies.</td>
</tr>
<tr>
<td>Scope</td>
<td>Enterprise name (e.g., Professional Main, Profession System, etc.)</td>
</tr>
<tr>
<td>Effective Date</td>
<td>The effective date of the override.</td>
</tr>
<tr>
<td>Expiration Date</td>
<td>The expiration date of the override.</td>
</tr>
<tr>
<td>Status</td>
<td>The status of the override (Enabled and Disabled).</td>
</tr>
<tr>
<td>Attribute-1</td>
<td>In addition to the above columns that are common to all overrides, some modules have additional data (attributes) that are specific to just that module. These columns are used to show these special attributes as a &quot;Name: Value&quot; pair.</td>
</tr>
<tr>
<td>Attribute-2</td>
<td></td>
</tr>
<tr>
<td>Attribute-3</td>
<td></td>
</tr>
</tbody>
</table>

### System Level Reports

The system level reporting subtab provides reports that can obtain data across all enterprises. The following reports are available at the system level:

- Summary Reports
- Detail Reports
- KB Customization

The Reports tab displays the Reports dashboard with a graphical representation of the system-level summary reports.

System level reports have the same properties as enterprise level reports, with the additional enterprise scope level selection as a dropdown filter for Summary reports and a radio button for Details and Customization reports.

<table>
<thead>
<tr>
<th>Scope</th>
<th>Select the enterprise from the drop-down filter for the Summary report (Professional/Inpatient/Outpatient) and the radio button (Professional/Facility) for the Detail or KB Customization report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>View</td>
<td>System level reports will be visible based on the “View system level reports” and “Manage system level reports” privilege.</td>
</tr>
</tbody>
</table>
Report Data
All filters including Enterprise filter with the multi-select option will be disabled in the Report data screen to avoid modifying the selection during post-report generation.

Reporting Tabs Detail

Properties Tab
The Properties tab contains three fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Displays the name of the report. It is set to “Claim Edit Summary” by default and is a non-editable field.</td>
</tr>
<tr>
<td>Display on Dashboard</td>
<td>Specifies whether the report should be displayed on the dashboard. It is set to “Yes” by default and is a non-editable field.</td>
</tr>
<tr>
<td>Days to Keep</td>
<td>Specifies for how many days the report’s result data is retained in the report archive. It is set to 14 days by default and can be changed by the user. The maximum number of days to keep is 9999.</td>
</tr>
</tbody>
</table>

Note
For all reports which were run before implementation of “Days to Keep” functionality (before 5.4 SP1), the “Days to Keep” value is set to 365 days by default.

Time Period Dropdown
Time period dropdown field descriptions.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today</td>
<td>Today’s claims through the timestamp of when the report is generated (12 AM to current time).</td>
</tr>
<tr>
<td>Yesterday</td>
<td>Yesterday’s claims.</td>
</tr>
<tr>
<td>Previous 7 Days</td>
<td>7 days ago until yesterday; does not include today’s claims.</td>
</tr>
<tr>
<td>Previous 30 Days</td>
<td>30 days ago until yesterday; does not include today’s claims.</td>
</tr>
<tr>
<td>This Week</td>
<td>Claims from Sunday through the day that the report is generated.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Previous Week</td>
<td>Previous week (Sunday until Saturday).</td>
</tr>
<tr>
<td>This Month</td>
<td>First day of the current calendar month through the day when the report is</td>
</tr>
<tr>
<td></td>
<td>generated.</td>
</tr>
<tr>
<td>Previous Month</td>
<td>First day of the previous calendar month to the last day of the previous</td>
</tr>
<tr>
<td></td>
<td>month.</td>
</tr>
<tr>
<td>Previous 6 Months</td>
<td>Previous 6 months, prior to the current month</td>
</tr>
<tr>
<td>This Quarter</td>
<td>First of the current quarter through the day when the report is generated.</td>
</tr>
<tr>
<td></td>
<td>Quarters considered are:</td>
</tr>
<tr>
<td></td>
<td>1st Quarter: Jan to March</td>
</tr>
<tr>
<td></td>
<td>2nd Quarter: April to June</td>
</tr>
<tr>
<td></td>
<td>3rd Quarter: July to Sept</td>
</tr>
<tr>
<td></td>
<td>4th Quarter: Oct to Dec</td>
</tr>
<tr>
<td>Previous Quarter</td>
<td>First of the previous quarter to the last day of previous quarter</td>
</tr>
<tr>
<td>Date-Range</td>
<td>Can specify the date range. Limited to 180 days, or a warning message occurs.</td>
</tr>
</tbody>
</table>

If **Date-Range** is selected, two calendars display. Date parameters look at the Last Analyzed Date field.
Report Layout Tab

Use the Report Layout Tab for Summary or Custom Reports.

To use the Report Layout tab:


2. Choose whether Environment should be Live or Test.

3. In the Group by dropdown, choose Count or Submitted Charge.

<table>
<thead>
<tr>
<th>Options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group by Count</td>
<td>Displays the count of total claims, count of claims with edits, and count of clean claims.</td>
</tr>
<tr>
<td>Group by Submitted Charge</td>
<td>Displays the total submitted charges for total claims, claims with edits, and clean claims.</td>
</tr>
</tbody>
</table>

4. In the Time Period dropdown, select a time option. It is recommended to select the time period value based on the user’s selection of Frequency.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>Select the Time Period as Today/Yesterday.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Select</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Weekly</td>
<td>Select the Time Period as This Week/Previous Week/Previous 7 Days.</td>
</tr>
<tr>
<td>Monthly</td>
<td>Select the Time Period as This Month/Previous Month/Previous 30 Days.</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Select the Time Period as This Quarter/Previous Quarter.</td>
</tr>
</tbody>
</table>

5. Select **Save**, and the scheduled report is saved.

6. Select **Delete**, and it prompts a message that says, "Are you sure you want to delete this scheduled report?"

7. Select **Delete** to delete the scheduled report.

8. Select **Cancel** to retain the scheduled report.
Filter Types

With wildcard filters you can use an asterisk (*) or percent sign (%) to search for portions of a value.

The following figure shows search results for a claim ID with the filter *ANE*.

When filtering by List, use comma-separated values.

To filter by mathematical function, specify values such as greater than/less than, greater than/equal to, less than/equal to, not equal to, etc.
To filter by numeric ranges, place a hyphen between two values and any value(s) within the range display.

There are multiple ways to filter by Date. For Beginning Date of Service, select Oldest and Latest.

To search for just one date, provide the same date in both Oldest and Latest fields.

To search for a range, provide both the Oldest and Latest fields.

To search for one date up until the date you are generating the report, leave the Latest field blank.
To search for a range of dates of **Beginning Date of Service** with **Ending Date of Service**, choose both filters. Only the dates in between that meet both filtering criteria will display.

**Frequency**

For scheduled reports, a frequency must be set to determine how often the report should run.

The following frequency values can be set:

- Daily
- Weekly
- Monthly
- Quarterly

**Daily:**

If the user sets the frequency as daily, the user is prompted to enter after how many days and the time when the report should run.
For the Frequency value for the number of days, the maximum acceptable value is 9999. The time must be entered in the 12-hour format. The time corresponds to the server time.

Weekly:

If the user sets the frequency as weekly, the user is prompted to enter after how many weeks, which day of the week and the time when the report should run.
For the Frequency value for the number of weeks, the maximum acceptable value is 9999, the Day of week is a dropdown containing values from Sunday to Saturday and the time needs to be entered in the 12-hour format. The time corresponds to the server time.

Monthly:

If the user sets the frequency as monthly, the user is given two options:

Option 1:

Specify after how many months, which day of the month and what time to run the report.

Number of months can be any value from 1 to 9999.

The day of the month is a dropdown menu containing values from 1 to 31.
If the user selects 29, 30 or 31, a message is displayed stating: “Some months do not have 29 days. If the intent is to run the report on the last day of every month, use the next radio button option for scheduling.”

Time needs to be entered in the 12-hour format. The time corresponds to the server time.

Option 2:

Specify after how many months, which weekday of the month and what time to run the report.
Number of months can be any value from 1 to 9999.

Which weekday to run the report has two dropdown menus:

The first dropdown contains values: First, Second, Third, Fourth, Last.
The second dropdown contains values: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Day.

How to run a report on the last day of the month

To schedule the report on the last day of the month, irrespective of the number of days in the month, use Option 2 and select the values Last and Day from the dropdowns to specify which day to run the report.

Time must be entered in the 12-hour format. The time corresponds to the server time.

Quarterly:

If the user sets the frequency as quarterly, the user is prompted to enter after how many quarters, on the first or last day of which month (first, second or third) and the time when the report should run.
The number of quarters can be any value from 1 to 9999.

To specify which day of which month of the quarter there are two dropdowns:

The first dropdown specifies the first or last day of months in the quarter.

The second dropdown specifies which month of the quarter – first, second or third.
Days to Keep: It specifies for how many days the report’s result data is retained in the report archive. The default is 14 days and can be changed by the user. After the stipulated number of days the report is not available in Report Archives.

The minimum number of days to keep should be 1; the maximum can be 9999.

**Note** For all reports which were run before implementation of “Days to Keep” functionality (before 5.4 SP1), the “Days to Keep” value is set to 365 days by default.
## Appendix

### User Management Panel-based UI Migration Mapping

<table>
<thead>
<tr>
<th>Module</th>
<th>Screen</th>
<th>Target (UI Function)</th>
<th>Action</th>
<th>New Privilege</th>
<th>New Roles (System Admin has all privileges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Browse Claims</td>
<td>Claims</td>
<td>Delete</td>
<td>Delete claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Frequency History</td>
<td>Frequency History</td>
<td>Delete</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>New Patient History</td>
<td>New Patient History</td>
<td>Delete</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Browse FE Claims</td>
<td>FE Claims</td>
<td>Delete</td>
<td>Delete claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>FE Frequency History</td>
<td>FE Frequency History</td>
<td>Delete</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Add Claims</td>
<td>Claims</td>
<td>Create</td>
<td>Edit claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Browse Claims</td>
<td>Claims</td>
<td>Modify</td>
<td>Edit claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Add FE Inpatient Claims</td>
<td>Claims</td>
<td>Create</td>
<td>Edit claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Add FE Outpatient Claims</td>
<td>Claims</td>
<td>Create</td>
<td>Edit claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Browse FE Claims</td>
<td>FE Claims</td>
<td>Modify</td>
<td>Edit claims</td>
<td>Claim Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Import Claims</td>
<td>Claims</td>
<td>Create</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Export Claims</td>
<td>Claims</td>
<td>Modify</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Claims History</td>
<td>Claims History</td>
<td>Create</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>--------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Claims</td>
<td>Frequency History</td>
<td>Frequency History</td>
<td>Create</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>New Patient History</td>
<td>New Patient History</td>
<td>Create</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>FE Frequency History</td>
<td>FE Frequency History</td>
<td>Create</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Browse Claims</td>
<td>Claims</td>
<td>View</td>
<td>View claims</td>
<td>Claim Manager, Claim Reviewer</td>
</tr>
<tr>
<td>Claims</td>
<td>Claims History</td>
<td>Claims History</td>
<td>View</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Frequency History</td>
<td>Frequency History</td>
<td>View</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>New Patient History</td>
<td>New Patient History</td>
<td>View</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Claims</td>
<td>Browse FE Claims</td>
<td>FE Claims</td>
<td>View</td>
<td>View claims</td>
<td>Claim Manager, Claim Reviewer</td>
</tr>
<tr>
<td>Claims</td>
<td>FE Frequency History</td>
<td>FE Frequency History</td>
<td>View</td>
<td>Manage claim data</td>
<td>Claim Data Manager</td>
</tr>
<tr>
<td>Code Repository</td>
<td>Diagnoses</td>
<td>Diagnosis</td>
<td>Create</td>
<td>Manage code repository</td>
<td>Ruleset Manager</td>
</tr>
<tr>
<td>Code Repository</td>
<td>Diagnoses</td>
<td>Diagnosis</td>
<td>Delete</td>
<td>Manage code repository</td>
<td>Ruleset Manager</td>
</tr>
<tr>
<td>Code Repository</td>
<td>Diagnoses</td>
<td>Diagnosis</td>
<td>Modify</td>
<td>Manage code repository</td>
<td>Ruleset Manager</td>
</tr>
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<td>Manage custom ILOG rules</td>
<td>Rule Developer</td>
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<td>Rule Developer</td>
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### User Management Permission Privilege Map

#### System Privilege Descriptions

**System Privileges**
<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Configure global settings</td>
<td>Configure applied edits, claim connections, enterprise groups, product licenses, security policies.</td>
</tr>
<tr>
<td>Install ILOG rules</td>
<td>Install ILOG rule bundles as well as import rules that have been exported from another system.</td>
</tr>
<tr>
<td>Load a KnowledgeBase (KB)</td>
<td>Perform a KB SmartLoad.</td>
</tr>
<tr>
<td>Load LCD policies</td>
<td>Load Local Coverage Determination files.</td>
</tr>
<tr>
<td>Manage enterprises</td>
<td>Create new enterprises, disable enterprises.</td>
</tr>
<tr>
<td>Manage roles</td>
<td>Create/edit/delete user roles.</td>
</tr>
<tr>
<td>Manage users</td>
<td>Create/edit/delete user accounts and memberships.</td>
</tr>
<tr>
<td>Purge claims</td>
<td>Delete large numbers of claims based on various filter criteria.</td>
</tr>
<tr>
<td>View Audit log</td>
<td>View logs of significant user activity related to configuration or access to PHI.</td>
</tr>
<tr>
<td>Manage custom DDR</td>
<td>Create, edit and delete custom data-driven rules.</td>
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</tbody>
</table>

**Enterprise Privileges**

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
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<tbody>
<tr>
<td>Configure Enterprise</td>
<td>Configure default claim field values, same provider definition, user-defined fields and enterprise properties.</td>
</tr>
<tr>
<td>View claims</td>
<td>View claim data with PHI.</td>
</tr>
<tr>
<td>Delete claims</td>
<td>Delete individual claims (for mass deletion see the Purge Claims section).</td>
</tr>
<tr>
<td>Edit claims</td>
<td>Edit and analyze claims</td>
</tr>
<tr>
<td>Manage claim data</td>
<td>Load CSV files containing frequency history new patient history, and claim history. Import and export claims.</td>
</tr>
<tr>
<td>Manage code</td>
<td>Create, edit and delete knowledge base overrides (for procedure</td>
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<tr>
<td>repository codes, diagnosis codes, code relationships, system lists, reduction records, relative value units, fee schedules, etc.)</td>
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</tr>
<tr>
<td>Manage custom ILOG rules Create, edit, and delete custom ILOG rules.</td>
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<tr>
<td>View reports View report data, including PHI.</td>
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<tr>
<td>Manage reports Generate and schedule reports; manage data in the report archive.</td>
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</tr>
<tr>
<td>Manage rules and rulesets Manage the content and behavior of rulesets, including routing and exceptions. Create, import, and export rules and manage their flags. Change rules status (New/Updated/Test/Live).</td>
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</tr>
</tbody>
</table>

**Important!** In a multi-tenant environment the following additional privileges are included. If a privilege has been removed it will be called out as Removed.

