BCoE General Implementation Configuration

In this course you will learn what to look for and the steps to complete when making Implementation changes to contracts for New Groups, Rebids and Renewals.

- General Implementation Information
- ABRT, ACUP, All BH, BLOO and CARH
- CHEM, CHIR, CRSP, DEDU and DENT
- DIAG, DIAS, and DMES/MDSP/PROP
- DRUG, ECIS/EPSD, EDMS, EMPS, ERSV, ESRD
- EXIS, FMPL, GBSU, GENT and GNDR
- GUAC, HCPS, HEAR, HEHM
- HMHC, HOSP, IMVA/VCFP and INFS
- IPAC, All LTSS, LHDM, MOOP, NURH
- OCOA, OTRH, OUTP, PODS and PRDN

- **PREV, RESP, RSST, SCHL and SELF**
- **SMCS, SNFS, STRH, TCMS and TRNS**
- **TRPT, VABS, VISN, WEBT and WEIT**
- **CONGRATULATIONS!**

General Implementation Information

General Information

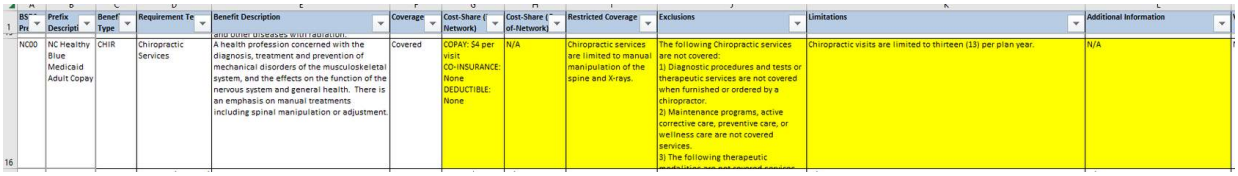
- The information contained in this module comes from the C.O.R.E. Policy and Procedure Document contained in the SharePoint here: General Implementation Configuration Document
- Configuration tickets for BRD are split out by Benefit Type by the BA, with the exception of benefits that are utilized by Medicare that are not utilized by Medicaid. However, these can change year to year.
- The Analyst will receive a spreadsheet wherein the BA has captured all benefit requirements which have gone through IBC and been approved by the health plan. Associates will focus on the Benefit Type(s) they have been assigned. In general codes will be provided by the BA on the tickets, unless otherwise noted.
- If there is a rebid, only the Benefit Types that are changing will come through.
- Authorizations have to come through HCMS Team, and go through the UMAROW Committee. If unsure about an authorization issue, reach out to the Designated Buddy. Use Encoder Pro to look at Revenue Codes.
- Behavioral Health Benefit Types (6) all tend to be grouped together, as do LTSS Benefit Types (16).
- There are Benefit Types that appear on the BRD that are not covered on this document as they are not covered by Medicaid and thus do not need to be configured. If an Analyst receives a ticket for a type not covered below, i.e. Telemonitoring, and the BRD is not clear, please contact the Designated Buddy for further guidance.

1	BSB Prefix	Prefix Description	Benefit Type	Requirement Tex	Benefit Description	Coverage
100	NC00	NC Healthy Blue Medicaid Adult Copay	TMON	Telemonitoring	Telemonitoring services include in-home equipment and telecommunication technology from contracted vendors to monitor members with specific health conditions. An initial physician visit and a physician's order for monitoring of data related to a specific diagnosis are required. Physicians determine the frequency of data transmission, and are trained on monitoring protocols and follow-up actions required. The member is instructed on the use of equipment, proper transmission and related processes. Telemonitoring services supplement but do not replace face-to-face physician visits.	Not Covered. This benefit type is not utilized under this Medicaid product or plan.

What to Look for in the BRD

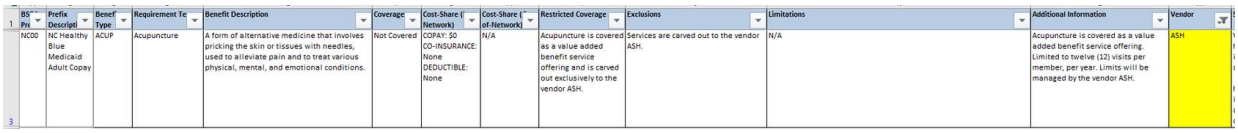
- Is there a Cost Share? Will it apply to other Benefit Types? For example, if there is a $4 cost share for an office visit for physician service, usually that $4 visit copay applies to other services that can be done in a physician office as well.

- Are there Restrictions? Exclusions? Limitations? Additional Information? If so, are they configurable, or just FYI?



1	BS Pr	Prefix Descripti	Benef Type	Requirement Te	Benefit Description	Coverage	Cost-Share (Network)	Cost-Share (of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
16	NC00	NC Healthy Blue Medicaid Adult Copay	CHIR	Chiropractic Services	A health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.	Covered	COPAY: $4 per visit CO-INSURANCE: None DEDUCTIBLE: None	N/A	Chiropractic services are limited to manual manipulation of the spine and X-rays.	The following Chiropractic services are not covered: 1) Diagnostic procedures and tests or therapeutic services are not covered when furnished or ordered by a chiropractor. 2) Maintenance programs, active corrective care, preventive care, or wellness care are not covered services. 3) The following therapeutic	Chiropractic visits are limited to thirteen (13) per plan year.	N/A

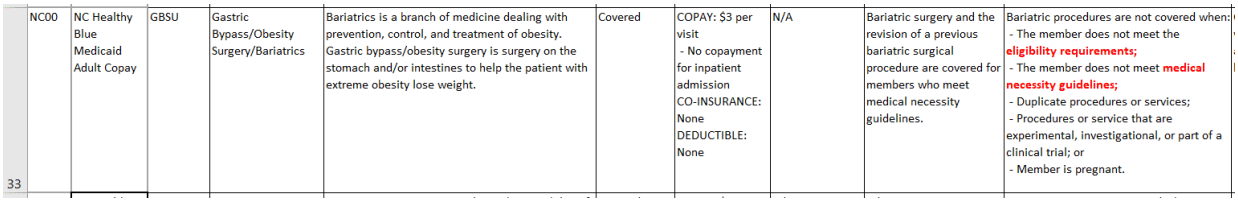
- Is there a Vendor? There are some generic "deny to vendor" service rules, while some vendors have specific service rules, e.g. ASH. If a vendor is listed in Column M or Q, there will also be something in the preceding Columns stating it is carved out to the vendor if Configuration is needed. Sometimes a reference phone number will be listed in the vendor column without an actual carve-out existing.



	BS Pri	Prefix Descripti	Benef Type	Requirement Te	Benefit Description	Coverage	Cost-Share (Network)	Cost-Share (of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
3	NC00	NC Healthy Blue Medicaid Adult Copay	ACUP	Acupuncture	A form of alternative medicine that involves pricking the skin or tissues with needles, used to alleviate pain and to treat various physical, mental, and emotional conditions.	Not Covered	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	N/A	Acupuncture is covered as a value added benefit service offering and is carved out exclusively to the vendor ASH.	Services are carved out to the vendor ASH.	N/A	Acupuncture is covered as a value added benefit service offering. Limited to twelve (12) visits per member, per year. Limits will be managed by the vendor ASH.	ASH

- BRDs may look slightly different from product to product as templates are updated over time. Despite differences in the number of Columns, the information covered remains the same.

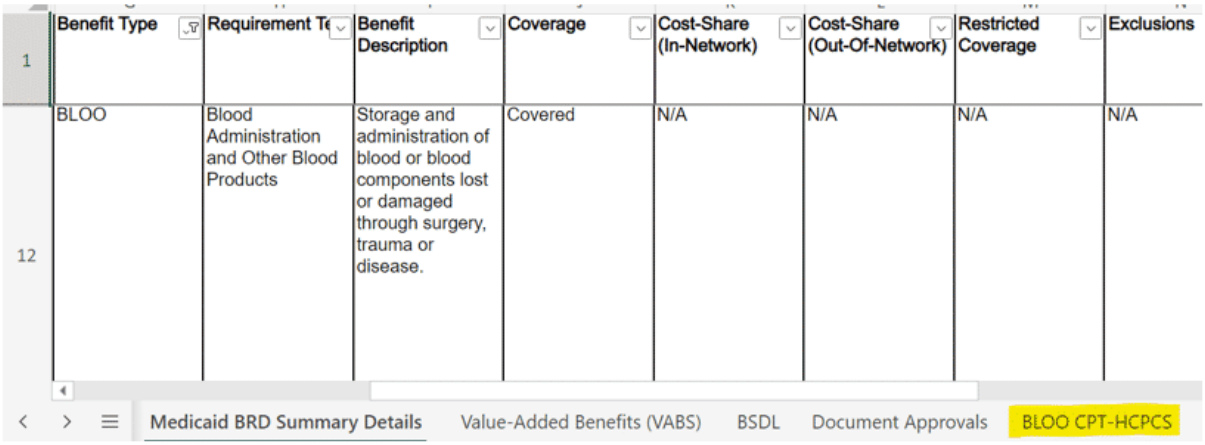
- The word "authorization" is avoided in recent BRDs, so look for key words like "case management" or "medical necessity" or "eligibility" to determine if UM or another body has to determine and code a level of care.



33	NC00	NC Healthy Blue Medicaid Adult Copay	GBSU	Gastric Bypass/Obesity Surgery/Bariatrics	Bariatrics is a branch of medicine dealing with prevention, control, and treatment of obesity. Gastric bypass/obesity surgery is surgery on the stomach and/or intestines to help the patient with extreme obesity lose weight.	Covered	COPAY: $3 per visit - No copayment for inpatient admission CO-INSURANCE: None DEDUCTIBLE: None	N/A	Bariatric surgery and the revision of a previous bariatric surgical procedure are covered for members who meet medical necessity guidelines.	Bariatric procedures are not covered when: - The member does not meet the **eligibility requirements;** - The member does not meet **medical necessity guidelines;** - Duplicate procedures or services; - Procedures or service that are experimental, investigational, or part of a clinical trial; or - Member is pregnant.

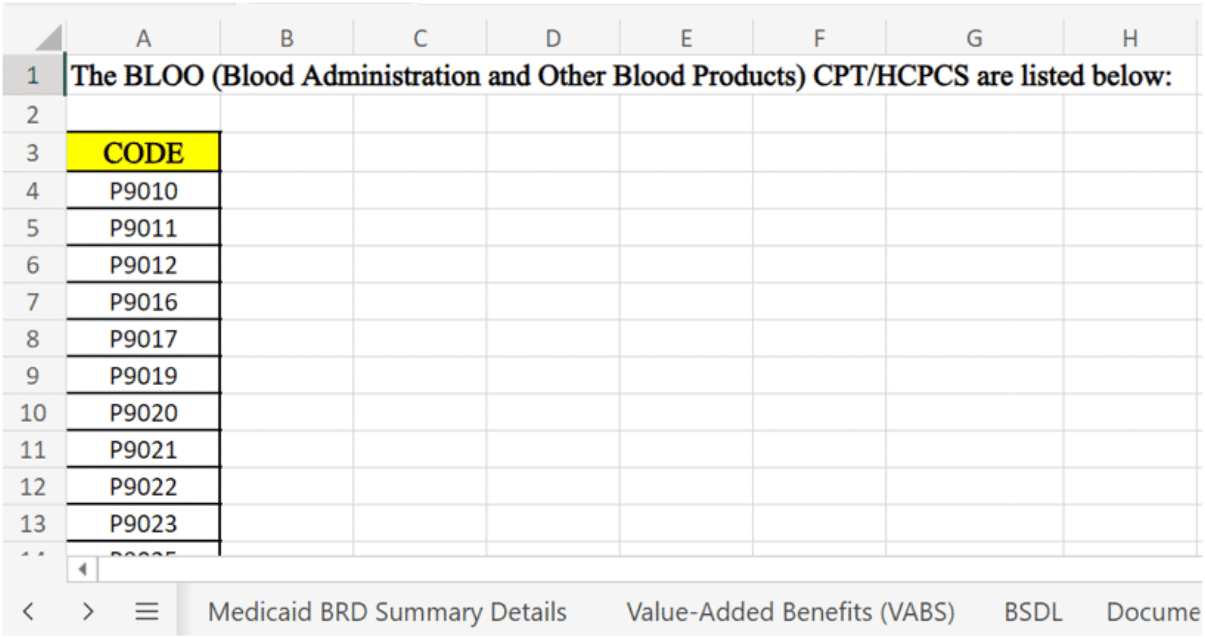
Emphasis added for the sake of the lesson

- Newer BRDs have separate sheets with listings of codes encompassed by different Benefit Types.



	Benefit Type	Requirement Te	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusions
1								
12	BLOO	Blood Administration and Other Blood Products	Storage and administration of blood or blood components lost or damaged through surgery, trauma or disease.	Covered	N/A	N/A	N/A	N/A

Medicaid BRD Summary Details | Value-Added Benefits (VABS) | BSDL | Document Approvals | BLOO CPT-HCPCS



	A	B	C	D	E	F	G	H
1	The BLOO (Blood Administration and Other Blood Products) CPT/HCPCS are listed below:							
2								
3	CODE							
4	P9010							
5	P9011							
6	P9012							
7	P9016							
8	P9017							
9	P9019							
10	P9020							
11	P9021							
12	P9022							
13	P9023							

Medicaid BRD Summary Details | Value-Added Benefits (VABS) | BSDL | Docume

- There will ALWAYS be questions, so it is expected that Analysts may need to reach out to their Designated Buddy or the BA who worked on the BRD for clarification on some issues. It is better to ask the question than to send through incorrect benefit information.

T/F: There may be differences between BRDs based on when they were created.

- ◯ True
- ◯ False

SUBMIT

Which of these phrases may indicate UM is involved with the benefit? Choose all that apply.

- ☐ case management
- ☐ medical necessity
- ☐ claims ops

- [ ] eligibility requirements

SUBMIT

T/F: An Analyst should always figure things out on their own and never reach out to their Designated Buddy or BA.

- ( ) True
- ( ) False

SUBMIT

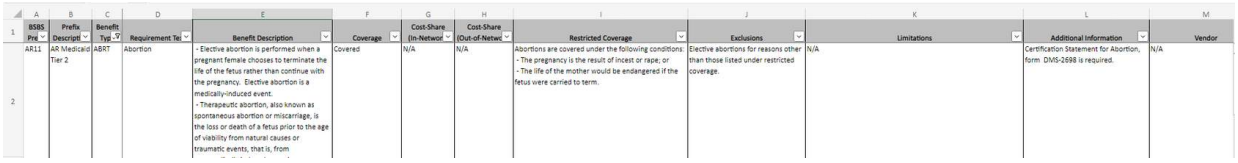
As you continue through this training, examples will be shown from various BRDs that are current as of this module's creation. They are for example only, and may not reflect the BRDs that you receive in the future.

CONTINUE

ABRT, ACUP, All BH, BLOO and CARH

ABRT: Abortion

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The ASH (Abortion/Sterilization/Hysterectomy) Committee finds out if the Health Plan will follow our standard code list. The ASH list has all the procedure diagnosis codes and exclusions that get configured by Claims Operations. Configuration will need to ensure if there is any Cost Share that needs to be configured. The BA will already have reached out to Janet Partin who owns/maintains the ASH standard code list before it comes to the Configuration team. If Abortion is NOT covered, then that should come through to the Configuration team with the needed codes that go along to have them set up as Non-Covered.



BSBS Pre	Prefix Descript	Benefit Typ	Requirement Ty	Benefit Description	Coverage	Cost-Share (In-Networ	Cost-Share (Out-of-Netwo	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
AR11	AR Medicaid Tier 2	ABRT	Abortion	- Elective abortion is performed when a pregnant female chooses to terminate the life of the fetus rather than continue with the pregnancy. Elective abortion is a medically-induced event. - Therapeutic abortion, also known as spontaneous abortion or miscarriage, is the loss or death of a fetus prior to the age of viability from natural causes or traumatic events, that is, from	Covered	N/A	N/A	Abortions are covered under the following conditions: - The pregnancy is the result of incest or rape; or - The life of the mother would be endangered if the fetus were carried to term.	Elective abortions for reasons other than those listed under restricted coverage.	N/A	Certification Statement for Abortion, form DMS-2698 is required.	N/A

ACUP: Acupuncture

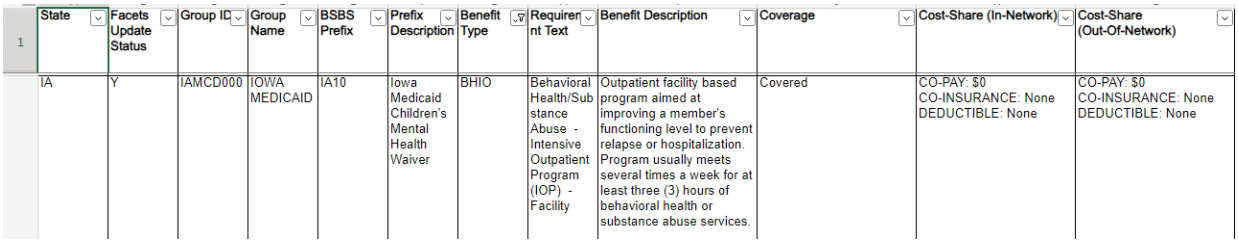
Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This can be covered by us and/or covered as part of a Value Added Benefit. It can also be carved out to a vendor, for instance, American Specialty Health (ASH.) The codes will be supplied and if carved out to a vendor will need to deny to the vendor. In the situation

where the service is carved out to the vendor, then any limits would also be handled by the vendor and would not need to be configured in Facets.

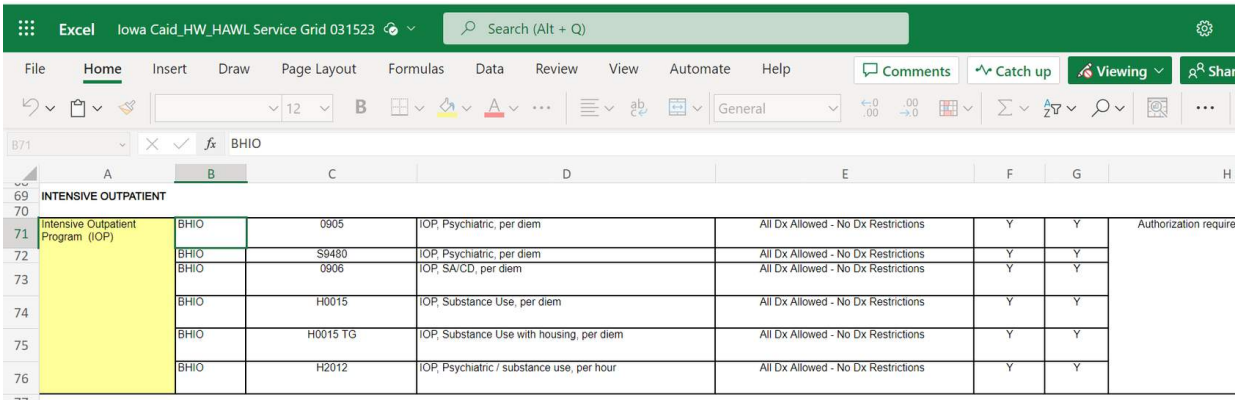
BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Netw	Restricted Coverage	Exclusions	Limitations	Additional Informati	Vendor
NC08	NC Healthy Blue Medicaid Child No Copay	ACUP	Acupuncture	A form of alternative medicine that involves pricking the skin or tissues with needles, used to alleviate pain and to treat various physical, mental, and emotional conditions.	Not Covered	N/A	N/A	Acupuncture is covered as a value added benefit service offering for members 18 years of age and older. Acupuncture is carved out exclusively to the vendor ASH.	Carved out to the vendor ASH.	N/A	N/A	ASH

BH: All Behavioral Health (BHCS, BHIO, BHIP, BHOP, BHPH, BHRT)

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The most important item listed on the BRD is the Cost Share, as the BH grid (https://collaborate.wellpoint.com/sites/HCMSBehavioralHealth/Service%20Grids/Forms/Edit.aspx) has all of the other needed information for Configuration EXCEPT Cost Share. Always read the BRD carefully and ask for clarification if necessary. The BH Grid is not an exact one-to-one to the Benefit Types in the BRD, but are similar enough to easily match up.



State	Facets Update Status	Group ID	Group Name	BSBS Prefix	Prefix Description	Benefit Type	Requirent Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)
IA	Y	IAMCD000	IOWA MEDICAID	IA10	Iowa Medicaid Children's Mental Health Waiver	BHIO	Behavioral Health/Substance Abuse - Intensive Outpatient Program (IOP) - Facility	Outpatient facility based program aimed at improving a member's functioning level to prevent relapse or hospitalization. Program usually meets several times a week for at least three (3) hours of behavioral health or substance abuse services.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None



From the Iowa Behavioral Health Grid, found through https://collaborate.wellpoint.com/sites/HCMSBehavioralHealth/Service%20Grids/Forms/Edit.aspx

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BLOO: Blood

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Sometimes there will be a limitation but it is rare. Codes should be supplied.

	BSBS Pre	Prefix Descripti	Benefit Typ	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Networ	Cost-Share (Out-of-Netwo	Restricted Coverage	Exclusions	Limitation	Additional Information
10	AR12	Arkansas Medicaid Tier 3	BLOO	Blood Administration and Other Blood Products	Storage and administration of blood or blood components lost or damaged through surgery, trauma or disease.	Covered	N/A	N/A	N/A	N/A	N/A	N/A

CARH: Cardiac Rehabilitation Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The ticket should have codes provided.