### System Privileges

<table>
<thead>
<tr>
<th>Configure system settings</th>
<th>Limited configuration settings that can be customized for individual tenants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage tenant</td>
<td>Create new tenants and modify tenant data.</td>
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</table>

### Tenant Privileges

<table>
<thead>
<tr>
<th>Manage roles</th>
<th>Create/edit/delete user roles.</th>
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</thead>
<tbody>
<tr>
<td>Manage users</td>
<td>Create/edit/delete user accounts and memberships.</td>
</tr>
<tr>
<td>Manage tenant</td>
<td>Modify tenant organization data.</td>
</tr>
<tr>
<td>View Audit Log</td>
<td>View logs of significant user activity related to configuration or access of PHI.</td>
</tr>
<tr>
<td>Configure system settings</td>
<td>Limited configuration settings that can be customized for individual tenants.</td>
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</table>
Manage custom DDRs
Create, edit and delete custom data-driven rules.

**Enterprise Privileges**

*Removed - Manage custom ILOG rules*

Removed the ability to create, edit, and delete custom ILOG rules.

**System Role Descriptions**

<table>
<thead>
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<th>New Role</th>
<th>Description</th>
<th>Privileges</th>
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<td>Claim Data Manager</td>
<td>• Load claim history</td>
<td>Manage claim data</td>
<td>Enterprise</td>
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<tr>
<td></td>
<td>• New patient data (NPT)</td>
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<td></td>
<td>• Frequency data</td>
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<td></td>
<td>• Import X12/837 batches</td>
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<td>• Export claims</td>
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<tr>
<td>Claim Manager</td>
<td>• View, edit, and create claims</td>
<td>Delete claims (implies View)</td>
<td>Enterprise</td>
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<tr>
<td></td>
<td>• Delete single claims via the Edit Claim screen. Reanalyze claims [A2].</td>
<td>Edit claims (implies View)</td>
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<tr>
<td>Claim Reviewer</td>
<td>• View claims.</td>
<td>View claims</td>
<td>Enterprise</td>
</tr>
<tr>
<td>Data Manager</td>
<td>• Load KnowledgeBase</td>
<td>Load KnowledgeBase</td>
<td>System</td>
</tr>
<tr>
<td></td>
<td>• Load LCD Data</td>
<td>Load LCD</td>
<td></td>
</tr>
<tr>
<td>Administrator's Guide</td>
<td>Page 530</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Install ILOG rule**
- **Data Install ILOG rules**

<table>
<thead>
<tr>
<th>Enterprise Admin</th>
<th>Enterprise customization such as:</th>
<th>Configure enterprise</th>
<th>Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Claim Field Settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Same Provider Configuration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- User-Defined Fields</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Manager</th>
<th>View reports</th>
<th>Manage reports (implies View)</th>
<th>Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Generate new reports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Viewer</th>
<th>View Reports</th>
<th>View reports</th>
<th>Enterprise</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Rule Developer (DDR)</th>
<th>Manage Custom DDR</th>
<th>Manage Custom DDR</th>
<th>System</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Rule Developer (ILOG)</th>
<th>Manage Custom ILOG rules</th>
<th>Manage Custom ILOG rules</th>
<th>Enterprise</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ruleset Manager</th>
<th>Migrate rules from “New” or “Updated” to “Test” or “Live”</th>
<th>Manage code repository</th>
<th>Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Define claim routing rules, rulesets, and ruleset exceptions</td>
<td>Manage rules and rulesets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manage code repository overrides. Create custom LCD carrier</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Import system lists</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Import and export rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manage user-defined tables (CES)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>System Admin</th>
<th>Can perform all system administration functions:</th>
<th>Configure system</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Set configuration values that apply to all System (Security Policy Configuration, Connection Con-</td>
<td>Global settings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CPT only © 2019 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Restrictions Apply to Government Use. Current Dental Terminology, © 2019 American Dental Association. All rights reserved. Optum, Inc. • 2525 Lake Park Blvd. • Salt Lake City, Utah • 84120 • (800) 765-6818
- Configuration, Account Timeout, Manage Product Licenses
- Set default values for configuration settings that can be customized by tenant (Security Policy Configuration, Enterprise properties, Enterprise Group Configuration, Claim History Crosswalking, Applied Edits, Claim Map)
- Install ILOG rules
- Load KB and LCD data
- Manage product licenses
- Manage all enterprises
- Manage users for the system
- Manage roles for the system
- Manage memberships for users/enterprises
- Purge claims
- View audit log

<table>
<thead>
<tr>
<th>View Only (Enterprise)</th>
<th>View enterprise specific data. Cannot view data with PHI (claims and reports).</th>
</tr>
</thead>
<tbody>
<tr>
<td>View Only (System)</td>
<td>View all the data in the system. Cannot view data with PHI (claims and reports).</td>
</tr>
<tr>
<td>REMOVED Rule Developer (ILOG)</td>
<td>Create, edit, and delete custom data-driven rules.</td>
</tr>
<tr>
<td></td>
<td>Managed custom DDR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Install ILOG rules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Load Knowledge Base</td>
</tr>
<tr>
<td></td>
<td>Load LCD Data Manage enterprises</td>
</tr>
<tr>
<td></td>
<td>Manage memberships</td>
</tr>
<tr>
<td></td>
<td>Manage roles (implies View)</td>
</tr>
<tr>
<td></td>
<td>Manage users (implies View)</td>
</tr>
<tr>
<td></td>
<td>Purge claims</td>
</tr>
<tr>
<td></td>
<td>View audit log</td>
</tr>
</tbody>
</table>
In a multi-tenant environment the following additional/updated roles are included.

<table>
<thead>
<tr>
<th>New Role</th>
<th>Description</th>
<th>Privileges</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Admin</td>
<td>Additional permissions for multi-tenant installations</td>
<td>• Configure System Settings</td>
<td>System</td>
</tr>
<tr>
<td></td>
<td>• Limited configuration settings that can be customized for individual tenants.</td>
<td>• Manage tenant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Create new tenants and modify tenant data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tenant Admin</td>
<td>• Create/edit/delete user roles.</td>
<td>• Manage roles</td>
<td>Tenant</td>
</tr>
<tr>
<td></td>
<td>• Create/edit/delete user accounts and memberships.</td>
<td>• Manage users</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Limited configuration settings that can be customized for individual tenants.</td>
<td>• Configure system settings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• View logs of significant user activity related to configuration or access of PHI.</td>
<td>• View audit log</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Create, edit, and delete custom data-driven rules.</td>
<td>• Manage custom DDR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Create new tenants and modify tenant data.</td>
<td>• Manage Tenant</td>
<td></td>
</tr>
<tr>
<td>View Only (Tenant)</td>
<td>• View tenant-specific data. Cannot view data with PHI (claims and reports).</td>
<td></td>
<td>Tenant</td>
</tr>
<tr>
<td>REMOVED: Rule Developer (ILOG)</td>
<td>• Create, edit, and delete custom data-driven rules.</td>
<td>Manage custom DDR</td>
<td>Enterprise</td>
</tr>
</tbody>
</table>

Rule Vocabulary

The Rule Vocabulary is a repository for Rule Elements. Each rule that you create is made up of these rule elements, which act as building blocks you can put together to make your rule work. These elements can be used interchangeably to create versatile and effective rules.
Before working with rule elements, be sure you understand the structure of rules and the process used to build them. Refer to the Creating Rules section for details.

Within the rule vocabulary, there are two basic types of rule elements:

- **Condition Statements**: These are command statements that tell the rule to look for specific pieces of data that meet specific conditions.
- **Action Statements**: These are command statements that tell the rule what to do when it finds the data meeting the conditions specified above.

Below are lists of condition statements and actions divided into applicable categories.

### Condition Statements

Condition statements are used in the portion of a rule that looks for data to work with. Therefore, the natural question to ask when trying to pick a condition statement is, “Where must the system look to find the data I need to work with?” Thus, the following list is organized according to where you would look for specific data:

<table>
<thead>
<tr>
<th>Claim Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elements that look at the claim itself</td>
</tr>
<tr>
<td><strong>Claim → Header</strong></td>
</tr>
<tr>
<td><code>&lt;a date claim field&gt;</code> of <code>&lt;a claim&gt;</code></td>
</tr>
<tr>
<td><code>&lt;a facility alpha numeric claim field&gt;</code> of <code>&lt;a facility claim&gt;</code></td>
</tr>
<tr>
<td><code>&lt;a facility date claim field&gt;</code> of <code>&lt;a facility claim&gt;</code></td>
</tr>
<tr>
<td><code>&lt;a facility numeric claim field&gt;</code> of <code>&lt;a facility claim&gt;</code></td>
</tr>
<tr>
<td><code>&lt;an alpha numeric claim field&gt;</code> of <code>&lt;a claim&gt;</code></td>
</tr>
<tr>
<td>the alpha numeric logical field <code>&lt;a string&gt;</code> of <code>&lt;a claim&gt;</code></td>
</tr>
<tr>
<td>the alpha numeric logical field <code>&lt;a string&gt;</code> of <code>&lt;a facility claim&gt;</code></td>
</tr>
<tr>
<td>the current claim</td>
</tr>
<tr>
<td>the patient on <code>&lt;a claim&gt;</code></td>
</tr>
<tr>
<td>the plan ID on <code>&lt;a claim&gt;</code> is missing</td>
</tr>
</tbody>
</table>
the service start date of <an Extended history record>

<table>
<thead>
<tr>
<th>Claim → Line → (General)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;a claim line&gt; has been analyzed before</td>
</tr>
<tr>
<td>&lt;a claim line&gt; is the first line in &lt;claim lines&gt;</td>
</tr>
<tr>
<td>&lt;a claim line&gt; is the first line in &lt;claim lines&gt; ranked by &lt;a null&gt;</td>
</tr>
<tr>
<td>&lt;a facility alpha numeric claim line field&gt; of &lt;a facility claim line&gt;</td>
</tr>
<tr>
<td>&lt;a facility date claim line field&gt; of &lt;a facility claim line&gt;</td>
</tr>
<tr>
<td>&lt;a facility numeric claim line field&gt; of &lt;a facility claim line&gt;</td>
</tr>
<tr>
<td>&lt;a modifier&gt; is a valid modifier for &lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;a modifier&gt; on &lt;a claim line&gt; is disabled</td>
</tr>
<tr>
<td>&lt;a modifier&gt; on &lt;a claim line&gt; is effective</td>
</tr>
<tr>
<td>&lt;a modifier&gt; on &lt;a claim line&gt; is invalid</td>
</tr>
<tr>
<td>&lt;a modifier&gt; on &lt;a claim line&gt; is not yet effective</td>
</tr>
<tr>
<td>&lt;a modifier&gt; on &lt;a claim line&gt; is valid</td>
</tr>
<tr>
<td>&lt;a numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;an alpha numeric claim line field&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>&lt;claim lines&gt; contains &lt;a number&gt; claim line</td>
</tr>
<tr>
<td>all lines on &lt;a claim&gt; have been analyzed by DUP</td>
</tr>
<tr>
<td>any of the adjusted modifier on &lt;a claim line&gt; or on &lt;a claim line&gt; overrides 1</td>
</tr>
<tr>
<td>any of the lines from &lt;a collection&gt; has multiple units</td>
</tr>
<tr>
<td>maximum value specified in MAX of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>NPT crosswalked value for procedure code on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>number of lines excluding virtual lines on &lt;a claim&gt;</td>
</tr>
<tr>
<td>the adjusted modifier on &lt;a claim line&gt; or on &lt;a claim line&gt; or on &lt;a claim line&gt; overrides 1</td>
</tr>
<tr>
<td>the adjusted modifier on &lt;a claim line&gt; or on &lt;a claim line&gt; or on &lt;a claim line&gt; with in the &lt;claim lines&gt; overrides 1</td>
</tr>
<tr>
<td>the alpha numeric logical field &lt;a string&gt; of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the alpha numeric logical field &lt;a string&gt; of &lt;a facility claim line&gt;</td>
</tr>
<tr>
<td>the claim of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the crosswalked description for speciality on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the first line among &lt;a claim line&gt; and &lt;claim lines&gt; sorted by sequence number</td>
</tr>
<tr>
<td>the first line among &lt;claim lines&gt; sorted by sequence number</td>
</tr>
<tr>
<td>the grouper message of &lt;a rules grouper list&gt; for &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the modifier &lt;a string&gt; on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the modifier relationship of &lt;a modifier&gt; on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the submitted modifier code on &lt;a claim line&gt; for &lt;a modifier&gt;</td>
</tr>
</tbody>
</table>

**Claim → Line → Age**

- minimum age for <a diagnosis age relationship> on <a claim line>
- minimum age for procedure code on <a claim line>

**Claim → Line → Date**

- <a claim line> is in the same period as the Beginning DOS for <a claim line> within <claim lines>
- <a date claim line field> of <a claim line>
Beginning DOS of a claim line within frequency specified by a claim line
the Medicare follow-up end date of a claim line

**Claim → Line → Diagnosis**

- a diagnosis code is typical for the adjusted procedure code on a claim line
- a diagnosis code of a claim line indicates third party
- a diagnosis code on a claim line is deleted
- a diagnosis code on a claim line is disabled
- a diagnosis code on a claim line is effective
- a diagnosis code on a claim line is effective and enabled
- a diagnosis code on a claim line is invalid
- a diagnosis code on a claim line is not specific
- a diagnosis code on a claim line is not typical for a patient
- a diagnosis code on a claim line is not typical for a string
- a diagnosis code on a claim line is specific
- any one diagnosis of diagnosis is the same as any one diagnosis of a claim line
- no diagnosis of diagnosis is the same as any diagnosis of a claim line
- primary diagnosis code on a claim line
- the diagnosis relationship of a diagnosis code on a claim line
- the diagnosis source code of a claim line
- the order of a facility claim diagnosis code

**Claim → Line → Diagnosis → Age**

- maximum age for a diagnosis age relationship on a claim line
- the diagnosis age relationship of a diagnosis code on a claim line

**Claim → Line → Diagnosis → Gender**

- the diagnosis gender relationship of a diagnosis code on a claim line
### Claim → Line → Diagnosis → System Lists

- The diagnosis for the procedure code on `<a claim line>` is not in the suppression list of MAX.

### Claim → Line → Flag

- The `<a claim line flag mnemonic>` flag that is set on `<a claim line>` with `<a disclosure>` and the message: `<a string>`
- The `<a claim line flag mnemonic>` flag that is set on `<a claim line>` with the message: `<a string>` and the recommended fix of adding the procedure code `<a string>`
- The `<a string>` flag from `<claim line flags>`
- The `<a string>` flag on `<a claim line>` from `<claim line flags>`
- The `<a string>` flag is dropped from `<a claim line>`
- The action of `<a claim line flag>`
- The action of `<a string>` flag for `<a claim line>`
- The flag in `<a claim line>` with the highest severity
- The flag in `<claim line flags>` with the highest severity on `<a claim line>`
- The flag mnemonic of `<a claim line flag>`
- The message of `<a claim line flag>`

### Claim → Line → Grouper

- The history rebundle message of `<a rules grouper list>` for `<a claim line>`
- The rebundle message (CM) of `<a rules grouper list>` for `<a claim line>`
- The rebundle message of `<a rules grouper list>` for `<a claim line>`
- The rules grouper list with maximum weight for `<a claim line>` and `<claim lines>`

### Claim → Line → History

- The history grouper message of `<a rules grouper list>` for `<a claim line>`
- The history message detail of `<a claim line>`
the history rebundle message (CM) of `<a rules grouper list>` for `<a claim line>`

### Claim → Line → Maximum Frequency

- A claim line is present in frequency history with the same procedure code as `<a claim line>`
- The MFD for the adjusted procedure on `<a claim line>`
- The MFD for the adjusted procedure on `<a claim line>` is undefined
- The MFD for the adjusted procedure on `<a procedure MFD record>`
- The procedure MFD relationship on `<a claim line>`

### Claim → Line → Modifier

- `<a claim line>` has an assistant surgery modifier which is appropriate for the adjusted procedure
- `<a modifier>` is a valid modifier for `<an alpha numeric claim line field>` of `<a claim line>`
- `<a modifier>` on `<a claim line>` is disabled
- `<a modifier>` on `<a claim line>` is effective
- `<a modifier>` on `<a claim line>` is invalid
- `<a modifier>` on `<a claim line>` is not yet effective
- `<a modifier>` on `<a claim line>` is valid
- Modifier `<a string>` is on `<a claim line>`
- The adjusted modifier `<a string>` is present on `<a claim line>`
- The facility claim line modifier `<a string>` is not present on `<a facility claim line>`
- The modifier `<a string>` on `<a claim line>`
- The modifier relationship of `<a modifier>` on `<a claim line>`
- The procedure modifier relationship for `<a modifier>` on `<a claim line>`
- The procedure modifier relationship for a modifier on `<a claim line>`
- The submitted modifier code on `<a claim line>` for `<a modifier>`
### Claim → Line → Modifier → Adjusted Procedure

- `<a modifier>` is not typical for the adjusted procedure code on `<a claim line>`
- `<a modifier>` is typical for the adjusted procedure code on `<a claim line>`
- the Medicare record for the adjusted procedure code and `<modifiers>` on `<a claim line>`
- the adjusted modifier `<a string>` is appropriate for the adjusted procedure code on `<a claim line>`

### Claim → Line → Modifier → E/M

- `<a claim line>` has no EM line with appropriate modifier on the same day in `<claim lines>`

### Claim → Line → Modifier → Overrides

- an override modifier is allowed for `<an unbundle relationship>`
- the adjusted modifier on `<a claim line>` or on `<a claim line>` overrides 1
- the modifier override category of `<an unbundle relationship>`

### Claim → Line → Modifier → System Lists

- `<a modifier>` is in `<a system list name>` for `<a claim line>`
- any modifier code on `<a claim line>` is not in `<a system list name>`
- any of `<modifiers>` on `<a claim line>` are in `<a system list name>`
- any of `<modifiers>` on `<a claim line>` are not in `<a system list name>`
- any of the line from `<claim lines>` with modifiers that are in `<a system list name>`
- both `<a claim line>` and `<a claim line>` have the same modifiers from `<a system list name>`
- the modifiers on `<a claim line>` that are in `<a system list name>`
- the same appropriate modifier from `<a claim line>` and `<a claim line>` is in the `<a system list name>`
- the same modifier from `<a claim line>` and `<a claim line>` is not in the `<a system list name>`
## Claim → Line → MPFS

- the MPFS that contains the adjusted procedure code and TC modifier on a claim line or the adjusted procedure code and no modifier on a claim line
- the MPFS that contains the adjusted procedure code and any of modifiers or the adjusted procedure code and no modifier on a claim line
- the MPFS unbundle record for the adjusted procedure code on a claim line and a claim line

## Claim → Line → Place of Service (POS)

- place of service is not typical for procedure code of a claim line
- place of service is typical for procedure code of a claim line
- the procedure POS combination on a claim line

## Claim → Line → Procedure

- a claim line is a major procedure line
- a claim line is a minor procedure line
- a claim line is endoscopy reducible from a collection
- an assistant surgeon is not allowed for the adjusted procedure code on a claim line
- description of adjusted procedure code on a claim line
- the adjusted procedure code (object) on a claim line
- the adjusted procedure code (object) on a claim line is bilateral specific
- the adjusted procedure code on a claim line is effective and enabled
- the adjusted procedure code on a claim line is not medicare only designated primary to the adjusted procedure code on a claim line
- the adjusted procedure code on a claim line is primary to the adjusted procedure code on a claim line
- the adjusted procedure code on a claim line is same as the adjusted procedure code on a claim line as per MAX
- the anesthesia crosswalk code for the adjusted procedure code on a claim line
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>the procedure code of &lt;a claim line&gt; is a survival code for &lt;groupers&gt;</td>
<td></td>
</tr>
<tr>
<td>the procedure code on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>the procedure follow-up relationship on&lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>there is a major procedure line in &lt;claim lines&gt;</td>
<td></td>
</tr>
<tr>
<td>there is a minor procedure line in &lt;claim lines&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Age</td>
<td></td>
</tr>
<tr>
<td>maximum age for procedure code on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>the procedure age relationship on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Category</td>
<td></td>
</tr>
<tr>
<td>the category for the adjusted procedure on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>the sub category for the adjusted procedure on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → E/M</td>
<td></td>
</tr>
<tr>
<td>an EM from the Medicare EM codes list is not found for &lt;a claim line&gt; and &lt;claim lines&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Gender</td>
<td></td>
</tr>
<tr>
<td>procedure gender relationship on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Global Period</td>
<td></td>
</tr>
<tr>
<td>the global days for the adjusted procedure code on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>the last date of the global period for an adjusted procedure code on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>the last date of the global period of &lt;a procedure follow-up relationship&gt; for &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → History</td>
<td></td>
</tr>
<tr>
<td>the adjusted procedure code of &lt;an Extended history record&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Maximum Frequency</td>
<td></td>
</tr>
<tr>
<td>maximum frequency procedure codes for &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Object</td>
<td></td>
</tr>
<tr>
<td>Claim → Line → Procedure → Reductions</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>the adjusted procedure code (object) on &lt;a claim line&gt;</td>
<td></td>
</tr>
<tr>
<td>the adjusted procedure code (object) on &lt;a claim line&gt; is a minor procedure</td>
<td></td>
</tr>
<tr>
<td>the adjusted procedure code (object) on &lt;a claim line&gt; is an unlisted code</td>
<td></td>
</tr>
<tr>
<td>the adjusted procedure code (object) on &lt;a claim line&gt; is not an unlisted code</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim → Line → Procedure → System Lists</th>
</tr>
</thead>
<tbody>
<tr>
<td>the procedure code of &lt;a claim line&gt; in &lt;a system list name&gt;</td>
</tr>
<tr>
<td>the procedure code on &lt;a claim line&gt; is in &lt;a system list name&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim → Line → Procedure → Unbundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>the current line is the deny code of &lt;an unbundle relationship&gt;</td>
</tr>
<tr>
<td>the medicaid unbundle record for &lt;an alpha numeric claim line field&gt; on &lt;a claim line&gt; and &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the medicare unbundle relationship of the adjusted procedure codes on &lt;a claim line&gt; and &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the unbundle relationship of the adjusted procedure codes on &lt;a claim line&gt; and &lt;a claim line&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim → Line → Procedure → Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Medicare Medically Unlikely Edits, the units of service billed for procedure code on this claim line exceed the allowed units on &lt;a claim line&gt;</td>
</tr>
<tr>
<td><strong>Claim → Line → RVU</strong></td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>the allowed medicaid units of the adjusted procedure code of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the allowed units of the adjusted procedure code of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>a claim line having highest RVU among all the claim lines in &lt;claim lines&gt;</td>
</tr>
<tr>
<td>all the lines from &lt;a claim line&gt; and &lt;claim lines&gt; with the practice expense RVU for Medicaid</td>
</tr>
<tr>
<td>all the lines from &lt;a claim line&gt; and &lt;claim lines&gt; with the updated RVU</td>
</tr>
<tr>
<td>all the lines from &lt;a claim line&gt; and &lt;claim lines&gt; with the updated practice expense RVU</td>
</tr>
<tr>
<td>the first line in &lt;a collection&gt; and &lt;a claim line&gt; sorted by RVU</td>
</tr>
<tr>
<td>the first line in &lt;claim lines&gt; sorted by RVU from the claim of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the MPFS non-facility practice expense RVU of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the non-facility practice expense RVU of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the mMP updated RVU of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the RVU lookup value for &lt;a string&gt; on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the RVU of the adjusted procedure code of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the RVU lookup for the adjusted procedure code of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the RVU of &lt;a claim line&gt;</td>
</tr>
<tr>
<td><strong>Claim → Line → String</strong></td>
</tr>
<tr>
<td>description of &lt;a string&gt; in &lt;a system list name&gt; for &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the &lt;a claim line flag mnemonic&gt; flag that is set on &lt;a claim line&gt; with the message: &lt;a string&gt;</td>
</tr>
<tr>
<td>the &lt;a string&gt; for &lt;a claim line&gt; is in Off status</td>
</tr>
<tr>
<td>the adjusted modifier &lt;a string&gt; is not present on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the adjusted modifier &lt;a string&gt; is present on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the adjusted modifier codes on &lt;a claim line&gt; is any one of &lt;strings&gt;</td>
</tr>
<tr>
<td><strong>Claim → Line → Value</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>the adjusted specialty code string of <strong>&lt;a claim line&gt;</strong></td>
</tr>
<tr>
<td>the adjusted type of service code string of <strong>&lt;a claim line&gt;</strong></td>
</tr>
<tr>
<td>the multiple procedure indicator on <strong>&lt;a claim line&gt;</strong> is <strong>&lt;a string&gt;</strong></td>
</tr>
<tr>
<td><strong>Claim → Line → Units</strong></td>
</tr>
<tr>
<td>the line adjusted units of <strong>&lt;a claim line&gt;</strong></td>
</tr>
<tr>
<td>the sum of the service units on <strong>&lt;a claim line&gt;</strong> plus the service units on <strong>&lt;claim lines&gt;</strong></td>
</tr>
<tr>
<td>the sum of the service units on <strong>&lt;a claim line&gt;</strong> plus the service units on <strong>&lt;claim lines&gt;</strong> plus <strong>&lt;a number&gt;</strong></td>
</tr>
<tr>
<td>the sum of the service units on <strong>&lt;a claim line&gt;</strong> plus the service units on <strong>&lt;claim lines&gt;</strong> that are non-dropped</td>
</tr>
<tr>
<td>the sum of units on <strong>&lt;objects&gt;</strong> based on patient on <strong>&lt;a claim line&gt;</strong> and frequency duration specified by <strong>&lt;a max frequency group&gt;</strong></td>
</tr>
<tr>
<td>units to be removed on <strong>&lt;a claim line&gt;</strong></td>
</tr>
<tr>
<td>units to be retained on <strong>&lt;a claim line&gt;</strong></td>
</tr>
<tr>
<td><strong>Claim → Line → User-Defined Fields</strong></td>
</tr>
<tr>
<td>the <strong>&lt;an user-defined field&gt;</strong> of <strong>&lt;a claim line&gt;</strong></td>
</tr>
<tr>
<td>the <strong>udf &lt;a string&gt;</strong> of <strong>&lt;a facility claim line&gt;</strong></td>
</tr>
</tbody>
</table>

**KnowledgeBase Elements**
- Elements that look at the KnowledgeBase or Code Repository

**KnowledgeBase (General)**

<table>
<thead>
<tr>
<th>KnowledgeBase</th>
</tr>
</thead>
<tbody>
<tr>
<td>the end date of <strong>&lt;an occurrence span code&gt;</strong></td>
</tr>
<tr>
<td>KnowledgeBase → Age</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>the age of &lt;a patient&gt; as of &lt;a date&gt; formatted for edit message</td>
</tr>
<tr>
<td>the age of &lt;a patient&gt; as of &lt;a date&gt; in days</td>
</tr>
<tr>
<td>the age of &lt;a patient&gt; as of &lt;a date&gt; in months</td>
</tr>
<tr>
<td>the age of &lt;a patient&gt; as of &lt;a date&gt; in years</td>
</tr>
<tr>
<td>the beginning age of &lt;a diagnosis age relationship&gt;</td>
</tr>
<tr>
<td>the beginning age of &lt;a procedure age relationship&gt;</td>
</tr>
<tr>
<td>the beginning age type of &lt;a diagnosis age relationship&gt;</td>
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<tr>
<td>the beginning age type of &lt;a procedure age relationship&gt;</td>
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<td>the max age type of &lt;a procedure age relationship&gt;</td>
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<td>the maximum age of &lt;a procedure age relationship&gt;</td>
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</tr>
<tr>
<td>the min age type of &lt;a procedure age relationship&gt;</td>
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<tr>
<td>KnowledgeBase → Anesthesia Crosswalk</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>crosswalked values in &lt;anesthesia crosswalk codes&gt;</td>
</tr>
<tr>
<td>the submitted procedure code of &lt;an anesthesia crosswalk&gt;</td>
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<table>
<thead>
<tr>
<th>KnowledgeBase → Diagnosis</th>
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</thead>
<tbody>
<tr>
<td>any one diagnosis class of &lt;diagnosis&gt; is the same as any one diagnosis class of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the code of &lt;a facility claim diagnosis code&gt;</td>
</tr>
<tr>
<td>the code type of &lt;a diagnosis age relationship&gt;</td>
</tr>
<tr>
<td>the code type of &lt;a diagnosis code&gt;</td>
</tr>
<tr>
<td>the code type of &lt;a diagnosis gender relationship&gt;</td>
</tr>
<tr>
<td>the code type of &lt;a diagnosis relationship&gt;</td>
</tr>
<tr>
<td>the code type of &lt;a diagnosis relationship&gt;</td>
</tr>
<tr>
<td>the diagnosis code of &lt;a diagnosis age relationship&gt;</td>
</tr>
<tr>
<td>the diagnosis code of &lt;a diagnosis gender relationship&gt;</td>
</tr>
<tr>
<td>the diagnosis code of &lt;a diagnosis TPL relationship&gt;</td>
</tr>
<tr>
<td>the diagnosis comparison file name</td>
</tr>
<tr>
<td>the diagnosis source code of &lt;a rules diagnosis comparison&gt;</td>
</tr>
<tr>
<td>the diagnosis TPL relationship of &lt;a diagnosis code&gt; on &lt;a claim line&gt;</td>
</tr>
<tr>
<td>the ending age of &lt;a diagnosis age relationship&gt;</td>
</tr>
<tr>
<td>the ending age type of &lt;a diagnosis age relationship&gt;</td>
</tr>
<tr>
<td>the facility present on admission indicator of &lt;a facility claim diagnosis code&gt;</td>
</tr>
<tr>
<td>the gender of &lt;a diagnosis gender relationship&gt;</td>
</tr>
<tr>
<td>the inappropriate diagnosis code of &lt;an inappropriate diagnosis and modifier combination&gt;</td>
</tr>
<tr>
<td>KnowledgeBase → Disclosure</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>the disclosure for &lt;a diagnosis age relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a diagnosis gender relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a diagnosis relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a diagnosis TPL relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a grouper&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a modifier relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a multiple procedure reducible procedure code&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a primary diagnosis relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a procedure age relationship&gt;</td>
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<tr>
<td>the disclosure for &lt;a procedure code record&gt;</td>
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<tr>
<td>the disclosure for &lt;a procedure follow-up relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a procedure gender relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a procedure MFD record&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a procedure modifier relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;a procedure POS combination&gt;</td>
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<tr>
<td>the disclosure for &lt;a system list data relationship&gt;</td>
</tr>
<tr>
<td>the disclosure for &lt;an anesthesia crosswalk code&gt;</td>
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<tr>
<td>the disclosure for &lt;an unbundle relationship&gt;</td>
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<table>
<thead>
<tr>
<th>KnowledgeBase → Fee Schedules</th>
</tr>
</thead>
<tbody>
<tr>
<td>the category of &lt;a DME fee schedule&gt;</td>
</tr>
<tr>
<td>the fee of &lt;a DME fee schedule&gt;</td>
</tr>
<tr>
<td>the fee of &lt;a PEN fee schedule&gt;</td>
</tr>
<tr>
<td>KnowledgeBase → Grouper</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>the ending occurrences of &lt;a grouper&gt;</td>
</tr>
<tr>
<td>the transfer message of &lt;a rules grouper list&gt; for &lt;a string&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KnowledgeBase → History</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient history</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KnowledgeBase → LCD Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;a group of LCD policy evaluations&gt; with &lt;a LCD Policy Evaluation&gt; added</td>
</tr>
<tr>
<td>a policy with status &lt;a string&gt; exists in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>a relation with status &lt;a string&gt; was satisfied per &lt;a LCD Policy Evaluation&gt;</td>
</tr>
<tr>
<td>policies indicating age flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating C2C flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating deny flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating documentation flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating frequency flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating gender flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating modifier flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating non-covered procedure flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating non-sequenced dx flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating POS flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating primary diagnosis flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating profile flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating secondary diagnosis flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating specialty flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>policies indicating tertiary diagnosis flag in &lt;a group of LCD policy evaluations&gt;</td>
</tr>
<tr>
<td>the cms number of &lt;a LCD Policy&gt;</td>
</tr>
<tr>
<td>the primary status of &lt;a LCD Policy Evaluation&gt;</td>
</tr>
</tbody>
</table>