	BSBS Pre	Prefix Description	Benefit Type	Requirement Tei	Description	Coverage	Cost-Share (In-Network	Cost-Share (Out-of-Netwo	Restricted Coverage	Exclusions	Limitations	Additional Information
11	CO09	CO CCHA Medicaid Behavioral Health	CARH	Cardiac Rehabilitation Services	Cardiac rehabilitation is a program recommended for patients who have had a heart attack, angina, congestive heart failure, or other forms of heart disease or those who have undergone heart surgery. A	Not Covered	N/A	N/A	N/A	Medical related services are not covered and are carved out to CCHA who administers the Physical Health (medical) benefits.	N/A	N/A

The usual vendor for Acupuncture is:

- ◯ The state

- ◯ American Specialty Health (ASH)
- ◯ Alternative Medicine Association (AMA)

SUBMIT

The BRD provides the _____ for Behavioral Health Services, but the rest of the needed information is in the Behavioral Health Grid.

Type your answer here

SUBMIT

T/F: BLOO and CARH tickets should have codes provided on the tickets.

- ◯ True

False

SUBMIT

CONTINUE

CHEM, CHIR, CRSP, DEDU and DENT

CHEM: Chemotherapy/Radiation

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Look for procedure codes, including J codes. Typically there are no exclusions or limitations.

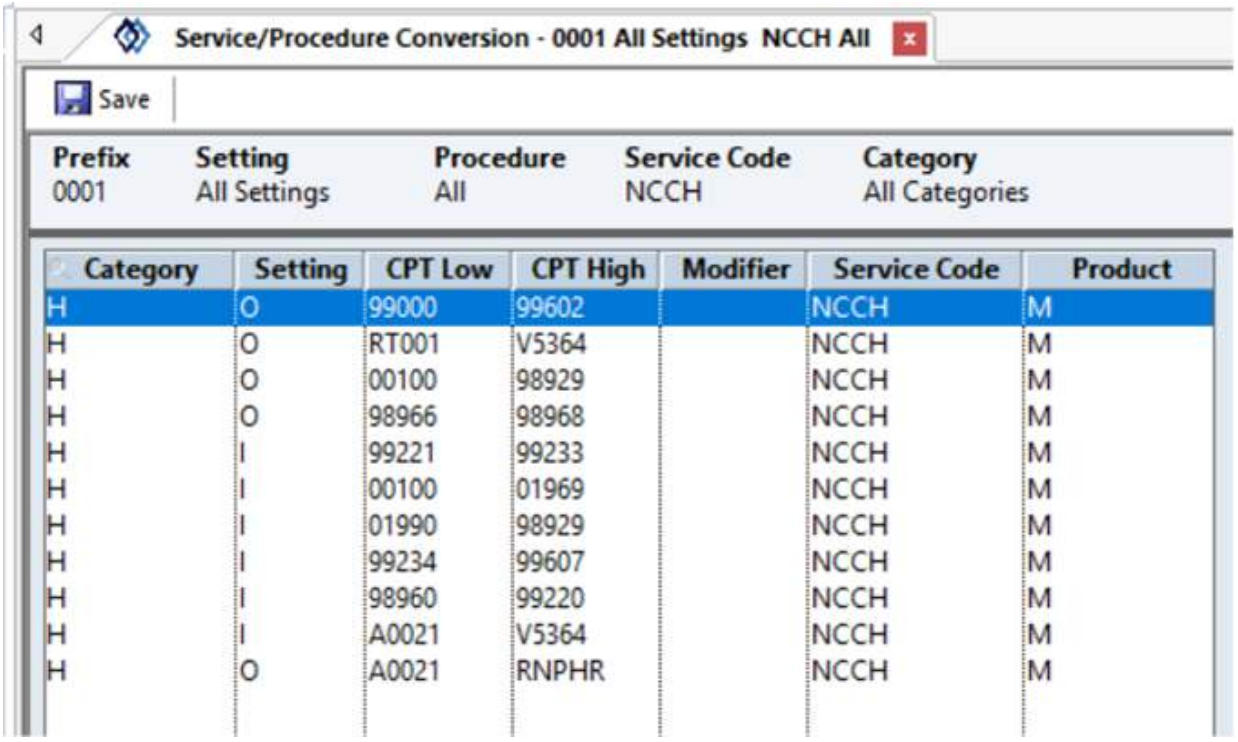
Some BRDs will have a sheet with CHEM codes listed.

CHIR: Chiropractic Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This is usually defined by provider specialty. Find hits with "H" category on the Service/Procedure Conversion (TPCT Table) in Facets with Service Code NCCH and do supplemental mapping from there. There are often restrictions, exclusions and limitations-focus on what IS covered for chiropractic; the Analyst should get codes from the BA for what is covered. For limitations, the BA will get things defined, i.e. if a visit is ANY trip to the chiro, or only one that involves spinal manipulation.

	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverag	Cost-Sha (In-Networ k)	Cost-Sha (Out-Of-Ne twork)	Restricted Coverage	Exclusions	Limitations	Additiona Information	Vendor
1												
13	Iowa Medicaid Elderly Waiver	CHIR	Chiropractic Services	A health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	Chiropractic manipulative therapy is covered only for the manual manipulation of the spine for the purpose of correcting a subluxation, as demonstrated by x-ray. No x-ray is required for pregnant women and children aged 18 and under.	1) Iowa Medicaid has not approved use of magnetic resonance (MRI) or videofluoroscopy to determine the diagnosis of subluxation for chiropractic manipulations. Only diagnostic x-rays can be used to support the diagnosis. 2) Iowa Medicaid does not cover the use of chiropractic manipulative treatment to prevent disease, promote health, prolong and enhance the quality of life, or to treat most other spinal disease or other pathological disorders. Examples of these include, but are not limited to rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema. 3) Maintenance therapy (such as therapy that is performed to stabilize a chronic condition or to prevent deterioration) is not a Medicaid benefit. Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be reasonable and necessary under the Medicaid program.	1) X-rays are limited to one (1) per condition. No payment will be made for subsequent x-rays absent a new condition. The documenting x-ray must be taken at a time reasonably near the initiation of treatment, i.e., no more than 12 months before or three months after the initiation of treatment. 2) Generally, Medicaid limits chiropractic manipulative treatment to one code per day per patient. Any treatments beyond the utilization guidelines listed must be submitted with documentation to support the medical necessity. If documentation is not submitted, the claim will be denied for lack of information. The claim may be resubmitted with documentation for reconsideration for the following: - Category I diagnoses generally require short term treatment (12 manipulations per 12-month period); - Category II diagnoses generally require moderate term treatment (18 manipulations per 12- month period); and - Category III diagnoses generally require longer term treatment (24 manipulations per 12- month period); The utilization guideline for diagnostic combinations between categories is 28 manipulations per 12-month period.	N/A	N/A

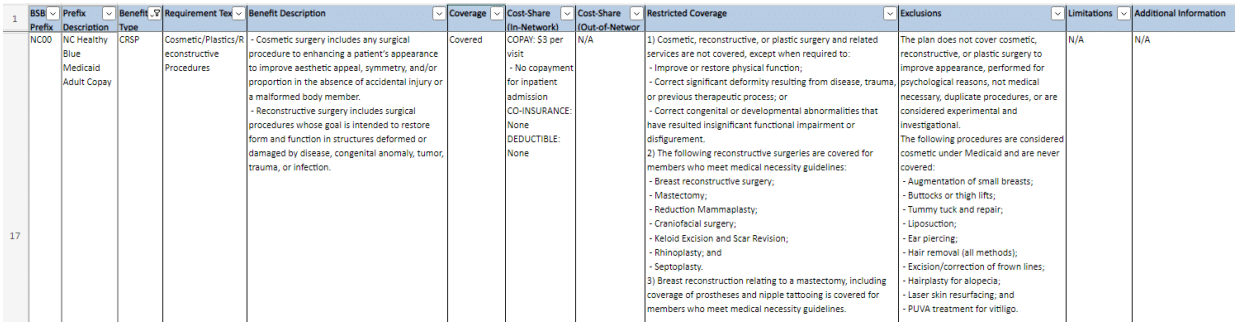
This plan has a lot of Restrictions/Exclusions/Limitations



An example of the TPCT Table in Facets

CRSP: Cosmetic/Plastics/Reconstructive Procedures

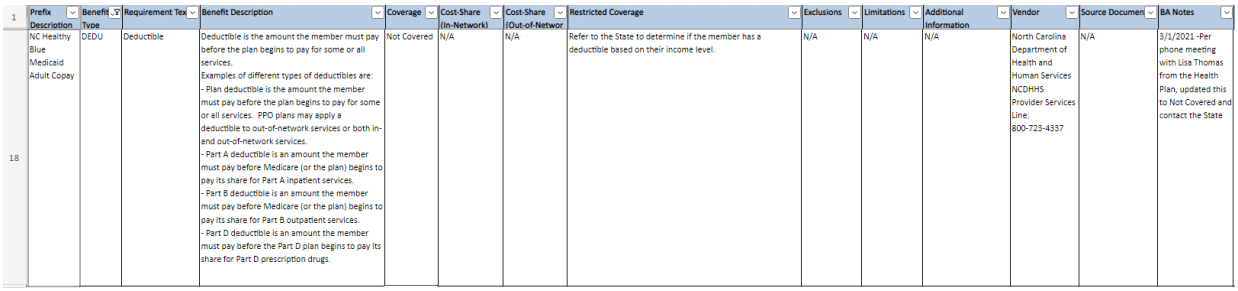
Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. There are clinical edits around these services, so normally only the copay is going to be handled by the Analyst at the Configuration level unless there are some requirements that need to be configured by benefits.



	BSB Prefix	Prefix Description	Benefit Type	Requirement Tex	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Networ	Restricted Coverage	Exclusions	Limitations	Additional Information
17	NC00	NC Healthy Blue Medicaid Adult Copay	CRSP	Cosmetic/Plastics/Reconstructive Procedures	- Cosmetic surgery includes any surgical procedure to enhancing a patient's appearance to improve aesthetic appeal, symmetry, and/or proportion in the absence of accidental injury or a malformed body member. - Reconstructive surgery includes surgical procedures whose goal is intended to restore form and function in structures deformed or damaged by disease, congenital anomaly, tumor, trauma, or infection.	Covered	COPAY: $3 per visit - No copayment for inpatient admission CO-INSURANCE: None DEDUCTIBLE: None	N/A	1) Cosmetic, reconstructive, or plastic surgery and related services are not covered, except when required to: - Improve or restore physical function; - Correct significant deformity resulting from disease, trauma, or previous therapeutic process; or - Correct congenital or developmental abnormalities that have resulted insignificant functional impairment or disfigurement. 2) The following reconstructive surgeries are covered for members who meet medical necessity guidelines: - Breast reconstructive surgery; - Mastectomy; - Reduction Mammaplasty; - Craniofacial surgery; - Keloid Excision and Scar Revision; - Rhinoplasty; and - Septoplasty. 3) Breast reconstruction relating to a mastectomy, including coverage of prostheses and nipple tattooing is covered for members who meet medical necessity guidelines.	The plan does not cover cosmetic, reconstructive, or plastic surgery to improve appearance, performed for psychological reasons, not medical necessary, duplicate procedures, or are considered experimental and investigational. The following procedures are considered cosmetic under Medicaid and are never covered: - Augmentation of small breasts; - Buttocks or thigh lifts; - Tummy tuck and repair; - Liposuction; - Ear piercing; - Hair removal (all methods); - Excision/correction of frown lines; - Hairplasty for alopecia; - Laser skin resurfacing; and - PUVA treatment for vitiligo.	N/A	N/A

DEDU: Deductible

Most Medicaid markets do not have a deductible. There are instances, i.e North Carolina, where the market wanted to see verbiage for this benefit type but no configuration was needed. If a Medicaid market was to have a true deductible, then it would need to be configured.

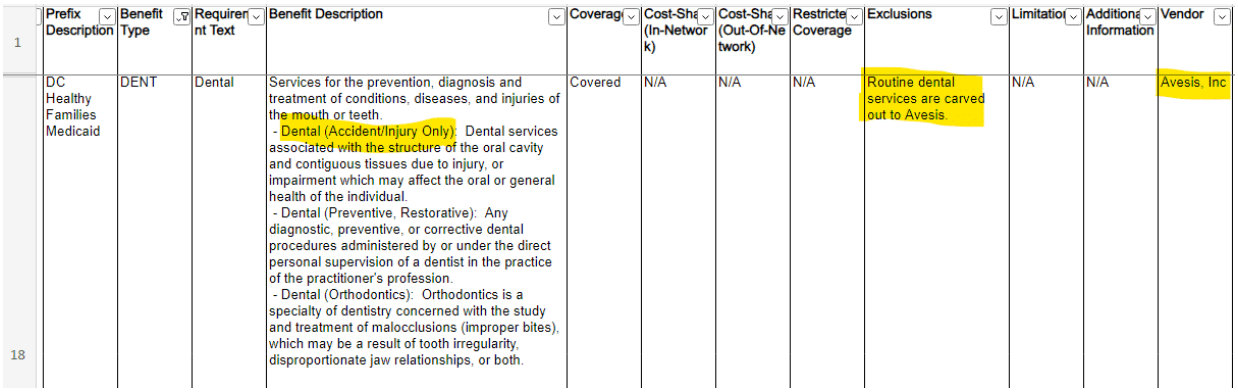


	Prefix Description	Benefit Type	Requirement Tex	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Networ	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor	Source Documen	BA Notes
18	NC Healthy Blue Medicaid Adult Copay	DEDU	Deductible	Deductible is the amount the member must pay before the plan begins to pay for some or all services. Examples of different types of deductibles are: - Plan deductible is the amount the member must pay before the plan begins to pay for some or all services. PPO plans may apply a deductible to out-of-network services or both in- and out-of-network services. - Part A deductible is an amount the member must pay before Medicare (or the plan) begins to pay its share for Part A inpatient services. - Part B deductible is an amount the member must pay before Medicare (or the plan) begins to pay its share for Part B outpatient services. - Part D deductible is an amount the member must pay before the Part D plan begins to pay its share for Part D prescription drugs.	Not Covered	N/A	N/A	Refer to the State to determine if the member has a deductible based on their income level.	N/A	N/A	N/A	North Carolina Department of Health and Human Services NCDHHS Provider Services Line: 800-723-4337	N/A	3/1/2021 -Per phone meeting with Lisa Thomas from the Health Plan, updated this to Not Covered and contact the State

DENT: Dental

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Routine dental services (ADA codes) billed by a dentist are normally carved out to a dental vendor and will need to deny as such. There are some medical or facility pieces

that we/Elevance will cover, so the Analyst has to look for the services that should be covered by us, like accidental/injury dental coverage, ASC (Ambulatory Surgical Centers), etc. The BA should have those defined on the BRD. For ASC they might provide POS and/or bill type, but if not provided, configuration should be able to run a query to find them.



	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusions	Limitation	Additional Information	Vendor
1												
18	DC Healthy Families Medicaid	DENT	Dental	Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the mouth or teeth. - Dental (Accident/Injury Only): Dental services associated with the structure of the oral cavity and contiguous tissues due to injury, or impairment which may affect the oral or general health of the individual. - Dental (Preventive, Restorative): Any diagnostic, preventive, or corrective dental procedures administered by or under the direct personal supervision of a dentist in the practice of the practitioner's profession. - Dental (Orthodontics): Orthodontics is a specialty of dentistry concerned with the study and treatment of malocclusions (improper bites), which may be a result of tooth irregularity, disproportionate jaw relationships, or both.	Covered	N/A	N/A	N/A	Routine dental services are carved out to Avesis.	N/A	N/A	Avesis, Inc

J codes are often important in:

- ○ CHIR
- ○ CHEM
- ○ DENT

SUBMIT

An Analyst may need to run a TPCT Table in Facets for:

- ◯ CHIR
- ◯ CHEM
- ◯ DENT

SUBMIT

The Benefit Type _____ is primarily for the state's information needs, but in some cases will need to be configured.

- ◯ CHEM
- ◯ CRSP
- ◯ DEDU

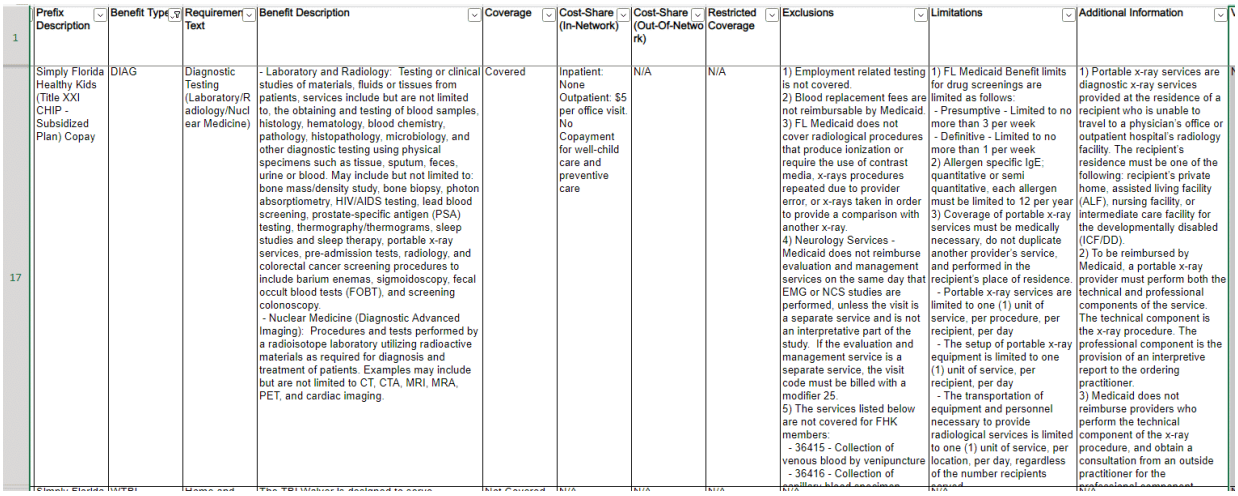
SUBMIT

CONTINUE

DIAG, DIAS, and DMES/MDSP/PROP

DIAG: Diagnostic Testing (Laboratory/Radiology/Nuclear Medicine)

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This Benefit Type covers a wide range of testing.
- Most substance abuse and mental health codes are captured under BH Benefit Types, so the BH Grid is the ultimate Source of Truth for those tests.
- The BA should send all applicable procedure codes for diagnostic testing, so the Analyst may have to search on the list to determine what might be for any procedure listed as excluded. The Analyst can reach back out to BA with questions or concerns, i.e. they can't find a code referring to Paternity testing, even though it is specifically listed in the Exclusions.
- Per day limits have historically been done by Code Editing, but if Configuration CAN code for it, they SHOULD. If in doubt, verify! MUE can be changed or withdrawn at any time, so if our limits differ from MUE, still code them as the MUE will hit first then ours will hit if the MUE is changed or removed.
- Always check Additional Information to be sure that there is nothing else needed- i.e. pull diagnostic mammogram codes, be sure they're set on the supp table to B for Both male and female.

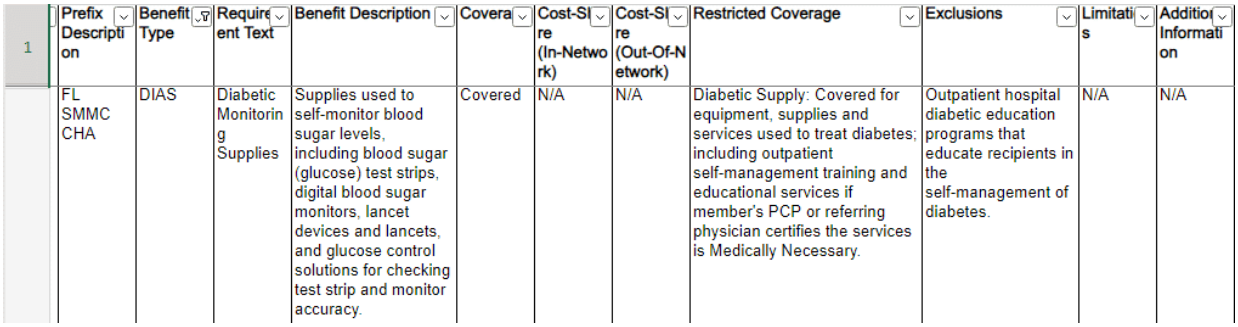


	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
1											
17	Simply Florida Healthy Kids (Title XXI CHIP - Subsidized Plan) Copay	DIAG	Diagnostic Testing (Laboratory/Radiology/Nuclear Medicine)	- Laboratory and Radiology: Testing or clinical studies of materials, fluids or tissues from patients; services include but are not limited to, the obtaining and testing of blood samples, histology, hematology, blood chemistry, pathology, histopathology, microbiology, and other diagnostic testing using physical specimens such as tissue, sputum, feces, urine or blood. May include but not limited to: bone mass/density study, bone biopsy, photon absorptiometry, HIV/AIDS testing, lead blood screening, prostate-specific antigen (PSA) testing, thermography/thermograms, sleep studies and sleep therapy, portable x-ray services, pre-admission tests, radiology, and colorectal cancer screening procedures to include barium enemas, sigmoidoscopy, fecal occult blood tests (FOBT), and screening colonoscopy. - Nuclear Medicine (Diagnostic Advanced Imaging): Procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Examples may include but are not limited to CT, CTA, MRI, MRA, PET, and cardiac imaging.	Covered	Inpatient: None Outpatient: $5 per office visit. No Copayment for well-child care and preventive care	N/A	N/A	1) Employment related testing is not covered. 2) Blood replacement fees are not reimbursable by Medicaid. 3) FL Medicaid does not cover radiological procedures that produce ionization or require the use of contrast media, x-rays procedures repeated due to provider error, or x-rays taken in order to provide a comparison with another x-ray. 4) Neurology Services - Medicaid does not reimburse evaluation and management services on the same day that EMG or NCS studies are performed, unless the visit is a separate service and is not an interpretative part of the study. If the evaluation and management service is a separate service, the visit code must be billed with a modifier 25. 5) The services listed below are not covered for FHK members: - 36415 - Collection of venous blood by venipuncture - 36416 - Collection of	1) FL Medicaid Benefit limits for drug screenings are limited as follows: - Presumptive - Limited to no more than 3 per week - Definitive - Limited to no more than 1 per week 2) Allergen specific IgE; quantitative or semi quantitative, each allergen must be limited to 12 per year 3) Coverage of portable x-ray services must be medically necessary, do not duplicate another provider's service, and performed in the recipient's place of residence. - Portable x-ray services are limited to one (1) unit of service, per procedure, per recipient, per day - The setup of portable x-ray equipment is limited to one (1) unit of service, per recipient, per day - The transportation of equipment and personnel necessary to provide radiological services is limited to one (1) unit of service, per location, per day, regardless of the number recipients	1) Portable x-ray services are diagnostic x-ray services provided at the residence of a recipient who is unable to travel to a physician's office or outpatient hospital's radiology facility. The recipient's residence must be one of the following: recipient's private home, assisted living facility (ALF), nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD). 2) To be reimbursed by Medicaid, a portable x-ray provider must perform both the technical and professional components of the service. The technical component is the x-ray procedure. The professional component is the provision of an interpretive report to the ordering practitioner. 3) Medicaid does not reimburse providers who perform the technical component of the x-ray procedure, and obtain a consultation from an outside practitioner for the

There may be a lot of material to digest in Exclusions, Limitations and Additional Information.