**KnowledgeBase → Maximum Frequency**

- <a procedure MFD record> is valid
- beginning procedure of <a max frequency codes>
- end procedure code of <a max frequency codes>
- maximum allowed of <a max frequency group>
- maximum frequency for <a claim line>
- modifier of <a Medicare MPFS record>
- time span of <a max frequency group>

**KnowledgeBase → Modifier**

- <modifiers> and <modifiers> are bilateral eligible with required modifiers
- <modifiers> are <modifiers>
- <modifiers> contain the same assistant surgery modifiers as <modifiers>
- a modifier override is allowed for <a rules CCI>
- a modifier override is allowed for <a rules Medicaid CCI>
- the first character of <a modifier> is any one of <strings>
- the inappropriate modifier code of <an inappropriate diagnosis and modifier combination>
- the modifier <a string>
the order of `<a modifier>`

the second character of `<a modifier>` is any one of `<strings>`

the value of `<a modifier relationship>`

the value of `<a modifier>`

**KnowledgeBase → MPFS**

`<a Medicare MPFS record>` is effective for `<a claim line>`

`<a Medicare MPFS record>` is valid

calculation flag of `<a Medicare MPFS record>`

conversion factor of `<a Medicare MPFS record>`

description of `<a Medicare MPFS record>`

diagnosis imaging family indicator of `<a Medicare MPFS record>`

frequency duration of `<a max frequency group>`

intra operative percent of `<a Medicare MPFS record>`

non facility NA Indicator of `<a Medicare MPFS record>`

physician supervision diagnosis procedure of `<a Medicare MPFS record>`

post operative percent of `<a Medicare MPFS record>`

pre operative percent of `<a Medicare MPFS record>`

procedure code of `<a Medicare MPFS record>`

the assistant surgery indicator in `<a Medicare MPFS record>`

the base endoscopy code of `<a Medicare MPFS record>`

the bilateral surgery indicator in `<a Medicare MPFS record>`

the co-surgeons indicator in `<a Medicare MPFS record>`

the diagnostic family indicator of `<a Medicare MPFS record>`

the global follow-up days of `<a Medicare MPFS record>`

the multiple procedure indicator in `<a Medicare MPFS record>`
<table>
<thead>
<tr>
<th>KnowledgeBase → Place of Service (POS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>the value of &lt;a place of service code&gt;</td>
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</table>

<table>
<thead>
<tr>
<th>KnowledgeBase → Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;a procedure age relationship&gt; for the line is not typical for &lt;a patient&gt; as of &lt;a date&gt;</td>
</tr>
<tr>
<td>facility service date of &lt;a facility ICD procedure code&gt;</td>
</tr>
<tr>
<td>the code type indicator of &lt;a primary diagnosis relationship&gt;</td>
</tr>
<tr>
<td>the deny code of &lt;a rules CCI&gt;</td>
</tr>
<tr>
<td>the deny code of &lt;a rules medicaid CCI&gt;</td>
</tr>
<tr>
<td>the edit type of &lt;an unbundle relationship&gt;</td>
</tr>
<tr>
<td>the ending age of &lt;a procedure age relationship&gt;</td>
</tr>
<tr>
<td>the ending age type of &lt;a procedure age relationship&gt;</td>
</tr>
<tr>
<td>the expiration date of &lt;a procedure code&gt;</td>
</tr>
<tr>
<td>the gender of &lt;a procedure gender relationship&gt;</td>
</tr>
<tr>
<td>the pay code of &lt;a rules medicaid CCI&gt;</td>
</tr>
<tr>
<td>the pay code of &lt;a rules CCI&gt;</td>
</tr>
<tr>
<td>the unbundle type of &lt;an unbundle relationship&gt;</td>
</tr>
<tr>
<td>the value of &lt;a facility ICD procedure code&gt;</td>
</tr>
<tr>
<td>the value of &lt;a procedure code&gt;</td>
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</table>

<table>
<thead>
<tr>
<th>KnowledgeBase → Reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>the assistant surgeon percent of &lt;a reduction record&gt;</td>
</tr>
<tr>
<td>the bilateral procedure percent of &lt;a reduction record&gt;</td>
</tr>
</tbody>
</table>
the bpr percent of <a reduction record> for <a claim line> within <claim lines>
the co surgeon percent of <a reduction record>
the procedure reduction set
the team surgeon percent of <a reduction record>

KnowledgeBase → RVU
facility practice RVU of <a Medicare MPFS record>
malpractice RVU of <a Medicare MPFS record>
non facility practice RVU of <a Medicare MPFS record>
the description of <a CMS RVU>
the facility practice RVU of <a CMS RVU>
the facility practice RVU of <a MPFS RVU>
the gap code of <a CMS RVU>
the malpractice RVU of <a CMS RVU>
the malpractice RVU of <a MPFS RVU>
the modifier code of <a CMS RVU>
the modifier code of <a MPFS RVU>
the nonfacility practice RVU of <a CMS RVU>
the nonfacility practice RVU of <a MPFS RVU>
the procedure code of <a CMS RVU>
the procedure code of <a MPFS RVU>
the procedure code of <an Ingenix RVU>
the RVU of <an Ingenix RVU>
the total facility RVU of <a CMS RVU>
total facility RVU of <a Medicare MPFS record>
the total facility RVU of <a MPFS RVU>
<table>
<thead>
<tr>
<th>KnowledgeBase → System Lists</th>
</tr>
</thead>
<tbody>
<tr>
<td>the code of &lt;a system list data relationship&gt;</td>
</tr>
<tr>
<td>the combination of &lt;a string&gt; and &lt;a string&gt; are in &lt;a system list name&gt; as of &lt;a date&gt;</td>
</tr>
<tr>
<td>the related code of &lt;a system list data relationship&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KnowledgeBase → User-Defined Tables</th>
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</thead>
<tbody>
<tr>
<td>the &lt;an user-defined table&gt; where &lt;a UDT Condition&gt;</td>
</tr>
<tr>
<td>the &lt;an user-defined table&gt; where &lt;a UDT Condition&gt; &lt;a UDTCondition operator&gt; &lt;a UDT Condition&gt;</td>
</tr>
<tr>
<td>the &lt;an user-defined table&gt; where &lt;a UDT Condition&gt; &lt;a UDTCondition operator&gt; &lt;a UDT Condition&gt; &lt;a UDTCondition operator&gt; &lt;a UDT Condition&gt;</td>
</tr>
<tr>
<td>the value of alphanumeric &lt;an user-defined column&gt; &lt;an alphanumeric operator&gt; &lt;a string&gt;</td>
</tr>
<tr>
<td>the value of alphanumeric &lt;an user-defined column&gt; of &lt;an user-defined table row&gt;</td>
</tr>
<tr>
<td>the value of date &lt;an user-defined column&gt; &lt;a date operator&gt; &lt;a date&gt;</td>
</tr>
<tr>
<td>the value of date &lt;an user-defined column&gt; of &lt;an user-defined table row&gt;</td>
</tr>
<tr>
<td>the value of numeric &lt;an user-defined column&gt; &lt;a numeric operator&gt; &lt;a number&gt;</td>
</tr>
<tr>
<td>the value of numeric &lt;an user-defined column&gt; of &lt;an user-defined table row&gt;</td>
</tr>
</tbody>
</table>

**General (Other) Elements**

→ Elements that perform calculations or derive data in other ways

**General → Calculations**
**none of the following conditions are true:**

- the amount that `<a number>` exceeded `<a number>` by
- the number associated to `<a string>` in `<a system list name>` as of `<a date>`
- the number of `<a date>`

### General → Calculations → Date

- `<a date>` does not equal `<a date>`
- `<a date>` equals `<a date>`
- `<a date>` is earlier or the same as `<a date>`
- `<a date>` is earlier than `<a date>`
- `<a date>` is later or the same as `<a date>`
- `<a date>` is later than `<a date>`
- `<a date>` shifted by `<a number>` days
- `<a date>` shifted by `<a number>` months
- `<a date>` shifted by `<a number>` years
- `<a string>` in date format of `<a string>`
- difference in years between `<a date>` and `<a date>` is at most `<a number>`
- the elapsed days (total days) between `<a date>` and `<a date>`
- the elapsed days between `<a date>` and `<a date>`
- the elapsed months between `<a date>` and `<a date>`
<table>
<thead>
<tr>
<th><strong>General → Calculations → Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>the elapsed years between <code>&lt;a date&gt;</code> and <code>&lt;a date&gt;</code></td>
</tr>
<tr>
<td>the month of <code>&lt;a date&gt;</code></td>
</tr>
<tr>
<td><code>&lt;a number&gt;</code> + <code>&lt;a string&gt;</code></td>
</tr>
<tr>
<td><code>&lt;a number&gt;</code> adjusted for edit message</td>
</tr>
<tr>
<td><code>&lt;a number&gt;</code> rounded to <code>&lt;a number&gt;</code> places</td>
</tr>
<tr>
<td><code>&lt;a string&gt;</code> + <code>&lt;a number&gt;</code></td>
</tr>
<tr>
<td><code>&lt;a string&gt;</code> in number format</td>
</tr>
<tr>
<td>difference between <code>&lt;a number&gt;</code> and <code>&lt;a number&gt;</code></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>General → Miscellaneous</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>General → Multiple Conditions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>all of the following conditions are true :</td>
</tr>
<tr>
<td>any of the following conditions is true :</td>
</tr>
<tr>
<td>there are</td>
</tr>
<tr>
<td>there are at least</td>
</tr>
<tr>
<td>there are at most</td>
</tr>
<tr>
<td>there are less than</td>
</tr>
<tr>
<td>there are more than</td>
</tr>
<tr>
<td>there is at least one</td>
</tr>
<tr>
<td>there is at most one</td>
</tr>
<tr>
<td>there is no</td>
</tr>
<tr>
<td>there is one</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>General → Object</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><code>&lt;objects&gt;</code> contain <code>&lt;an object&gt;</code></td>
</tr>
</tbody>
</table>
<objects> do not contain <an object>

**General → String**

the length of <a string>

the substring at position <a number> of <a string> parsed with delimiter <a string>

the substring of <a string> from position <a number> with <a number> characters

**General → Value**

the value of <a date>

<enter a value>

<expr> is a kind of <target>

### Action Statements

Action statements are the elements of a rule that tell the system what to do when it finds data matching the conditions expressed in other parts of the rule. Thus, the following list is organized according to what action the system should take when it finds specific data:

**Actions**

**Add**

add <a claim line> to the claim lines of <a patient claim history pro>

add <a string> to the adjusted modifiers of <a claim line>

**Adjust**

adjust the adjusted amount of <a claim line> by <a number>

undrop <a claim line>

**Copy**

create virtual copy of the line using <a claim line>, <a rules grouper list> and <a string> and add to <a patient history>

**Delete/Clear/Ignore**

remove <a claim line> from the claim lines of <a claim>
<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>remove</td>
<td>&lt;a string&gt; from the adjusted modifiers of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>&lt;a string&gt; from the edits of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>&lt;a string&gt; from the submitted modifiers of &lt;a claim line&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>all edits from &lt;a claim line&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>dropped history lines from &lt;a patient claim history impl&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>dropped history lines from &lt;a patient history&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>the duplicate edits from &lt;a claim line&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>the mEH edit from &lt;a claim line&gt;</td>
</tr>
<tr>
<td>remove</td>
<td>the mEM edit from &lt;a claim line&gt;</td>
</tr>
</tbody>
</table>

**Deny-and-Set**

for every <a number>, deny a unit, and set the <a claim line flag mnemonic> flag on <a claim line>, linked to <a claim line flag>, with the message: <a string>

**Drop-and-Set**

drop <a claim line> and set the <a claim line flag mnemonic> flag on <a claim line> with <a disclosure> and the message: <a string>

drop <a claim line> and set the <a claim line flag mnemonic> flag on <a claim line> with the message: <a string>

drop the line and set the <a claim line flag mnemonic> flag on <a claim line> with <a disclosure> and the message: <a string>

drop the line and set the <a claim line flag mnemonic> flag on <a claim line> with the message: <a string>

drop the line, set the number of units to deny to <a number>, and set the <a claim line flag mnemonic> flag on <a claim line> with <a disclosure> and the message: <a string>

drop the line, set the number of units to deny to <a number>, and set the <a claim line flag mnemonic> flag on <a claim line> with the message: <a string>

for each of <a number> drop <a claim line> and set the <a claim line flag mnemonic> flag on <a claim line> with the message: <a string>

for every <a number> drop <a claim line> and set the <a claim line flag mnemonic> flag on <a claim line> with <a disclosure> and the message: <a string>
### Drop → Flag

*drop the flag* `<a string>`

### Execute/Prevent Execution

*declare* `<variable>` *as* `<concept>`

*for every* `<a number>`, *deny a unit, set the* `<a claim line flag mnemonic>` *flag on* `<a claim line>`, *linked to* `<a claim line flag>`, *with the message:* `<a string>`

*perform ncd-lcd logic for* `<a group of LCD policy evaluations>`

*prevent ncd-lcd logic on* `<a group of LCD policy evaluations>`

*print* `<a string>`

### Operator

*for each ...*

*if*

### Mark

*mark* `<a claim line>` *as being referenced by the HRB flag*

### Set → Claim

*set* `<a claim>` *as not analyzed by DUP*

### Set → Claim Line

*set* `<a claim line>` *as analyzed by DUP*

*set* `<a claim line>` *as analyzed for* `<a string>`

*set* `<a claim line>` *as analyzed by mERh*

*set* `<a claim line>` *is analyzed For mMP*

*set the adjusted procedure code of* `<a claim line>` *to* `<a procedure code>`

*set the disposition of* `<a claim line>` *to* `<a string>`

*set the modified indicator of* `<a claim line>`

*set the mMPUpdated RVU of* `<a claim line>` *to* `<a number>`

*set the RVU on* `<a claim line>` *to* `<a number>`
<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>set</td>
<td>set the units to be removed for TRA of <code>&lt;a claim line&gt;</code> to <code>&lt;a number&gt;</code></td>
</tr>
<tr>
<td></td>
<td>set the units to be retained for TRA of <code>&lt;a claim line&gt;</code> to <code>&lt;a number&gt;</code></td>
</tr>
<tr>
<td><strong>Set → Data</strong></td>
<td></td>
</tr>
<tr>
<td>set : <code>&lt;an alpha numeric claim line field&gt;</code> of <code>&lt;a claim line&gt;</code> to <code>&lt;an object&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set <code>&lt;a date claim field&gt;</code> of <code>&lt;a claim&gt;</code> to <code>&lt;a date&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set <code>&lt;a date claim line field&gt;</code> of <code>&lt;a claim line&gt;</code> to <code>&lt;a date&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set <code>&lt;a numeric claim line field&gt;</code> of <code>&lt;a claim line&gt;</code> to <code>&lt;a number&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set <code>&lt;an alpha numeric claim field&gt;</code> of <code>&lt;a claim&gt;</code> to <code>&lt;an object&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set <code>&lt;variable&gt;</code> to ...</td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a string&gt;</code>, <code>&lt;a string&gt;</code> and <code>&lt;a string&gt;</code> edits appropriately on <code>&lt;a collection&gt;</code> including <code>&lt;a claim line&gt;</code> in <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the alpha numeric logical field <code>&lt;a string&gt;</code> of <code>&lt;a claim line&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the alpha numeric logical field <code>&lt;a string&gt;</code> of <code>&lt;a claim&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the alpha numeric logical field <code>&lt;a string&gt;</code> of <code>&lt;a facility claim line&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the alpha numeric logical field <code>&lt;a string&gt;</code> of <code>&lt;a facility claim&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the beginning age of <code>&lt;a diagnosis age relationship&gt;</code> to <code>&lt;a number&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the beginning age of <code>&lt;a procedure age relationship&gt;</code> to <code>&lt;a number&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the beginning age type of <code>&lt;a diagnosis age relationship&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the beginning age type of <code>&lt;a procedure age relationship&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the code type indicator of <code>&lt;a primary diagnosis relationship&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the code type of <code>&lt;a diagnosis gender relationship&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the diagnosis code of <code>&lt;an inappropriate diagnosis and modifier combination&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the diagnosis source code of <code>&lt;a rules diagnosis comparison&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the ending age of <code>&lt;a diagnosis age relationship&gt;</code> to <code>&lt;a number&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the ending age of <code>&lt;a procedure age relationship&gt;</code> to <code>&lt;a number&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set → Flag</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>set the ending age type of <code>&lt;a diagnosis age relationship&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the ending age type of <code>&lt;a procedure age relationship&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the modifier code of <code>&lt;an inappropriate diagnosis and modifier combination&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the primary status of <code>&lt;a LCD Policy Evaluation&gt;</code> to <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>for each of <code>&lt;a number&gt;</code> set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>for every <code>&lt;a number&gt;</code> set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>for every <code>&lt;a number&gt;</code> set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code>, linked to <code>&lt;a claim line flag&gt;</code>, with the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the BPR percent of <code>&lt;a null&gt;</code> within <code>&lt;claim lines&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and set the adjusted procedure code on <code>&lt;a claim line&gt;</code> to <code>&lt;a procedure code&gt;</code>, the RVU on <code>&lt;a claim line&gt;</code> to <code>&lt;a number&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and the recommended fix of adding the modifier <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> and adjust the charge amount by <code>&lt;a number&gt;</code> percent and the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the Assistant Surgeon percent of <code>&lt;a reduction record&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the BPR percent of <code>&lt;a reduction record&gt;</code> within <code>&lt;claim lines&gt;</code></td>
<td></td>
</tr>
<tr>
<td>set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the Co Surgeon percent of <code>&lt;a reduction record&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the Team Surgeon percent of <code>&lt;a reduction record&gt;</code></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and the recommended fix of adding the procedure code <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the Assistant Surgeon percent of <code>&lt;a reduction record&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the BPR percent of <code>&lt;a reduction record&gt;</code> within <code>&lt;claim lines&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the Co Surgeon percent of <code>&lt;a reduction record&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the MPR percent of <code>&lt;a reduction record&gt;</code> within <code>&lt;claim lines&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the Team Surgeon percent of <code>&lt;a reduction record&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with <code>&lt;a disclosure&gt;</code> and the message: <code>&lt;a string&gt;</code> and adjust the charged amount by the MPR percent of <code>&lt;a reduction record&gt;</code> within <code>&lt;claim lines&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and the recommended fix of adding the modifier <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and the recommended fix of adding the procedure code <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and the recommended fix of changing the modifier <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code> and the recommended fix of changing the procedure code <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
<tr>
<td>Set the <code>&lt;a claim line flag mnemonic&gt;</code> flag on <code>&lt;a claim line&gt;</code> with the message: <code>&lt;a string&gt;</code></td>
<td></td>
</tr>
</tbody>
</table>
string> and the recommended fix of deleting the modifier <a string>

set the <a claim line flag mnemonic> flag on <a claim line> with the message: <a string> and the recommended fix of deleting the procedure code <a string>

set the <a claim line flag mnemonic> flag on <a claim line> with <a disclosure> and the message: <a string> and adjust the charged amount by the MPR percent of <a null> within <claim lines>

set the <a claim line flag mnemonic> flag on <a claim line>, linked to <a claim line flag>, with <a disclosure> and the message: <a string>

set the applied flag message of <a claim line> to <a string>

set the applied flag mnemonic of <a claim line> to <a string>

set the number of units to deny to <a number> and set the <a claim line flag mnemonic> flag on <a claim line> with <a disclosure> and the message: <a string>

set the number of units to deny to <a number> and set the <a claim line flag mnemonic> flag on <a claim line> with the message: <a string>

## DDR Rule Import Warning Messages

This section outlines the warnings that can be generated when importing DDR rules.

<table>
<thead>
<tr>
<th>Use Case/Scenario</th>
<th>Warning Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>When importing a rule that already exists in the target system.</td>
<td>There is already an existing copy of this rule. If you continue and save, the existing rule will be replaced.</td>
</tr>
<tr>
<td>When importing a rule from a CM environment into a CES environment (or vice-versa).</td>
<td>A line of business was converted from CM to CES.</td>
</tr>
<tr>
<td>When importing a rule with a line of business that the target system does not have a license for or does not exist, it will remove it.</td>
<td>A line of business (the line of business) was removed because it was not found on this system.</td>
</tr>
<tr>
<td>When importing a rule into CM from CES with flag status = Deny.</td>
<td>[In the Expression tab] Flag status of “Deny” was changed to “Review.” Priority of (original error level) was changed to 25000.</td>
</tr>
<tr>
<td>Use Case/Scenario</td>
<td>Warning Message</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If a claim field doesn’t exist in the target system.</td>
<td>[In the Expression tab] A claim field used does not exist on this system.</td>
</tr>
<tr>
<td>When importing a rule with a claim field specific to CES onto a CM box (or vice-versa).</td>
<td>[In the Expression tab] A claim field that is not intended for this product is being used; you may need to revise.</td>
</tr>
<tr>
<td>If a referenced system list doesn’t exist on the target system.</td>
<td>[In the Expression tab] The system list “(system list name)” does not exist on this system.</td>
</tr>
<tr>
<td>When the imported rule has a dependency on another rule that is not found on the target system.</td>
<td>[In the Expression tab] A rule referenced does not exist on this system.</td>
</tr>
<tr>
<td>If you use the enterprise name claim field map, it warns you that you need to check the enterprises because those can be unique to the system.</td>
<td>[In the Expression tab] This statement references a specific enterprise name claim field map on the source system; you may need to revise the selected enterprises for your system.</td>
</tr>
<tr>
<td>If the imported rule references a table lookup that does not exist on the target system.</td>
<td>[In the Expression tab] A table lookup used does not exist on this system.</td>
</tr>
<tr>
<td>If the imported rule references a calculation that does not exist on the target system.</td>
<td>[In the Expression tab] A calculation used does not exist on this system.</td>
</tr>
</tbody>
</table>

**Rule Editor Options**

When selecting a new statement within a rule, the following options are available.

**Custom Statements**

<table>
<thead>
<tr>
<th><strong>a claim field</strong></th>
<th>This statement checks for values within fields on the claim or claim line, such as procedure code, modifier or diagnosis. Common Claim Level and Line Level Fields are presented at the top with the ability to see All Fields at the bottom.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>the result of a table</strong></td>
<td>This statement takes specified claim data and matches it</td>
</tr>
<tr>
<td>lookup after matching claim data against table data</td>
<td>against the specified table to obtain a lookup result. Example: Lookup “Diagnosis Gender” column “Gender” ≠ the current claim’s Patient Gender.</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>a calculated value</td>
<td>This statement returns the count of history lines or sum of units from lines that match the given condition.</td>
</tr>
<tr>
<td>a particular value</td>
<td>This statement uses a particular value which is given as input by the user.</td>
</tr>
<tr>
<td></td>
<td>An expression statement within a rule returns a yes or no, whereas a calculated value returns a value from the claim. The value can be compared with a claim field, a calculated field, another value or a value from table lookup.</td>
</tr>
<tr>
<td>a system List, including custom lists</td>
<td>This statement returns the sum of all the field values specified by parameter 3 within the lines specified in parameter 2 that match the expression in parameter 1.</td>
</tr>
<tr>
<td>an association list, including crosswalk lists</td>
<td>This statement uses an association list during claim processing.</td>
</tr>
<tr>
<td>a list of particular values</td>
<td>This statement uses set of values which are given as input by the user.</td>
</tr>
<tr>
<td></td>
<td>An expression statement within a rule returns a yes or no, whereas a calculated value returns a value from the claim.</td>
</tr>
</tbody>
</table>

### Claim History

<table>
<thead>
<tr>
<th>whether any History claim or claim line matches certain conditions</th>
<th>A group of statements evaluated against each history claim and/or history line. Example: Any history line meets all of the following 1 condition: The Patient ID on the current claim = the Patient ID from the history claim.</th>
</tr>
</thead>
<tbody>
<tr>
<td>check the frequency of one or more procedures</td>
<td>This statement checks that the procedure code on the claim line has a frequency relationship and that procedure code is submitted no more than a specified number of</td>
</tr>
</tbody>
</table>

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CPT only © 2019 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Restrictions Apply to Government Use. Current Dental Terminology, © 2019 American Dental Association. All rights reserved. Optum, Inc. • 2525 Lake Park Blvd. • Salt Lake City, Utah • 84120 • (800) 765-6818
Occurrences during a specified period.

Frequency relationships can be created for a procedure code or a range of procedure codes for a specified period of a day, week, month, quarter, year, month by date, year by date, fiscal year, or lifetime.

Modifier criteria can be added.
Place of service criteria can be added.
Other claim fields criteria can be added (e.g., Billing Provider).

| **the number of history lines that match certain conditions** | This statement returns the count of history lines or sum of units from lines that match the given condition. |
| **the whole number sum of a field from history lines matching certain conditions** | This statement returns the sum of all the field values specified by parameter 3 within lines specified in parameter 2 that match the expression in parameter 1. |
| **the decimal sum of a field from history lines matching certain conditions** | This statement returns the sum of all the field values specified by parameter 3 within the lines specified in parameter 2 that match the expression in parameter 1. |
| **a list of values from history lines matching certain conditions** | This statement returns all the codes in the field specified by parameter 3 within the lines specified in parameter 2 that match the expression in parameter 1. |

**Check for a flag or the result of another rule**

| **whether a particular flag fired on a claim or claim line** | This statement checks whether a specified flag was fired on a claim or claim line. Example: Current line does not have flag “MPR.” |
whether any non-profile flag fired on a claim or claim line

This statement checks whether a flag with a status other than profile was fired on a claim or claim line. Example: Current line does not have a non-profile flag.

whether another rule’s expression evaluated to true

Checks whether a specified rule’s expression evaluated to true or false. Example: Expression is true for rule ID 9 Department.

When + Claim Field Statement is selected within a rule, Calculated Fields is available as a selection option. Refer to the Calculated Field Statements section for more information.

When + Calculated Value Statement is selected, calculated value statements are available as a selection option. Refer to the Calculated Value Statements section for more information.

Operators

There are various operators that can be used to write a statement for a rule. The operator options displayed are based on the type of field selected. If the operator is evaluating against a single value such as a procedure code the following operators are displayed.

<table>
<thead>
<tr>
<th>Operator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>equal to</td>
<td>Values match. Example: Procedure code is equal to 99201.</td>
</tr>
<tr>
<td>not equal to</td>
<td>Values do not match. Example: Procedure code is not equal to 99201.</td>
</tr>
<tr>
<td>greater than</td>
<td>Value is greater than another value. Example: Patient age is greater than 18 years old.</td>
</tr>
<tr>
<td>greater than or equal to</td>
<td>Value is greater than or equal to another value. Example: Patient age is greater than or equal to 18 years old.</td>
</tr>
<tr>
<td>less than</td>
<td>Value is less than another value. Example: Patient age is less than 18 years old.</td>
</tr>
<tr>
<td>less than or equal to</td>
<td>Value is less than or equal to another value. Example: Patient age is less than or equal to 18 years old.</td>
</tr>
<tr>
<td>included in</td>
<td>Executes if the user-specified value is included in the claim field value.</td>
</tr>
</tbody>
</table>
matches | Executes if a part of the value matches the claim field value.
---|---
empty | Executes if the user-defined value is empty.

If the operator is evaluating against a value which includes multiple values such as diagnosis codes the following operators are displayed.