DIAS: Diabetic Monitoring Supplies

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Some markets have this as part of pharmacy and not medical. If so, it is called out through an exclusion stating it is carved out to the listed pharmacy vendor. Covered codes would be included.



	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
1											
	FL SMMC CHA	DIAS	Diabetic Monitoring Supplies	Supplies used to self-monitor blood sugar levels, including blood sugar (glucose) test strips, digital blood sugar monitors, lancet devices and lancets, and glucose control solutions for checking test strip and monitor accuracy.	Covered	N/A	N/A	Diabetic Supply: Covered for equipment, supplies and services used to treat diabetes; including outpatient self-management training and educational services if member's PCP or referring physician certifies the services is Medically Necessary.	Outpatient hospital diabetic education programs that educate recipients in the self-management of diabetes.	N/A	N/A

DMES/MDSP/PROR: Durable Medical Equipment/Medical Supplies/ Prosthetics/Orthotics

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information.

- For a new market implementation the Lead BA has a requirement to review all DMEPOS codes against state documentation to determine if there are any limitations. There is a new Groupings Template that includes all DMEPOS codes and their applicable groupings.; The BA will get all the code limitations input into this groupings template and get HP approval before sending over to configuration. There will be instructions on the ticket on how to filter the template to get the codes that should be grouped together within the same limitation.
- There are often LT/RT modifiers, in which case the limit normally gets doubled. However, if in doubt, reach out to the BA and/or the Designated Buddy.
- DME rentals, codes billed with a RR modifier and/or without a modifier, are not included in the limitations as these require authorizations and are part of the rent-to-own process which is currently handled via PEGA. On the TPCT, these will be mapped to a Rental Service ID. Rentals are always mapped to DR** Service IDs that will have the authorization flag checked on the Service Definition (SEDF).
- Limits are for PURCHASES. Procedure codes for a Purchase will be mapped on the TPCT with a NU modifier and mapped to Purchase Service ID.

	BSBS Prefix	Prefix Description	Bene Type	Requiremen Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Networ	Restricted Coverage	Exclusions	Limitations
22	NC05	Healthy Blue NCHC Copay (Enrollment Fee)	DMES	Durable Medical Equipment (DME)	Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use, and includes adaptive equipment/aids, humidifiers, oxygen and related respiratory equipment, nebulizers, and glucometers. DME does not include disposable medical supplies.	Covered	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	1) The following rental and purchase guidelines apply to durable medical equipment. - DME items needed for six (6) months or less are eligible for rental only; and - DME items needed for more than six (6) months are eligible for rental or purchase and rental items becomes the property of the member when the total rental payments reach the allowable new purchase price for the item. 2) CPAP or Bi-level device for the Treatment of Obstructive Sleep Apnea is covered on a rental basis only. 3) Children Transport Chairs/Roll-about Chairs are	The following durable medical equipment items and services are not covered: - Convenience items or features; - Powered patient lift chairs; - 3-wheeled scooters; - Pick-up, delivery, or assembly of a durable medical equipment item being serviced or repaired; - Maintenance or service contracts; - Hospital grade cribs, safety enclosures, pediatric specialty beds for caregiver convenience, behavior therapy, and physical restraint;	Children are eligible to receive additional services with prior authorization who meet medical necessity guidelines. North Carolina Medicaid State Plan limits will apply unless the AGP standard limit is a richer limit.
66	NC05	Healthy Blue NCHC Copay (Enrollment Fee)	MDSP	Medical Supplies	Medical supplies are generally disposable or consumable items designed for use by a single individual.	Covered	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE:	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE:	N/A	N/A	Children are eligible to receive additional services with prior authorization who meet medical necessity guidelines. North Carolina Medicaid State Plan limits
87	NC05	Healthy Blue NCHC Copay (Enrollment Fee)	PROR	Prosthetics/Orthotics	These are medical devices (other than dental) ordered by your doctor or other health care provider that replace all or part of an internal body organ (including	Covered	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE:	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE:	N/A	The following prosthetic and orthotic items and services are not covered: - Convenience items; - Maintenance or service contracts	Children are eligible to receive additional services with prior authorization who meet medical necessity guidelines. North Carolina Medicaid State Plan limits

Be sure to fully expand spreadsheet cells-there is much more to read under Restricted Coverage for DMES

Because _____ may change at any time, Analysts should configure Elevance limits as well to serve as a backup.

- ◯ Medicaid
- ◯ HCPCS
- ◯ MUE

SUBMIT

T/F: Analysts are able to configure rental limitations.

- ◯ True
- ◯ False

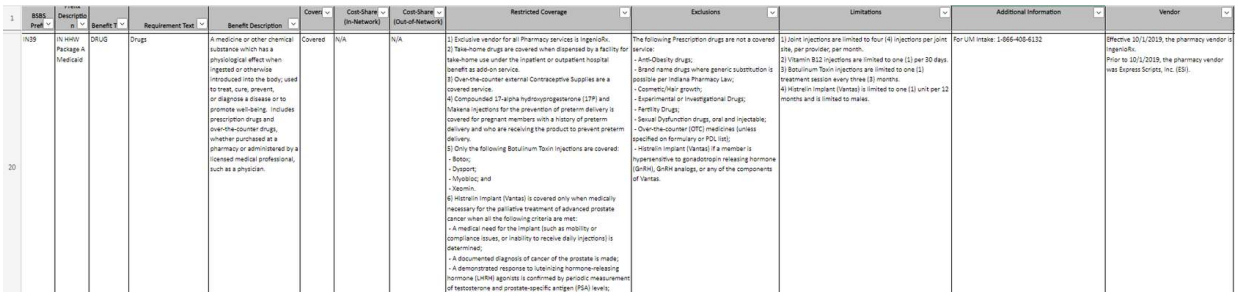
SUBMIT

CONTINUE

DRUG, ECIS/EPSD, EDMS, EMPS, ERSV, ESRD

DRUG: Drugs

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Cost share is usually for prescription drugs and Configuration does NOT configure for prescription medication, either retail or mail order. What IS reviewed is things like medical Injections- the Analyst will get a list of codes to review. Define and look to see what the services are and if could they be billed medically. If so, find how would they come in. The BA would get those defined and would note the pertinent information for the Configuration Analyst; if in doubt, reach back out to the BA.

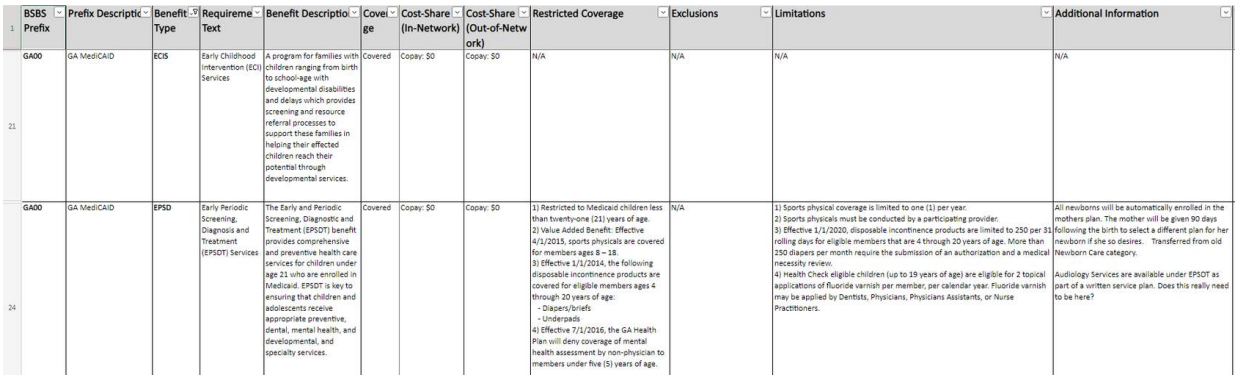


	BSBS Pref	Benefit Description	Benefit T	Requirement Text	Benefit Description	Cover	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
20	IN39	IN HHW Package A Medicaid	DRUG	Drugs	A medicine or other chemical substance which has a physiological effect when ingested or otherwise introduced into the body; used to treat, cure, prevent, or diagnose a disease or to promote well-being. Includes prescription drugs and over-the-counter drugs, whether purchased at a pharmacy or administered by a licensed medical professional, such as a physician.	Covered	N/A	N/A	1) Exclusive vendor for all Pharmacy services is Ingenioflx. 2) Take-home drugs are covered when dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit as add-on service. 3) Over-the-counter external Contraceptive Supplies are a covered service. 4) Compounded 17-alpha hydroxyprogesterone (17P) and Makena injections for the prevention of preterm delivery is covered for pregnant members with a history of preterm delivery and who are receiving the product to prevent preterm delivery. 5) Only the following Botulinum Toxin injections are covered: - Botox; - Dysport; - Myobloc; and - Xeomin. 6) Histrelin Implant (Vantas) is covered only when medically necessary for the palliative treatment of advanced prostate cancer when all the following criteria are met: - A medical need for the implant (such as mobility or compliance issues, or inability to receive daily injections) is determined; - A documented diagnosis of cancer of the prostate is made; - A demonstrated response to luteinizing hormone-releasing hormone (LHRH) agonists is confirmed by periodic measurement of testosterone and prostate-specific antigen (PSA) levels;	The following Prescription drugs are not a covered service: - Anti-Obesity drugs; - Brand name drugs where generic substitution is possible per Indiana Pharmacy Law; - Cosmetic/Hair growth; - Experimental or Investigational Drugs; - Fertility Drugs; - Sexual Dysfunction drugs, oral and injectable; - Over-the-counter (OTC) medicines (unless specified on formulary or POL list); - Histrelin Implant (Vantas) if a member's hypersensitive to gonadotropin releasing hormone (GnRH), GnRH analogs, or any of the components of Vantas.	1) Joint injections are limited to four (4) injections per joint site, per provider, per month. 2) Vitamin B12 injections are limited to one (1) per 30 days. 3) Botulinum Toxin injections are limited to one (1) treatment session every three (3) months. 4) Histrelin Implant (Vantas) is limited to one (1) unit per 12 months and is limited to males.	For UM Intake: 1-866-406-6132	Effective 10/1/2019, the pharmacy vendor is Ingenioflx. Prior to 10/1/2019, the pharmacy vendor was Express Scripts, Inc. (ESI).