<table>
<thead>
<tr>
<th>Operator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>include</td>
<td>Checks if a list of values (List 1) has elements from another list (List 2). Example: If List 1 has values A, B, C, D and list 2 has B and C, the operator will validate it as true because the B and C elements are present in List 1.</td>
</tr>
<tr>
<td>included in</td>
<td>Checks if a list of values (List 1) can be found in another list (List 2). eg., If List 1 has values Sam and Peter, it check if they are found in another list having Sam, Tan, Peter, Jenny and Arjun.</td>
</tr>
<tr>
<td>match</td>
<td>For a given text pattern expression, this operator checks if it can find any element in the list that matches that expression.</td>
</tr>
<tr>
<td>the same item as</td>
<td>This operator compares two list and checks if they are equal.</td>
</tr>
<tr>
<td>number of items</td>
<td>This operator returns the number of elements in a list</td>
</tr>
<tr>
<td>empty List</td>
<td>This operator checks if a list contains any element or is empty.</td>
</tr>
</tbody>
</table>

If using the manipulate this list in some way option you can manipulate a field with multiple values and use the result in a statement using the following options.

<table>
<thead>
<tr>
<th>Operator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>sort items in the list</td>
<td>Returns all the items from the list provided, sorted in alphanumeric order</td>
</tr>
<tr>
<td>repeated items that occur more than once in the list</td>
<td>Returns a list of items that appear more than once. If the list provided includes only unique values, the result will be an empty list.</td>
</tr>
<tr>
<td>unique items – without any duplicates</td>
<td>Returns a list of all the unique entries that occur in the list provided. All the duplicate records are removed.</td>
</tr>
<tr>
<td>combine this list of items with another list</td>
<td>Returns the items from two different lists combined into a single list without removing any repeated or duplicate values.</td>
</tr>
<tr>
<td>Operator</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>are the same order, in any order as</td>
<td>The items in the list can be in any order</td>
</tr>
<tr>
<td>are not the same items, regardless of order, as</td>
<td>No elements should be the equal</td>
</tr>
<tr>
<td>are the same items and in the same order as</td>
<td>The list have the same elements in the same order</td>
</tr>
<tr>
<td>are not the same items and in the same order as</td>
<td>The list might have the same elements but not in the same order</td>
</tr>
</tbody>
</table>

### Calculated Field Options

When Claim Field Statement is within a rule, Calculated Fields are available as a selection option, where the following options are available.

<p>| Age At EOS In Days | Indicates the age of the patient in days as of the ending date of |</p>
<table>
<thead>
<tr>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age At EOS In Months</td>
<td>Indicates the age of the patient in months as of the ending date of service.</td>
</tr>
<tr>
<td>Age At EOS In Weeks</td>
<td>Indicates the age of the patient in weeks from the ending date of service.</td>
</tr>
<tr>
<td>Age At EOS In Years</td>
<td>Indicates the age of the patient in years from the ending date of service.</td>
</tr>
<tr>
<td>Age In Days</td>
<td>Indicates the age of the patient in days.</td>
</tr>
<tr>
<td>Age In Months</td>
<td>Indicates the age of the patient in months.</td>
</tr>
<tr>
<td>Age In Weeks</td>
<td>Indicates the age of the patient in weeks.</td>
</tr>
<tr>
<td>Age In Years</td>
<td>Indicates the age of the patient in years.</td>
</tr>
<tr>
<td>History Days Since Current Start</td>
<td>Indicates the number of history days from the beginning date of service.</td>
</tr>
<tr>
<td>History Months Since Current Start</td>
<td>Indicates the number of history months from the beginning date of service.</td>
</tr>
<tr>
<td>History Weeks Since Current Start</td>
<td>Indicates the number of history weeks from the beginning date of service.</td>
</tr>
<tr>
<td>History Years Since Current Start</td>
<td>Indicates the number of history years from the beginning date of service.</td>
</tr>
<tr>
<td>Length of Service Days</td>
<td>Indicates the length of service days.</td>
</tr>
<tr>
<td>Service End Until Today In Days</td>
<td>Indicates the number of days between the service end date of service until today.</td>
</tr>
<tr>
<td>Service End Until Today In Months</td>
<td>Indicates the number of months between the service end date of service until today.</td>
</tr>
<tr>
<td>Service End Until Today In Weeks</td>
<td>Indicates the number of weeks between the service end date of service until today.</td>
</tr>
<tr>
<td>Service End Until Today In Years</td>
<td>Indicates the number of years between the service end date of service until today.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Service Start Until Today In Days</td>
<td>Indicates the number of days between the service start date of service until today.</td>
</tr>
<tr>
<td>Service Start Until Today In Months</td>
<td>Indicates the number of months between the service start date of service until today.</td>
</tr>
<tr>
<td>Service Start Until Today In Weeks</td>
<td>Indicates the number of weeks between the service start date of service until today.</td>
</tr>
<tr>
<td>Service Start Until Today In Years</td>
<td>Indicates the number of years between the service start date of service until today.</td>
</tr>
</tbody>
</table>

**Calculated Value Statements**

When + *Calculated Value Statement* is selected, calculated value statements are available as a selection option. The following options are available.

**Dates**

<table>
<thead>
<tr>
<th>Convert into date</th>
<th>Converts a value into a date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>date adjusted by days</td>
<td>Adjusts the date in parameter 1; parameter 2 is the number of days. A negative value goes back the specified number of days while a positive value goes forward the specified number of days.</td>
</tr>
<tr>
<td>date adjusted by months</td>
<td>Returns the given date adjusted by the specified number of months. A negative value goes back the specified number of months while a positive value goes forward the specified number of months.</td>
</tr>
<tr>
<td>first of month</td>
<td>Returns the date of the first of the calendar month for the date provided.</td>
</tr>
<tr>
<td>Function</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>first of quarter</td>
<td>Returns the date of the first of the calendar quarter for the date provided.</td>
</tr>
<tr>
<td>first of week</td>
<td>Returns the date of the first of the calendar week for the date provided.</td>
</tr>
<tr>
<td>first of year</td>
<td>Returns the date of the first of the calendar year for the date provided.</td>
</tr>
<tr>
<td>has same calendar year</td>
<td>Return the dates that has same calendar year to the date provided.</td>
</tr>
<tr>
<td>statement duration less overlapping days from spans</td>
<td>Subtracts the number of overlapping days from the spans matching the given list from the statement duration in days</td>
</tr>
<tr>
<td>year from date</td>
<td>Returns the year from the date provided</td>
</tr>
</tbody>
</table>

**Lists**

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>combined list</td>
<td>Returns the items from two different lists combined into a single list without removing any duplicates or repeated values.</td>
</tr>
<tr>
<td>combined list without duplicates</td>
<td>Returns the items from two different lists combined into a single list, removing any duplicates or repeated values.</td>
</tr>
<tr>
<td>correlated list items</td>
<td>Returns a list’s items that are located at the positions where a list of codes are found in another list.</td>
</tr>
<tr>
<td>descending sorted list</td>
<td>Returns all the items from the list provided, sorted in descending alphanumeric order.</td>
</tr>
<tr>
<td>first item from list</td>
<td>Returns the first item in the list. If the list is empty, an empty item is returned.</td>
</tr>
<tr>
<td>items in both lists</td>
<td>Returns a list of any items that are found in both lists.</td>
</tr>
<tr>
<td>items in</td>
<td>Returns a list of entries that appear in one list or the other, but not in</td>
</tr>
<tr>
<td>Function</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>only one list or the other</td>
<td>both lists.</td>
</tr>
<tr>
<td>list except the first item</td>
<td>Returns all the items in the list provided except for the first item. If</td>
</tr>
<tr>
<td></td>
<td>the list is empty, an empty item is returned.</td>
</tr>
<tr>
<td>list item at position</td>
<td>Returns the entry from the specified list at a given position in the list.</td>
</tr>
<tr>
<td></td>
<td>The first entry in the list has a position of 1. If the list has fewer</td>
</tr>
<tr>
<td></td>
<td>items than the requested position, it returns an empty item.</td>
</tr>
<tr>
<td>list items at positions</td>
<td>Returns a list of items located at the specified positions in parameter 2</td>
</tr>
<tr>
<td></td>
<td>within the list provided in parameter 1.</td>
</tr>
<tr>
<td>list items that are also in another list</td>
<td>Returns the items in the first list but removes all items that are not</td>
</tr>
<tr>
<td></td>
<td>present in the second list.</td>
</tr>
<tr>
<td>list size</td>
<td>Returns the number of items found in a given list.</td>
</tr>
<tr>
<td>list with items removed</td>
<td>Returns all the items from the first list that are not found in the other</td>
</tr>
<tr>
<td></td>
<td>list(s).</td>
</tr>
<tr>
<td>position of list item</td>
<td>Returns the position of an item specified by parameter 2 within the list</td>
</tr>
<tr>
<td></td>
<td>parameter 1. If the item cannot be found in the list, its position is</td>
</tr>
<tr>
<td></td>
<td>returned as 0.</td>
</tr>
<tr>
<td>positions of list items</td>
<td>Returns the position of the list of items in parameter 2 within the list</td>
</tr>
<tr>
<td></td>
<td>parameter 1. If an item cannot be found in the list, its position is</td>
</tr>
<tr>
<td></td>
<td>returned as 0.</td>
</tr>
<tr>
<td>repeated list entries</td>
<td>Checks the list provided and returns a list of the items that appear more</td>
</tr>
<tr>
<td></td>
<td>than once. If the list provided contains only unique entries, the result</td>
</tr>
<tr>
<td></td>
<td>will be an empty list.</td>
</tr>
<tr>
<td>sorted list</td>
<td>Returns all the items from the list provided, sorted in ascending</td>
</tr>
<tr>
<td></td>
<td>alphanumeric order.</td>
</tr>
<tr>
<td>unique</td>
<td>Returns a list of all the unique entries that occur in the list provided</td>
</tr>
</tbody>
</table>
### Association Lists

| association list first matching pair | Using the specified association list, it looks up the first code or list of codes to see if they’re associated with the second code or list of codes on the given date of concern. It returns the first pair of matching codes found as a two-item list. |
| association list full match | Determines whether the specified association list contains a match between two values effective on a given date of concern. |
| association list half match | Determines whether a value is found in a particular code column of the specified association list effective on a given date of concern, regardless of the value in the other code column. |
| association list values | Returns the values associated with a particular value in the specified association list effective on a given date of concern. |

### Math

| decimal value | Converts a value to a decimal, removing any leading zeros. |
| math formula | Uses a math formula/statement embedded directly in the expression (instead of using a math calculation). |
| numerical value | Converts a value to a number, removing any leading zeros. |
| ratio | Returns the ratio of one number divided by another. |
| sum | Returns the sum of the numbers specified. |
### Codes

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>the number of characters</td>
<td>Returns the number of alphanumeric characters in the provided code, field or result.</td>
</tr>
<tr>
<td>adjusted modifier submitted values</td>
<td>Creates a displayable list of the specified adjusted modifiers, correlated with their submitted values.</td>
</tr>
<tr>
<td>any procedure codes for jurisdiction and effective date are expired</td>
<td>Using the system list indicated, returns the procedure codes for jurisdiction for the given code that is valid on the specified date of concern. If the code is not found, is not valid for on that date, or is disabled, it returns an empty value.</td>
</tr>
<tr>
<td>code expiration date for jurisdiction</td>
<td>Using the base name of the specified system list, it obtains the expiration date for the given procedure code within a particular jurisdiction. It returns an empty value if the code is not found or if the entry is disabled for the applicable enterprise or rule-set.</td>
</tr>
<tr>
<td>days between procedure code date</td>
<td>Returns the number of days between ICD procedure dates for codes matching in the first list and ICD procedure dates for codes matching in the second list. If the date of the code found in the second list is prior to the date of the code found in the first list, the return value is zero days.</td>
</tr>
<tr>
<td>description for a code</td>
<td>Using the system list indicated by the specified list base name, it returns the description for the given code that is valid on the given date. If the code is not found, is not valid for that date or is disabled, then it returns an empty value.</td>
</tr>
<tr>
<td>earliest procedure code date</td>
<td>Returns the earliest procedure code date based on the ICD principal and other procedure codes found on a claim.</td>
</tr>
<tr>
<td>invalid code relationships</td>
<td>Returns a list of invalid code relationships of the specified type (diagnosis to diagnosis, procedure to modifier, Medicare pro-</td>
</tr>
<tr>
<td>Function</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><code>for date</code></td>
<td>Procedure to modifier, procedure to diagnosis, diagnosis to modifier, modifier to modifier) for a given date.</td>
</tr>
<tr>
<td><code>latest procedure code date</code></td>
<td>Returns the latest procedure code date based on the ICD principal and other procedure codes found on a claim.</td>
</tr>
<tr>
<td><code>procedure codes from history for date</code></td>
<td>Returns all procedure codes from patient history that occurred on the specified service date.</td>
</tr>
<tr>
<td><code>procedure duration less overlapping days from spans</code></td>
<td>Subtracts the number of overlapping days for the given spans from the length of time between the specified procedure(s) and the statement through in days.</td>
</tr>
<tr>
<td><code>substring</code></td>
<td>Given a string of text characters, it returns a substring of contiguous starting at one position and including the character at the ending position. The first character in the string has position of 1.</td>
</tr>
<tr>
<td><code>substrings from the list</code></td>
<td>Given a list of text strings, it returns a list of substrings of contiguous starting at one position and including the character at the ending position. The first character in each string has position of 1.</td>
</tr>
<tr>
<td><code>valid codes for jurisdiction and date</code></td>
<td>Returns the number of alphanumeric characters in the provided code, field or result.</td>
</tr>
</tbody>
</table>

**Claim Line**

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><code>is highest RVU</code></td>
<td>Given a CURRENT or HISTORY contexts in parameter 1, determines whether the current line or a history line has the highest RVU out of all lines with the same provider and date of service as the current line.</td>
</tr>
<tr>
<td><code>is highest RVU without modifier</code></td>
<td>Determines whether the current line or a history line has the highest RVU when considering all lines that have the same provider and date of service as the current line. Ignores lines that have adjusted modifiers in a given list.</td>
</tr>
</tbody>
</table>
the rank of the current line | Returns the rank of the current line compared to history lines that meet the desired criteria. Parameter 2 indicates the value to used to sort the lines that match the criteria defined in Parameter 1. Parameter 3 specifies sort order (default is descending). Parameter 4 is optional and indicates if the position in the sort should be 1 based or 0 based (0 based is the default if the parameter is missing).

Reduction

<table>
<thead>
<tr>
<th>reduction amount</th>
<th>Returns the reduction amount indicated for the specified line ranking and the given reduction type.</th>
</tr>
</thead>
<tbody>
<tr>
<td>reduction percentage</td>
<td>Returns the reduction percentage indicated for the specified line ranking and the given reduction type.</td>
</tr>
</tbody>
</table>

Statistical Editing

| statistic value | Returns the current value of the specified statistic measure for a given date |

Partial Denial

| the number of units that should be defined by a frequency rule | Returns the number of units that exceeded the latest frequency rule for use as a partial denial parameter to a flag action. |

Aggregation

| decimal sum from matching lines | Returns the sum of all the field values specified by parameter 3 within the lines specified in parameter 2 that match the expression in parameter 1. |
| get codes from matching lines | Returns all the codes in the field specified by parameter 3 within the lines specified in parameter 2 that match the expression in parameter 1. |
| the number of | Returns the count of history lines or the sum of units from lines |
### Revision History

This section outlines the revision history for this documentation.