ECIS/EPSD: Early Childhood Intervention Services/Early Periodic Screening, Diagnosis and Treatment

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. These Benefit Types are driven by age ranges, which can be difficult; codes can overlap between these two and medical services outside the age ranges. The Analyst should be sure to understand the project/plan they are working on. For example, a code might be listed as Covered, but looking at the Restrictions shows that it is only for ages 0-3. That can be

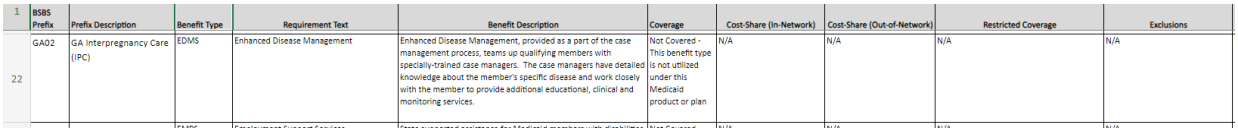
interpreted as once they reach 4 it could be covered under HCPS or another Benefit Type. Or it may state the plan only covers ages 21 and up. The Analyst should do their research and pay attention to the plan they are working in.



	BSBS Prefix	Prefix Descriptic	Benefit Type	Requireme Text	Benefit Descriptio	Cover age	Cost-Share (In-Network)	Cost-Share (Out-of-Netw ork)	Restricted Coverage	Exclusions	Limitations	Additional Information
21	GA00	GA MediCAID	ECIS	Early Childhood Intervention (ECI) Services	A program for families with children ranging from birth to school-age with developmental disabilities and delays which provides screening and resource referral processes to support these families in helping their effected children reach their potential through developmental services.	Covered	Copay: $0	Copay: $0	N/A	N/A	N/A	N/A
24	GA00	GA MediCAID	EPSD	Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.	Covered	Copay: $0	Copay: $0	1) Restricted to Medicaid children less than twenty-one (21) years of age. 2) Value Added Benefit: Effective 4/1/2015, sports physicals are covered for members ages 8 – 18. 3) Effective 1/1/2014, the following disposable incontinence products are covered for eligible members ages 4 through 20 years of age: - Diapers/briefs - Underpads 4) Effective 7/1/2016, the GA Health Plan will deny coverage of mental health assessment by non-physician to members under five (5) years of age.	N/A	1) Sports physical coverage is limited to one (1) per year. 2) Sports physicals must be conducted by a participating provider. 3) Effective 1/1/2020, disposable incontinence products are limited to 250 per 31 rolling days for eligible members that are 4 through 20 years of age. More than 250 diapers per month require the submission of an authorization and a medical necessity review. 4) Health Check eligible children (up to 19 years of age) are eligible for 2 topical applications of fluoride varnish per member, per calendar year. Fluoride varnish may be applied by Dentists, Physicians, Physicians Assistants, or Nurse Practitioners.	All newborns will be automatically enrolled in the mothers plan. The mother will be given 90 days following the birth to select a different plan for her newborn if she so desires. Transferred from old Newborn Care category. Audiology Services are available under EPSDT as part of a written service plan. Does this really need to be here?

EDMS: Enhanced Disease Management

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Case Management and UM are involved with this, determining the member's condition and what can be done to help them manage it. If there is a code given the Analyst would configure it, but generally there is NO benefit impact and Configuration should not even get a ticket on it.



1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions
22	GA02	GA Interpregnancy Care (IPC)	EDMS	Enhanced Disease Management	Enhanced Disease Management, provided as a part of the case management process, teams up qualifying members with specially-trained case managers. The case managers have detailed knowledge about the member's specific disease and work closely with the member to provide additional educational, clinical and monitoring services.	Not Covered - This benefit type is not utilized under this Medicaid product or plan	N/A	N/A	N/A	N/A

EMPS: Employment Support Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. These can be carved out to the state, so the given codes would be configured to deny to the vendor in that case. If they ARE listed as covered by us then the Analyst would configure them to pay as usual.

	BSBS Pre	Prefix Description	Benefit Typ	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions
26	NC04	Healthy Blue NCHC Copay (No Enrollment Fee)	EMPS	Employment Support Services	State supported assistance for Medicaid members with disabilities to gain and sustain paid competitive or self-employment.	Not Covered	N/A	N/A	N/A	Supported Employment and Employment Specialist services are excluded from the health plan benefit. These services are carved out to the State Medicaid Direct Program.

ERSV: Emergency Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This covers facility and professional services. Emergency Room services have specific ER procedure and revenue codes: 9928X/045X range. Coverage is always for In and Out of Network. The BA will define items like emergent vs non-emergent diagnosis codes and if a Cost Share applies in one situation but not another.

	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverag	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusio	Limitatio	Additional Information	Vendo	Configuration Notes
25	Iowa hawk-i	ERSV	Emergency Services	An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Emergency services are furnished by a qualified provider to evaluate or stabilize an emergency medical condition. This may include behavioral health emergency room services.	Covered	CO-PAY: 1) No copayment for emergency services. 2) Emergency services for non-emergent conditions are subject to a $25 copayment. This copay applies only for families with income that equals or exceeds 150% of FPL. The $25 copayment does not apply if the visit to the emergency room is for an emergent condition or results in a hospital admission, or if the member is otherwise exempt from copays, as follows: - Children eligible for Medicaid under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age; - Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty	CO-PAY: 1) No copayment for emergency services. 2) Emergency services for non-emergent conditions are subject to a $25 copayment. This copay applies only for families with income that equals or exceeds 150% of FPL. The $25 copayment does not apply if the visit to the emergency room is for an emergent condition or results in a hospital admission, or if the member is otherwise exempt from copays, as follows: - Children eligible for Medicaid under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age; - Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty	An emergency room visit is covered if at least one of the following conditions is met: - The member is evaluated or treated for a medical emergency, accident, or injury; - The member's evaluation or treatment results in approval for inpatient hospital admission; - The member is referred by a physician; - The member is suffering from an acute allergic reaction; or - The member is experiencing acute, severe respiratory distress.	N/A	N/A	A list of the diagnosis codes considered emergent is posted on the Iowa Medicaid Enterprise (IME) website.	N/A	See "ER Dx Codes" tab for the ICD-10 diagnosis codes for emergencies

Cover | Introduction | Document Tracking | Change History | References | Business Requirements | BSDL | Document Approvals | DME and Supplies | ER Dx Codes | Hopsice non-cov'd dx

3	ICD-10 Emergency diagnosis codes as of 1/1/18, per Regulatory Alert #7441				
4					
5	**Diagnosis Code**	**Diagnosis Name**	**Effective As Of**	**Termed Date**	**Notes**
6	A01.01	TYPHOID MENINGITIS	4/1/2016		
7	A02.1	SALMONELLA SEPSIS	4/1/2016		
8	A02.21	SALMONELLA MENINGITIS	4/1/2016		
9	A05.0	FOODBORNE STAPHYLOCOCCAL INTOXICATION	4/1/2016		
10	A05.1	BOTULISM FOOD POISONING	4/1/2016		
11	A05.4	FOODBORNE BACILLUS CEREUS INTOXICATION	4/1/2016		
12	A05.5	FOODBORNE VIBRIO VULNIFICUS INTOXICATION	4/1/2016		
13	A05.8	OTHER SPECIFIED BACTERIAL FOODBORNE INTOXICATIONS	4/1/2016		

Small sample of the diagnosis codes given in the "ER Dx Codes" sheet

ESRD: End Stage Renal Disease

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. A list of covered codes will be provided. Check for Limitations, though the BA should supply the codes that need to be limited.

1	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restrict Coverage	Exclusion	Limitation	Additional Information	Vendor
26	Iowa Medicaid State Plan	ESRD	End-Stage Renal Disease/Dialysis	- Renal failure (or kidney failure) occurs when the kidneys are not able to perform their normal functions. End stage renal disease (ESRD) is the term used to describe advanced renal failure. - Kidney disease education is for members with Stage IV chronic kidney disease (CKD) to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Kidney disease education teaches members how to take the best possible care of their kidneys and gives them information they need to make informed decisions about their care. - Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. Dialysis treatments are provided in various settings, including hospital inpatient, hospital outpatient, independent renal dialysis facility, or the home. - Dialysis home support services and self-dialysis training may be included if the member is a candidate for home dialysis.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	N/A	N/A	N/A	If a member under age 65 is eligible for Medicare because of the need for treatment for chronic renal disease, Medicaid payment will be made for Medicare deductibles and coinsurance.	N/A

What might an Analyst configure in DRUG?

- ◯ Over the Counter medications

- ◯ Injections
- ◯ Prescription medications

SUBMIT

Which Benefit Type is dependent on the member's age?

- ◯ ECIS/EPSD
- ◯ EDMS
- ◯ ESRD

SUBMIT

The 045X Revenue Code range is used for what Benefit Type?

- DRUG
- EMPS
- ERSV

SUBMIT

CONTINUE

EXIS, FMPL, GBSU, GENT and GNDR

EXIS: Experimental, Investigational, Clinical Trials

This Benefit Type is handled by code editing and should not come over to Configuration unless there are any requirements that are needed to be handled by benefits.

	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverag	Cost-Shar (In-Network)	Cost-Share (Out-Of-Network)	Restrict Coverage	Exclusions
1	Iowa Medicaid State Plan	EXIS	Experimental, Investigational, Clinical Trials	A drug, device or service that has not been approved as safe and effective for general use by the Food and Drug Administration or other governing body.	Not Covered	N/A	N/A	N/A	Unproven or experimental medical and surgical procedures are not covered.

FMPL: Family Planning

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. If there are any needed diagnosis codes, the BA will gather them and submit a list with the ticket.

	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
29	GA Family Planning	FMPL	Family Planning	Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control.	Covered	N/A	N/A	- Screening, treatment and follow up for sexually transmitted infections (STIs), except HIV/AIDS and Hepatitis - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit. - A follow up visit for the treatment/drugs may be covered - Subsequent follow-up visits to re-screen for STIs based on the Centers for Disease Control and Prevention guidelines - Counseling and referrals to social services and primary health care providers.	Non family planning related services	Non family planning related services	Family planning services and supplies for Members and Demonstration Participants include at a minimum: - Education and counseling necessary to make informed choices and understand contraceptive methods; - Initial and annual complete physical examinations including a pelvic examination and Pap test; - Follow up, brief and comprehensive visits – up to four (4) such visits for P4HB Participants; - Pregnancy testing; - Contraceptive supplies and follow up care; - Diagnosis of sexually transmitted infections; - Treatment of sexually transmitted infections with the following exception - P4HB Participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration; - For P4HB Participants - Drugs, supplies, or devices related to the services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements). - Infertility assessments with the following exception – P4HB Participants are excluded from receiving this benefit.