**Add**

New line, paragraph or table is added.

**Delete**

Previous line, paragraph or table is removed as strike-through.

**Update**

Existing text is modified; may include both Add and Delete revisions.

<table>
<thead>
<tr>
<th>Version Release</th>
<th>Section/Field</th>
<th>Type</th>
<th>Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 Q3A KnowledgeBase</td>
<td>Changing Your Password</td>
<td>Add</td>
<td>Added a section called Changing Your Password in the Data-Driven Rules - Panel-based UI section.</td>
</tr>
<tr>
<td>2020 Q3A KnowledgeBase</td>
<td>Importing and Exporting Custom Rules</td>
<td>Add</td>
<td>Added instructions for importing custom rules when a similar rule already exists.</td>
</tr>
<tr>
<td>2020 Q3A KnowledgeBase</td>
<td>Calculated Value Statements</td>
<td>Add</td>
<td>Added the statement is highest RVU without modifier to the Claim Line table.</td>
</tr>
<tr>
<td>2020 Q3A KnowledgeBase</td>
<td>Audit Log Definitions (Panel-based UI)</td>
<td>Delete</td>
<td>Removed this section.</td>
</tr>
<tr>
<td>2020 Q2A KnowledgeBase</td>
<td>Data-Driven Rules - Panel-based UI</td>
<td>Add</td>
<td>Added a section called Procedure Reduction Records - Panel-based UI.</td>
</tr>
<tr>
<td>Version Release</td>
<td>Section/Field</td>
<td>Type</td>
<td>Revision</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2020 Q2A KnowledgeBase</td>
<td>Claim Purge Panel-based UI</td>
<td>Update</td>
<td>The notes for the Save and Run Now buttons have been revised.</td>
</tr>
<tr>
<td>2020 Q2A KnowledgeBase</td>
<td>Data-Driven Rules - Panel-based UI, Rule Editor Options</td>
<td>Update/Add</td>
<td>Added information for the rule editor functionality, including new statement options organized into groups and new buttons to add, copy, move or delete statements. Also added a new section called Rule Editor Options in the Appendix. Refer to the CM/CES_KB_2020_Q2A release notes document for complete information.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2020 Q1A KnowledgeBase</td>
<td>Rule Filtering Options</td>
<td>Add</td>
<td>Added a filter option for Dependency.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2020 Q1A KnowledgeBase</td>
<td>Enterprise Panel Functionality</td>
<td>Add</td>
<td>Added a section called Viewing the Medicaid Jurisdictions Fiscal Year.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2020 Q1A KnowledgeBase</td>
<td>Creating Custom DDRs</td>
<td>Add</td>
<td>Added new information about flags to Adding Additional Actions to a custom rule.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2020 Q1A KnowledgeBase</td>
<td>Importing List Data</td>
<td>Add</td>
<td>Added information, procedures and notes about importing data to a selected list.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2020 Q1A KnowledgeBase</td>
<td>Custom Reports, System Level Reports</td>
<td>Add</td>
<td>Added information and notes about Custom Reports and System Level Reports.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2020 Q1A KnowledgeBase</td>
<td>Rulesets Panel Functionality, Calculated Value Statements</td>
<td>Add</td>
<td>Added information about Rule Sort Order, Rules Filtering Options, and Calculated Value Statements.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2019 Q4A KnowledgeBase</td>
<td>Professional Claim Fields</td>
<td>Add</td>
<td>Added line fields and descriptions for NDC, NDC Units, NDC Units of Measure, Billing Provider CLIA ID, and Servicing Provider CLIA.</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2019 Q4A KnowledgeBase</td>
<td>Professional Claim Fields</td>
<td>Add</td>
<td>Added header fields and descriptions for Alternate Claim ID and Tracking Number.</td>
</tr>
<tr>
<td>Version Release</td>
<td>Section/Field</td>
<td>Type</td>
<td>Revision</td>
</tr>
<tr>
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<td>----------</td>
</tr>
<tr>
<td>5.4 SP2-CU02 + 2019 Q4A KnowledgeBase</td>
<td>Searching for an existing claim</td>
<td>Add</td>
<td>Added search fields and descriptions for Message Control ID and Sender ID.</td>
</tr>
<tr>
<td>5.4 SP2-CU02</td>
<td>Claim Purge Panel-based UI</td>
<td>Update</td>
<td>Added information to the Patient History field description to indicate that starting with 5.4 SP2-CU02, claim purge stored procedures are modified to save the DDR frequency claim data such that DDR frequency edits flag accurately upon purging.</td>
</tr>
<tr>
<td>5.4 SP2-CU02</td>
<td>Loading the KnowledgeBase</td>
<td>Update</td>
<td>Added information to describe multi-node configurations (High-Availability Cluster and Multi-App).</td>
</tr>
<tr>
<td>2019 Q4A KnowledgeBase</td>
<td>Professional Claim Fields</td>
<td>Add</td>
<td>Added a header field and description for Accident Indicator.</td>
</tr>
<tr>
<td>2019 Q4A KnowledgeBase</td>
<td>Audit Log Panel-based UI</td>
<td>Update</td>
<td>Added information about the Scope column and filter.</td>
</tr>
<tr>
<td>2019 Q4A KnowledgeBase</td>
<td>Assigning an LCD carrier in the Dynamic DDR user interface</td>
<td>Update</td>
<td>Added information about NCD carriers.</td>
</tr>
<tr>
<td>2019 Q4A KnowledgeBase</td>
<td>System lists and crosswalks - Panel-based UI</td>
<td>Add</td>
<td>Added new sections called Adding List Data and Copying or Overriding List Data.</td>
</tr>
<tr>
<td>2019 Q4A KnowledgeBase</td>
<td>Rulesets &gt; Route Properties Tab</td>
<td>Add</td>
<td>Added new sections called Copying a Route Property and Route Property Descriptions.</td>
</tr>
</tbody>
</table>
| 2019 Q3A KnowledgeBase | System Lists and Crosswalks - Panel-based UI | Add/Update | • Added a section called Renaming a list.  
• Added a section called Used in tab.  
• Revised the System lists and crosswalks - panel-based UI section for clarity. |
<p>| 2019 Q3A KnowledgeBase | Rulesets Panel Functionality | Update | Updated the Example Exception section to reflect the ability to specify a default flag for a Data-Driven rule that has mul- |</p>
<table>
<thead>
<tr>
<th>Version Release</th>
<th>Section/Field</th>
<th>Type</th>
<th>Revision</th>
</tr>
</thead>
</table>
| 2019 Q3A KnowledgeBase | Reporting - Panel-based UI | Add/Update | - Added a section called *KB Customization Report* (PE only).  
- Added a section called *Custom Reports* (FE).  
- Revised the *Reporting - panel-based UI* section for clarity. |
| 2019 Q3A KnowledgeBase | Data-driven Panel-based UI | Add/Update | - Added details about Notes functionality for custom rules, rulesets and exceptions.  
- Added information about adding a custom category to a system rule.  
- Updated Ruleset Status wording to reflect Ruleset Environment.  
- Updated screenshot displaying Calculated Value Statement as an option for an expression statement. |
<p>| 2019 Q3A KnowledgeBase | Historical Claims | Add | Added a section called <em>Data Import – panel-based UI</em>. |
| 2019 Q2A KnowledgeBase | Calculated Value Statements | Update | Calculated value statements have been grouped into categories for Dates, Lists, Math and Special. |
| 2019 Q2A KnowledgeBase | System Lists and Crosswalks - Panel-based UI | Add | Added a section called <em>System Lists and Crosswalks - panel-based UI</em>. |
| 2019 Q2A KnowledgeBase | User-Defined Fields - Panel-based UI | Update | Added information describing the ability to send multiple comma-separated values in a single UDF (UDF as a list) and usage in rules/routing. The section has also been updated to describe the ability to display or hide the UDFs created in the enterprise. |</p>
<table>
<thead>
<tr>
<th>Version Release</th>
<th>Section/Field</th>
<th>Type</th>
<th>Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 Q2A KnowledgeBase</td>
<td>Same Provider Configuration - Panel-based UI</td>
<td>Add</td>
<td>Added a new section called Same Provider Configuration - panel-based UI.</td>
</tr>
<tr>
<td>5.4 SP2-CU01</td>
<td>User-Defined Fields</td>
<td>Update</td>
<td>Added information indicating that the maximum number of UDFs is increased from 25 to 50 (XMLv2 claim file format only). Also added a new section called User-Defined Fields in Panel-Based UI.</td>
</tr>
<tr>
<td>5.4 SP2-CU01</td>
<td>Summary Reports</td>
<td>Update</td>
<td>Added information about the new Analysis Type dropdown menu.</td>
</tr>
<tr>
<td>5.4 SP2-CU01</td>
<td>Loading LCD Data</td>
<td>Update</td>
<td>Added information about loading multiple LCD data files.</td>
</tr>
<tr>
<td>2019 Q1A KnowledgeBase</td>
<td>Rulesets Panel Functionality</td>
<td>Add</td>
<td>Added a section called Copy Exceptions.</td>
</tr>
<tr>
<td>2019 Q1A KnowledgeBase</td>
<td>Appendix</td>
<td>Add</td>
<td>Added a section called Calculated Value Statements.</td>
</tr>
<tr>
<td>2018 Q4A KnowledgeBase</td>
<td>Multi-Tenant Installation</td>
<td>Update</td>
<td>Added information about enabling and disabling the use of tokens.</td>
</tr>
<tr>
<td>2018 Q4A KnowledgeBase</td>
<td>New Rule Options</td>
<td>Add</td>
<td>Added information about Calculated Value Statement.</td>
</tr>
<tr>
<td>2018 Q4A KnowledgeBase</td>
<td>Enterprise Properties</td>
<td>Add</td>
<td>Added sections for DDR Flag Prefix and DDRERR.</td>
</tr>
<tr>
<td>2018 Q4A KnowledgeBase</td>
<td>Enterprise Panel Functionality</td>
<td>Add</td>
<td>Added a section called DDRERR Edit Level information.</td>
</tr>
<tr>
<td>2018 Q4A KnowledgeBase</td>
<td>Audit Log Panel-based UI</td>
<td>Add</td>
<td>Added a section called Audit Logging of Dynamic DDR Actions.</td>
</tr>
<tr>
<td>2018 Q4A KnowledgeBase</td>
<td>Rulesets Panel Functionality</td>
<td>Add</td>
<td>Added a section called Shared Exceptions.</td>
</tr>
<tr>
<td>2018 Q3A KnowledgeBase</td>
<td>Multi-Tenant Installation</td>
<td>Add</td>
<td>This section describes how to use the multi-tenant functionality. Notes related to</td>
</tr>
<tr>
<td>Version Release</td>
<td>Section/Field</td>
<td>Type</td>
<td>Revision</td>
</tr>
<tr>
<td>-----------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2018 Q3A KnowledgeBase</td>
<td>Disabling ILOG Rules</td>
<td>Add</td>
<td>This section describes how to disable ILOG rules within custom ILOG rulesets.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>XMP Connection Settings</td>
<td>Update</td>
<td>Added a section called Return Related Fields.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>User Management Permission Privilege Map</td>
<td>Update</td>
<td>Expanded the tables to include information about multi-tenant role functionality and the Rule Developer role.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>DDR FE LCD Rule Key Considerations</td>
<td>Update</td>
<td>This section was updated to indicate that two additional rules for the LCD Rule Excludes Broad Diagnostic have been added. A table with rule names and descriptions was also added. (FE only)</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Data-Driven Ruleset Option</td>
<td>Delete</td>
<td>This section has been removed.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Claim Purge</td>
<td>Add/Delete</td>
<td>This section describes the panel-based Purge functionality. The Purging Claims section (which describes the old purge functionality) has been removed.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Reduction Records</td>
<td>Add</td>
<td>Added the Entering Decimal Values in the Procedure Reduction User Interface section.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Working with Pattern Flags</td>
<td>Update</td>
<td>Updated to indicate that if a flag contains multiple flags or flags by line of business, they will display.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Creating Enterprises</td>
<td>Add</td>
<td>Added a note indicating that claim processing should be stopped while a client creates a new enterprise.</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Glossary</td>
<td>Add/Update</td>
<td>Definitions for multi-tenant and tenant were added. The name of the &quot;New UI&quot; glossary term was changed to &quot;panel-based UI.&quot;</td>
</tr>
<tr>
<td>Version Release</td>
<td>Section/Field</td>
<td>Type</td>
<td>Revision</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------</td>
<td>------</td>
<td>----------</td>
</tr>
<tr>
<td>5.4 SP1-CU05</td>
<td>Various sections</td>
<td>Update</td>
<td>The user interface is now referenced as “panel-based UI” instead of “New UI” for the user interface’s panel-based functionality.</td>
</tr>
<tr>
<td>2018 Q2A KnowledgeBase</td>
<td>New User Management Interface</td>
<td>Update</td>
<td>This section has been revised to include scoping of user roles as <strong>System or Enterprise</strong>. In addition, the User Account panel now displays username and password requirements and provides the option to map a role to multiple enterprises in a single selection.</td>
</tr>
<tr>
<td>2018 Q2A KnowledgeBase</td>
<td>Creating Custom DDRs</td>
<td>Add</td>
<td>Added a section called <strong>Adding an additional flag by Line of Business.</strong></td>
</tr>
<tr>
<td>2018 Q2A KnowledgeBase</td>
<td>Copying System Data-Driven Rules</td>
<td>Add</td>
<td>Added a section called <strong>Adding Multiple Flags by Line of Business.</strong></td>
</tr>
<tr>
<td>2018 Q2A KnowledgeBase</td>
<td>Flags Panel Functionality</td>
<td>Add</td>
<td>Added a section called <strong>Multiple Flags by Lines of Business.</strong></td>
</tr>
<tr>
<td>2018 Q2A KnowledgeBase</td>
<td>DDR LCD Rule</td>
<td>Update</td>
<td>Updated this section to include information for FE (Facility).</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Data-Driven rules (DDR) – Static DDR</td>
<td>Add</td>
<td>A new section called <strong>Accessing Static Data-Driven rulesets</strong> was added.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Data-Driven rules – Panel-based UI</td>
<td>Add</td>
<td>A new section called <strong>Accessing the Dynamic Data-Driven UI</strong> was added.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Claim Routes</td>
<td>Add/Update</td>
<td>In the <strong>Destination rulesets</strong> section, there are now three options to select rulesets for the route. This allows the ability to choose a Data-Driven ruleset to Run First, then select a Legacy Ruleset and then the option to choose a Data-Driven ruleset to Run Last.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Data-Driven rules – Panel-based UI</td>
<td>Update</td>
<td>The <strong>Panel-Based Navigation</strong> section has been updated to reflect that the <strong>System Tab &gt; Configuration &gt; Claim processing</strong> tab is no longer a valid setting due to the <strong>Destination rulesets</strong> functionality mentioned above. This functionality will be</td>
</tr>
<tr>
<td>Version Release</td>
<td>Section/Field</td>
<td>Type</td>
<td>Revision</td>
</tr>
<tr>
<td>-----------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Data-Driven rules – Panel-based UI</td>
<td>Add/Update</td>
<td>The Ruleset &gt; Properties Tab section was updated to reflect the Name, Processing Order and Environment fields, including a new screenshot. Processing Order is new functionality that works in coordination with the Destination ruleset update for the Run Last functionality.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Data-Driven rules – Panel-based UI</td>
<td>Add</td>
<td>The Rules &gt; Properties Tab section was updated to reflect a new field called Execution type that identifies if a rule executes at a claim-level or line-level.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Importing and Exporting Custom DDR Rules</td>
<td>Add</td>
<td>A section called Importing and Exporting Custom DDR Rules was added.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Audit Log Panel-based UI</td>
<td>Add</td>
<td>Added a row to the Application Version and Audit Log Compatibility table to indicate that if a user has 5.4 SP1-CU04 or later installed and 2017 Q4B KnowledgeBase or earlier loaded, the Audit Log will not be available.</td>
</tr>
<tr>
<td>5.4 SP1-CU04</td>
<td>Glossary</td>
<td>Add</td>
<td>Definitions for Legacy UI, New UI and UI were added.</td>
</tr>
<tr>
<td>2018 Q1B KnowledgeBase</td>
<td>Rules Panel Functionality</td>
<td>Add</td>
<td>Added information about the Execution Type field. Also updated the screen capture to reflect this functionality.</td>
</tr>
<tr>
<td>2018 Q1A KnowledgeBase</td>
<td>Audit Log Panel-based UI, Audit Log Definitions (panel-based UI)</td>
<td>Add</td>
<td>The Audit Log Panel-based UI and Audit Log Definitions (panel-based UI) sections describe how to use this functionality.</td>
</tr>
<tr>
<td>5.4 SP1-CU03</td>
<td>Reporting - New User Interface (UI)</td>
<td>Add</td>
<td>This new section outlines the Reporting - New UI. This interface is similar to the new Data-Driven Rules UI, with a panel-based infrastructure, that allows users to create reports.</td>
</tr>
<tr>
<td>5.4 SP1-CU03</td>
<td>DDR - Panel-based</td>
<td>Update</td>
<td>Updated screen captures to reflect insert</td>
</tr>
<tr>
<td>Version Release</td>
<td>Section/Field</td>
<td>Type</td>
<td>Revision</td>
</tr>
<tr>
<td>-----------------</td>
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<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UI: Flag message section</td>
<td>parameters that now distinguish Current claim parameters from History claim parameters. Updated custom rule flag message capabilities to include inserting parameters from all of the claim fields and ability to choose history claim fields.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 SP1-CU03</td>
<td>DDR - Panel-based UI: Delete functionality</td>
<td>Update</td>
<td>Replaced previous trashcan functionality with red X delete functionality related to removing enterprise overrides or expression condition statements.</td>
</tr>
<tr>
<td>5.4 SP1-CU03</td>
<td>DDR - Panel-based UI: Expression claim field search functionality</td>
<td>Update</td>
<td>Updated the search bar functionality used when writing an expression and choosing a claim field.</td>
</tr>
<tr>
<td>5.4 SP1-CU03</td>
<td>DDR - Panel-based UI: Exception sequence</td>
<td>Update</td>
<td>Updated to reflect that rules added by exception will run before rules suppressed by exception to ensure proper processing.</td>
</tr>
<tr>
<td>5.4 SP1-CU03</td>
<td>DDR - Panel-based UI: Export ruleset details to a spreadsheet</td>
<td>Add</td>
<td>Ability to export ruleset details for a single ruleset, multiple rulesets or at a global level.</td>
</tr>
</tbody>
</table>
| 5.4 SP1-CU03    | New User Management Interface | Add   | • Read-only login.  
• Privileges are simplified and more intuitive.  
• The concept of a Membership has been added. This allows a user to be assigned different roles in different enterprises.  
• LDAP (Lightweight Directory Access Protocol) enhances the security of password authentications. |
| 5.4 SP1-CU03    | Professional Claim Fields | Add   | Billing and Servicing Provider NPI value fields have been added to the Claim Results screen (for Claim Browse and Claim History) and the Add/Edit Claim screens (for Professional). |
Glossary

The following terms are used in this documentation.

A

adjusted value
The adjusted value in a crosswalk means the standard value that the system uses for analysis, in place of the value that was submitted. See also: Crosswalk, Submitted Value.

anesthesia crosswalk
This KnowledgeBase table correlates Surgical (non-Anesthesia) procedure codes with Anesthesia procedure codes. The crosswalk codes can have one of the following status codes: BR – “By Report,” IC – “Individual Consideration,” NA – “Not Applicable,” or SC – “Add On” DC – “Direct Crosscode Match.”

B

By Report
BR Status in the Anesthesia Crosswalk table.

C

CMS-1500
Physician Claim Form - Formerly the HCFA-1500 form. Used by physicians to bill for their services.

code repository
The section of the system interface that provides access to the KB (KnowledgeBase) data.

code set
Medical code and the associated records (e.g., procedure code 71010 and the max frequency, gender, and age range associated with 71010).
CR&D
Clinical Research and Development Team - a group of clinicians, physicians, nurses, and coders that maintain the KB data and provide clinical support.

crosswalk
A way of matching unique user codes to equivalent standardized codes. See also: Submitted Value and Adjusted Value.

data
Any form of information that exists in the system, such as claim records, patient records, crosswalks, etc.

database
The term "database" generally refers to all of the data stored for claims analysis. This includes the Optum KnowledgeBase plus any user-defined data, such as patients, providers, departments, etc.

Direct Crosscode
BR Status in the Anesthesia Crosswalk table. A definitive crosswalk has been established between the surgical procedure code and the anesthesia procedure code.

disabled
Disabled codes include any code in the KnowledgeBase (procedure codes, diagnosis codes, modifiers, etc.) that has been disabled by an override.

disclosure
Edit rationale and sourcing for the KnowledgeBase edit/relationship.

dropped line
A rule can "drop" a claim line if it determines that it cannot be properly analyzed. When a claim line is dropped, it is ignored by all of the rules except those that have the "run on dropped lines" setting enabled.
E

effective
   A code or relationship in the KnowledgeBase is only valid, or in effect, between its beginning and ending dates. If a code has no ending date, it is valid for any time past the beginning date.

effective code
   The code that is present in the KnowledgeBase and the date of service is between the effective date and expiration date. This is dependent on the KB selection date.

effective dates
   Effective dates are the beginning and ending dates for codes or relationships in the KnowledgeBase. Outside of this date range, the code or relationship is considered invalid.

enterprise
   An exclusive domain that exists to protect a block of data. Only users assigned to an enterprise can access the data associated with that enterprise. This makes the data secure from users who should not be allowed to view or work with that data.

expired code
   This code is found in the KB, but the Date of Service (DOS) is later than the Expiration Date.

F

facility claims
   Facilities typically bill insurance payers using either the paper UB-92 or UB-04 forms, or the electronic 837I Message format.

G

gender codes
   Gender codes are single character codes that describe the gender of the patient. Optum generally recognizes three genders by default: F (female), M (male), and U (unknown or undefined).
ICD-10-CM
International Classification of Diseases (ICD), Tenth revision (-10), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval. These codes allow more specific reporting of diseases and patient conditions.

ICD-9-CM
International Classification of Diseases (ICD), Ninth revision (-9), Clinical Modification (-CM) classifies morbidity and mortality information for statistical purposes. It is also used for the indexing of hospital records by disease and operations, and for data storage and retrieval.

incurred date
The Beginning Date of Service (BDOS) on the claim line.

Individual Consideration
IC status in the Anesthesia Crosswalk table. This means a definitive crosswalk cannot be established. When multiple anesthesia service codes could be mapped to a given procedure code, the Status Indicator is IC.

invalid code
The code is not found in the Code Repository. See also: KnowledgeBase.

jurisdiction
The specific geographical area serviced by a single Medicaid Administrator. Since Medicaid policies can vary at the regional level, the Centers for Medicare and Medicaid Services (CMS) works with independent Medicaid Administrators to develop and publish these policies within their assigned geographical jurisdictions. The size of jurisdictions can vary from an area within a single state to an area combining several states.
**KB selection date**
The date that should be used when getting information from the KnowledgeBase (KB). This will be either the incurred or processed/entry date for each ruleset. See also: Incurred Date, Processed/Entry Date, Ruleset, KnowledgeBase.

**KnowledgeBase**
The Optum KnowledgeBase is a compiled and sourced database of many different medical code sets, published quarterly by Optum. The KnowledgeBase includes standard codes, definitions, and coding relationships, including unbundle and CCI relationships.

**legacy UI**
The legacy UI (User Interface) is the original UI that includes much of the traditional page-based screens. Delivery of the legacy UI updates are part of the Cumulative Update (CU) process.

**line of business**
A category assigned to data-driven rule patterns to help distinguish what kind of business is involved (e.g., Medicaid, Medicare, Commercial, ASC, DME, etc.).

**medical code**
Type of codes that can be overridden. Includes Procedure (CPT), Medical Supplies/Drugs/Procedures (HCPCS), Diagnosis (ICD-9), Modifier Code, Type of Bill, or Revenue Codes.

**modifier**
A two-digit code that is supplied along with a procedure code to show that the procedure performed was different than the basic procedure. The KnowledgeBase includes both CPT and HCPCS modifiers.

**multi-tenant**
CM and CES can be installed as a multi-tenant solution by applying a multi-tenant license. This is done in cases where the software is hosted by one
organization so it can be used by many other organizations (tenants) that want to benefit from its functions but need to keep their data and configuration information separate and secure.

negative table
The codes referenced in the table are not appropriate. When they are used together, a flag will be issued.

Not Applicable
NA status in the Anesthesia Crosswalk table. This means a definitive crosswalk cannot be established. If the CPT® description states "without anesthesia," the Status Indicator is NA and no crosswalk is established. If a non-anesthesia procedure code can be allowed in addition to the anesthesia services, an NA status is assigned to the code that is additionally allowed.

origin
The origin of a code in the Code Repository, or KnowledgeBase, is the Enterprise that the code (or any change to it) applies to.

override
A user-specified record in the KnowledgeBase. An override includes a system record that the user has modified (to change the values or disable) as well as a new record created by the user (e.g., to add codes).

panel-based UI
The panel-based UI is the enhanced UI structure that the product is moving towards. It is panel-based and allows more flexibility for future functionality. Delivery of the panel-based UI updates is part of the KnowledgeBase process.

patient ID
The "PatientID" field on the claim header. Every patient must have a unique Patient ID.
permissions
The rights to perform specific tasks in the system. Just as enterprises control access to data, permissions control usage of data.

physician claims
Physicians typically bill insurance payers for their services using either the paper CMS-1500 form or the electronic 837P Message format.

positive table
The codes referenced in the table are appropriate. When they are used together, no flag will be issued.

privilege
A logically combined set of permissions. Existing permissions have been converted into privileges. For example: Edit Claims and Create Claims permissions can be combined to create a new privilege called Edit Claims, allowing the user to create and edit claims.

procedure code
The Optum KnowledgeBase contains several kinds of procedure codes, including CPT codes, HCPCS codes, T codes, and S codes.

processed/entry date
The date the claim line is being processed.

record
The KnowledgeBase relationship that applies to a code set (e.g., procedure code and appropriate gender).

Rule Elements
Every rule in the system is made up of logical building blocks, which direct the system how to react when certain conditions are met during claims analysis. These building blocks are known as "rule elements."

ruleset
A list of rules that the system uses to analyze a particular claim or claim line. Rulesets provide settings for the rules they list, so the same rule can behave differently because of the ruleset that runs it.
S

scope
The scope of a code in the Code Repository, or KnowledgeBase, is the enterprise or ruleset that the original code (or a change to it) applies to.

Secondary Code
SC Status in the Anesthesia Crosswalk table. i.e., a definitive crosswalk cannot be established. If the service is an Add-on procedure, the Status Indicator is SC. The appropriate Anesthesia Crosswalk is attached to the primary procedure and not to the Add-on code. Therefore, this Status Indicator is for informational purposes only.

source
A recognized entity (publication, government agency, etc.) that validates a coding relationship (such as procedure to modifier, procedure to ICD, procedure to procedure) or coding attribute (valid age range, gender, maximum daily frequency, or global period).

Status - Medicare
Indicates whether the code is in the MPFS and whether the service is covered or separately payable. The current valid Status indicators are: A – Active Codes. These codes are paid separately, if covered. B – Bundled Codes. These codes are not paid separately. C – Codes priced by the carrier. The RVUs for these codes are determined by the carrier. D – Deleted Codes. These are codes which are no longer covered. E – Excluded from fee schedule by regulation. These codes are for items and services that CMS excludes from the fee schedule, by regulation. F – Deleted/Discontinued Codes. H – Deleted Modifier. These codes had an associated modifier in the previous year. I – Not valid for Medicare purposes. N – Non-covered services. These services are not covered by Medicare. P – Bundled/Excluded Codes. R – Restricted Coverage. T – Injections X – Statutory Exclusion.

submitted value
The submitted value is the original code sent on the claim. The system may be set up to crosswalk this original value to a standard code, called an adjusted value. See also: Adjusted Value, Crosswalk.
**system-updated data**
Data that cannot be modified manually, but can only change by running an update or an import. However, usually overrides can be created as substitute entries for this kind of data.

**system list**
A list maintained by the Clinical Research and Development (CR&D) team and used for rule validation.

**tenant**
An organization that shares use of the software with other unrelated organizations (tenants). The “tenant” construct was added to the software to ensure that data associated with one tenant can never be viewed or accessed by other tenants. It also prevents claims belonging to one tenant from being routed to enterprises belonging to another tenant.

**TOS**
Type of Service. The TOS Indicator on the CMS-1500 claim line is a single-digit code that describes the service rendered. TOS codes can be crosswalked, but are not crosswalked by default.

**UB-04**
Facility (institutional) claim form - The "Universal Billing 2004" form is a replacement for the UB-92 form, used to bill facility (institutional) charges for both inpatient and outpatient services.

**UB-92**
Facility (institutional) claim form - The "Universal Billing 1992" form is used by facilities (or institutions) to bill for both inpatient and outpatient services. Also called the CMS-1450.

**unlisted codes**
A set of procedure codes designated by CPT for reporting unlisted procedures. See Unlisted procedure.
unlisted procedure
A procedure or service performed by a physician that is not found in the CPT codebook. Unlisted procedures are reported using CPT's "unlisted codes." See Unlisted codes.

user-updated data
Data that remains stored in the system and does not change unless someone intentionally modifies it.

user account
Needed to authenticate a user and all logins to the system. Memberships are added to the user account to authorize the user to perform functions that are granted by specific roles (see the User Roles section).

user defined lists
Lists created by a user to be used in rules.

user interface (UI)
The screens, pages and visual elements such as buttons and icons that you use to interact with a device.

user role
A set of standard privileges grouped together for a user to grant access to the corresponding or assigned modules. User roles can be seen only at the system level. There are two types of user roles – system and custom roles.

valid code
A code that is in the KnowledgeBase but can have different attributes that can affect the flag issues (not yet effective or expired).

validation list
A list of codes used to check if a submitted value is valid. If the code is on the list, it is considered valid.
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