GBSU: Gastric Bypass/Obesity Surgery/Bariatrics

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information, then ensure the procedure codes supplied are configured as covered and/or not covered.
- Any services that require an authorization would be supplied by HCMS via a separate ticket.
- For limitations, it is usually configured based on surgical procedures.
- Configuration would ensure that if there's a copay for an office visit for services that it is configured.

	BSBS Pre	Prefix Descriptio	Benefit Typ	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
	NC04	Healthy Blue NCHC Copay (No Enrollment Fee)	GBSU	Gastric Bypass/Obesity Surgery/Bariatrics	Bariatrics is a branch of medicine dealing with prevention, control, and treatment of obesity. Gastric bypass/obesity surgery is surgery on the stomach and/or intestines to help the patient with extreme obesity lose weight.	Covered	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	COPAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	Bariatric surgery and the revision of a previous bariatric surgical procedure are covered for members 18 years of age only who meet medical necessity guidelines.	Bariatric procedures are not covered when: - The member does not meet the eligibility requirements; - The member does not meet medical necessity guidelines; - Duplicate procedures or services; - Procedures or service that are experimental, investigational, or part of a clinical trial; or - Member is pregnant.	One (1) bariatric surgical procedure is allowed per member, per lifetime; except when a member had a previous primary bariatric surgical procedure, other than as a Medicaid beneficiary, then the member may have an additional primary bariatric surgical procedure.	N/A

GENT: Genetic Testing

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The BA will provide codes. There may also be code/diagnosis combinations provided. There can be limitations, such as DNA testing only once per lifetime.

1	Prefix Descriptic	Benefit Type	Requirement Tex	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restrict Coverage	Exclusions	Limitations	Additional Information
30	IN HCC Copay Medicaid	GENT	Genetic Testing	Genetic testing services evaluate the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders.	Covered	Copay: $0	Copay: $0		Genetic testing is not a covered service in the following circumstances: - For the sole convenience of information for the patient without impacting treatment; - Screening tests; - Genetic testing panels; - Tests performed for the medical management of other family members unless otherwise specified in policy; - History, physical examination, pedigree analysis, genetic counseling, or completion of conventional diagnostic studies has given a definitive diagnosis; - If a genetic test has previously been performed in order to provide a conclusive diagnosis of the same genetic disorder; - The establishment of paternity.	Genetic tests specific to a gene or a condition is payable only once in the lifetime of a member.	N/A

GNDR: Transgender Related Care and Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Codes will be provided.

1	BSB Prefix	Prefix Description	Bene Type	Requirem Text	Benefit Description	Coverag	Cost-Shar (In-Network)	Cost-Share (Out-of-Network)	Restrict Coverage	Exclusions	Limitatic	Additional Information	Vendor
32	MD00	Maryland - Medicaid,	GNDR	Transgender Related Care and Services	Gender dysphoria is the diagnosis given to persons whose gender assigned at birth does not match the gender with which they identify, and who experience clinically significant distress as a result. Gender dysphoria may be manifested by a strong desire to be treated as the other gender or to be rid of one's sex characteristics, or by a strong conviction that one has feelings and reactions typical of the other gender. Treatments for gender dysphoria include counseling, hormone therapy, and gender reassignment surgery. Gender reassignment surgery (GRS) is a term for the surgical procedures by which the physical appearance and function of a person's existing sexual characteristics are altered to resemble those of the other sex.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	N/A	Any cosmetic procedure or surgery is excluded from coverage: 1. Abdominoplasty 2. Blephraoplasty 3. Breast enlargement procedures, except in connection with covered augmentation mammoplasty 4. Brow lift 5. Cheek implants 6. Chin/nose implants 7 Cryopreservation, storage and thawing of reproductive tissue (i.e. oocytes, ovaries, testicular tissue) and the charges associated therewith (e.g., office, hospital, ultrasounds, laboratory tests, etc.) 8. Electrolysis 9. Face/forehead lifts 10. Facial bone reconstruction 11. Hair removal/hairplasty/hair transplants 12. Laryngoplasty 13. Lip reduction/enhancement 14. Liposuction 15. Mastopexy 16. Neck tightening 17. Nipple/areola reconstruction, except in connection with a covered augmenta ltion Mammoplasty or Mastectomy 18. Penile prosthesis(non-inflatable/inflatable), except in connection with a covered phalloplasty(implantation of the prosthesis shall not be considered a second state phalloplasty) in the female-to-male transition (subsequent	N/A	Effective 12/10/2015, MCOs are responsible for gender reassignment surgeries when billed with the diagnosis codes for pre/post gender dysphoria, with the exception of cosmetic portions. The following is a list of the non-cosmetic procedure codes that are covered: 1. - Intersex surgery; male to female 2. - Intersex surgery; female to male 3. - Also combinations of individual procedures billed separately, including but not limited to: a. - Mammaplasty augmentation; with prosthetic implant b. - Amputation of penis; complete c. - Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach d. - Insertion of testicular prosthesis e. - Laparoscopy, surgical; orchiectomy f. - Scrotoplasty; complicated g. - Vulvectomy, simple; complete h. - Plastic repair of introitus i. - Clitoroplasty for intersex state j. - Vaginectomy, complete removal of vaginal wall; k. - Construction of artificial vagina; without graft l. - Revision (including removal) of prosthetic m. - vaginal graft; vaginal approach	N/A

Which Benefit Type would typically NOT come over to Configuration?

- ○ EXIS
- ○ GBSU

- ◯ GNDR

SUBMIT

Limitations for this Benefit Type are usually configured based on surgical procedures.

- ◯ EXIS
- ◯ GBSU
- ◯ GENT

SUBMIT

GNDR

SUBMIT

Limitations for this Benefit Type are usually configured based on surgical procedures.

EXIS

GBSU

GENT

SUBMIT

T/F: For most of the Benefit Types in this lesson, the BA should provide diagnosis and/or procedure codes that apply.

- ○ True
- ○ False

SUBMIT

CONTINUE

GUAC, HCPS, HEAR, HEHM

GUAC: Guest Accommodations

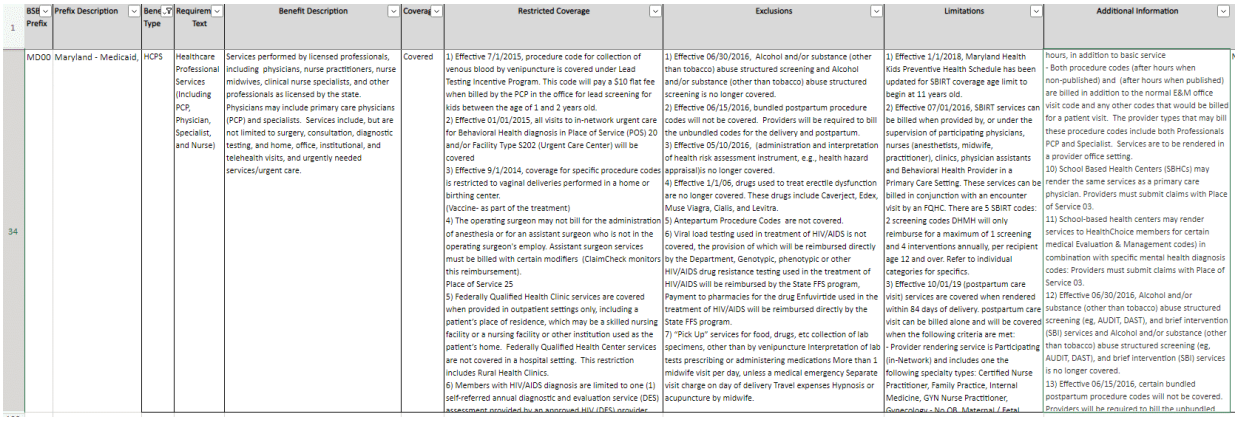
Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Codes will be provided.

	Group ID	Group Name	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)
1	LAMCD000	Louisiana Medicaid	LA00	LA Medicaid	GUAC	Guest Accommodations (Lodging/Meals/Items)	Guest accommodations refer to lodging for a member's family or guardian while the member is hospitalized. This may include guest meals provided for a member's family or guardian while the member is hospitalized. Comfort and convenience items that do not contribute meaningfully to the treatment of the member are not covered.	Not covered	N/A	N/A

HCPS: Healthcare Professional Services (Including PCP, Physician, Specialist, and Nurse)

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information.
- This Benefit Type is a catch all, so there is a lot to look at outside of those specific services that may be called out. At this time there will not be a list of codes due to the sheer volume involved, but teams are working toward BAs being able to provide all of the procedure codes for the items that do NOT fall within specific benefit categories.
- Check copay exclusions to make sure those services are not pulling a copay.
- Services with their own Benefit Type should already be handled, but collaboration with others working those Benefit Types is important.

- Become familiar with the state plans available, as some have a separate Pregnancy-specific plan that will cover pregnancy/maternal claims.
- Places of Service RHC (Rural Health Clinic) and FQHC (Federally Qualified Health Clinic) don't have a Benefit Type of their own so they fall under HCPS.
- The Analyst can't do a time table on a "per episode" basis, as there's not a way to handle that on a Configuration table.
- The Health Plan would have to approve any time limits or how to equate the time limit, so that information should have been clarified and then included on the ticket. For example, a code that is billed in 15-minute increments and has a limit of 4 units/calendar year. The question, "Is the 15-minute increment considered 1 unit or is an hour considered 1 unit?" would be answered in the ticket.



	BSE Prefix	Prefix Description	Bene Type	Requirem Text	Benefit Description	Coverag	Restricted Coverage	Exclusions	Limitations	Additional Information
1										
34	MD00	Maryland - Medicaid,	HCPS	Healthcare Professional Services (Including PCP, Physician, Specialist, and Nurse)	Services performed by licensed professionals, including physicians, nurse practitioners, nurse midwives, clinical nurse specialists, and other professionals as licensed by the state. Physicians may include primary care physicians (PCP) and specialists. Services include, but are not limited to surgery, consultation, diagnostic testing, and home, office, institutional, and telehealth visits, and urgently needed services/urgent care.	Covered	1) Effective 7/1/2015, procedure code for collection of venous blood by venipuncture is covered under Lead Testing Incentive Program. This code will pay a $10 flat fee when billed by the PCP in the office for lead screening for kids between the age of 1 and 2 years old. 2) Effective 01/01/2015, all visits to in-network urgent care for Behavioral Health diagnosis in Place of Service (POS) 20 and/or Facility Type S202 (Urgent Care Center) will be covered 3) Effective 9/1/2014, coverage for specific procedure codes is restricted to vaginal deliveries performed in a home or birthing center. (Vaccine- as part of the treatment) 4) The operating surgeon may not bill for the administration of anesthesia or for an assistant surgeon who is not in the operating surgeon's employ. Assistant surgeon services must be billed with certain modifiers (ClaimCheck monitors this reimbursement). Place of Service 25 5) Federally Qualified Health Clinic services are covered when provided in outpatient settings only, including a patient's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as the patient's home. Federally Qualified Health Center services are not covered in a hospital setting. This restriction includes Rural Health Clinics. 6) Members with HIV/AIDS diagnosis are limited to one (1) self-referred annual diagnostic and evaluation service (DES) assessment provided by an approved HIV (DES) provider.	1) Effective 06/30/2016, Alcohol and/or substance (other than tobacco) abuse structured screening and Alcohol and/or substance (other than tobacco) abuse structured screening is no longer covered. 2) Effective 06/15/2016, bundled postpartum procedure codes will not be covered. Providers will be required to bill the unbundled codes for the delivery and postpartum. 3) Effective 05/10/2016, (administration and interpretation of health risk assessment instrument, e.g., health hazard appraisal)is no longer covered. 4) Effective 1/1/06, drugs used to treat erectile dysfunction are no longer covered. These drugs include Caverject, Edex, Muse Viagra, Cialis, and Levitra. 5) Antepartum Procedure Codes are not covered. 6) Viral load testing used in treatment of HIV/AIDS is not covered, the provision of which will be reimbursed directly by the Department, Genotypic, phenotypic or other HIV/AIDS drug resistance testing used in the treatment of HIV/AIDS will be reimbursed by the State FFS program, Payment to pharmacies for the drug Enfuvirtide used in the treatment of HIV/AIDS will be reimbursed directly by the State FFS program. 7) "Pick Up" services for food, drugs, etc collection of lab specimens, other than by venipuncture Interpretation of lab tests prescribing or administering medications More than 1 midwife visit per day, unless a medical emergency Separate visit charge on day of delivery Travel expenses Hypnosis or acupuncture by midwife.	1) Effective 1/1/2018, Maryland Health Kids Preventive Health Schedule has been updated for SBIRT coverage age limit to begin at 11 years old. 2) Effective 07/01/2016, SBIRT services can be billed when provided by, or under the supervision of participating physicians, nurses (anesthetists, midwife, practitioner), clinics, physician assistants and Behavioral Health Provider in a Primary Care Setting. These services can be billed in conjunction with an encounter visit by an FQHC. There are 5 SBIRT codes: 2 screening codes DHMH will only reimburse for a maximum of 1 screening and 4 interventions annually, per recipient age 12 and over. Refer to individual categories for specifics. 3) Effective 10/01/19 (postpartum care visit) services are covered when rendered within 84 days of delivery. postpartum care visit can be billed alone and will be covered when the following criteria are met: - Provider rendering service is Participating (in-Network) and includes one the following specialty types: Certified Nurse Practitioner, Family Practice, Internal Medicine, GYN Nurse Practitioner, Gynecology - No OB, Maternal / Fetal	hours, in addition to basic service - Both procedure codes (after hours when non-published) and (after hours when published) are billed in addition to the normal E&M office visit code and any other codes that would be billed for a patient visit. The provider types that may bill these procedure codes include both Professionals PCP and Specialist. Services are to be rendered in a provider office setting. 10) School Based Health Centers (SBHCs) may render the same services as a primary care physician. Providers must submit claims with Place of Service 03. 11) School-based health centers may render services to HealthChoice members for certain medical Evaluation & Management codes) in combination with specific mental health diagnosis codes: Providers must submit claims with Place of Service 03. 12) Effective 06/30/2016, Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services and Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services is no longer covered. 13) Effective 06/15/2016, certain bundled postpartum procedure codes will not be covered. Providers will be required to bill the unbundled

You're gonna need a bigger spreadsheet.

HEAR: Hearing Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. There is usually a copay for office visits involving hearing services, but it normally does not apply to hearing aids. Exclusions are also important, as cochlear implants and hearing aids may not be covered at all. Sometimes there is a vendor for hearing services.

	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
34	LA Medicaid with NEAT/NEMT	HEAR	Hearing Services	Outpatient diagnostic hearing and balance evaluations performed by a physician, audiologist, or other qualified provider to determine if member needs medical treatment. - Audiology is the branch of science that studies hearing, balance, and their disorders. Its practitioners, who study hearing and treat those with hearing losses, are audiologists. Employing various testing strategies (e.g. hearing tests, optoacoustic emission measurements, and electrophysiologic tests), audiology aims to determine whether someone can hear within the normal range, and if not, which portions of hearing (high, middle, or low frequencies) are affected and to what degree. If an audiologist diagnoses a hearing loss he or she will provide recommendations to a patient as to what options (e.g. hearing aids, cochlear implants, surgery, appropriate medical referrals) may be of assistance. - Hearing aid is an apparatus/electronic device that amplifies sound for persons with impaired hearing. The device consists of a microphone, a battery power supply, an amplifier, and a receiver.	Covered	N/A	N/A	Recipients must have a written authorization from their primary care physician for the audiologist's services.	N/A	Payment for each individual audiology code (below) is limited to one (1) per recipient per 180 days: 92552 92565 92576 92553 92567 92577 92555 92568 92579 92556 92569 92582 92557 92571 92583 92563 92572 92584 92564 92575 92585	For members under the age of 21; please refer to EPSDT Services for specific benefit coverage.	N/A

HEHM: Health Homes

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This is NOT Home Health, it is a care management service model and often requires medical necessity. The BA will provide codes.

	BSBS Prefix	Description	Benefit Type	Requirement Text	Benefit Description	Coverage	(In-Network)	(Out-of-Network)	Restricted Coverage	Exclusions
35	IN32	IN HIP State Plan Plus No Copay (ZCS) Medicaid	HEHM	Health Homes	Health Homes is a care management service model where all of the professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status. Federal core Health Home services include: - Comprehensive care management; - Care coordination; - Health promotion; - Comprehensive transitional care/follow-up; - Member and family support; and - Referral to community and social support services.	Not Covered	N/A	N/A	N/A	Health Homes is not a covered service

This Benefit Type is a catch-all, likely to have a lot of information to process.

○ HCPS

- ◯ HEAR
- ◯ HEHM

SUBMIT

This Benefit Type, sometimes confused with Home Health, may involve UM since it often relies on medical necessity.

- ◯ HEAR
- ◯ HEHM
- ◯ HCPS

SUBMIT

CONTINUE

HMHC, HOSP, IMVA/VCFP and INFS

HMHC: Home Health Care

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This can have overlap with other Benefit Types. The POS/bill type is a big piece of it.

Procedure codes should be provided, but in any case look carefully at the Restrictions, Exclusions, Limitations and Additional Information. The primary Restriction/Exclusion is based on home setting, e.g consider home services for PT/ST/OT and look to see if there is a difference in limits between POS that would require additional build out.

	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
36	MN00	MN Medicaid MA-Copay (Blue Advantage)	HMHC	Home Health Care	Home health services include skilled and non-skilled services, medication administration, and medication management. - Skilled services include skilled nurse services, PT/OT/RT/ST, dieticians and social workers that are provided to eligible	Covered	N/A	N/A	1) Home health agency services are covered for members who meet medical necessity guidelines. 2) Skilled nursing visits can be provided via telehome care. A onetime perinatal visit does not require the face-to-face encounter.	The following services are not covered: 1) Home Health Aide visits for the sole purpose of providing household tasks, transportation, companionship, or socialization. 2) Services that are not medically necessary. 3) Services provided for residents of a hospital, nursing facility, and intermediate care	• One face-to-face visit e	1) Telemedicine services are covered. 2) MHCP refers to the program as Telehomecare Note: Covered services include and are not limited to: - Skilled nurse visits; - Home health aide visits; - Physical therapy; - Occupational therapy; - Respiratory therapy; - Language-speech therapy; - Rehabilitation therapy;

HOSP: Hospice Care

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information, though there's typically no Limitations. Pay particular attention to the Place of Service aspect. There is a UM aspect as well that deals with the duration of the HEP (Hospice Election Period) that the Analyst does not have to configure.

1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverag	Cost-Shar (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusion	Limitations
37	LA04	LA Medicaid with NEAT/NEMT	HOSP	Hospice Care	Hospice care or palliative care is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and supporting the partner and family. Hospice care is multidisciplinary and includes home visits, professional medical help available on call, teaching and emotional support of the family, and physical care of the client. Some hospice programs provide care in a center, as well as in the home.	Covered	N/A	N/A	Services provided to terminally ill individuals with a prognosis of six (6) months or less, who elect to receive hospice services provided by a certified hospice agency.	N/A	Effective 7/1/2020, hospice service limits are changed as follows: Inpatient Respite Care: 1 per day up to 5 per lifetime and Other Respite Care: 7 units per lifetime

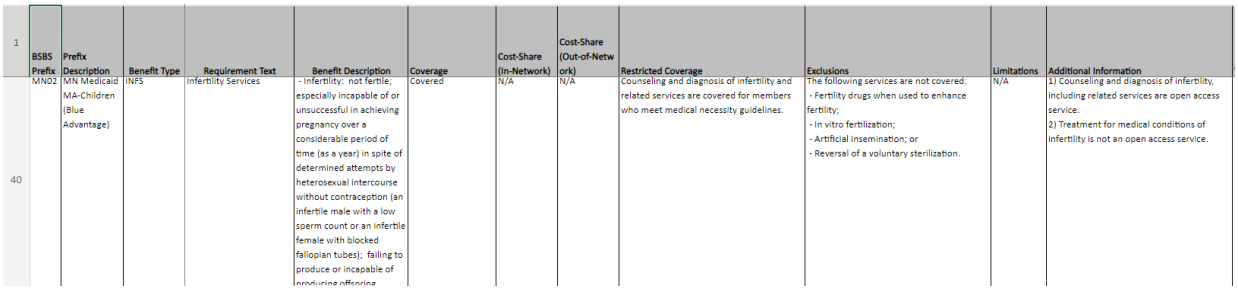
IMVA/VFCP: Immunizations/Vaccinations/Vaccines for Children (VFC) Program

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Immunizations for adults and Vaccines for Children are typically covered with no Cost Share. Vaccines for Children (VFC) program is normally ages 0-18 and are denied by us as they are vaccines that are covered/paid by the State. Look at Additional Information in case there are specific immunizations called out as being covered, such as for HPV. Non-covered may show if the plan only covers members over a certain age, but clinical edits may catch some of those requirements as the procedure codes themselves are age-restricted, for example, 90644 - Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-18 months of age.

1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Restricted Coverage	Exclusions	Limitations	Additional Information
46	NC00	NC Healthy Blue Medicaid Adult Copay	IMVA	Immunizations/Vaccinations	Immunization – The process of becoming immune or the process of rendering a patient immune. Vaccination - The administration, usually by injection, of immunogens as a means of protecting individuals from developing specific diseases; included, but not limited to hepatitis B, influenza, pneumococcal pneumonia and	Covered	N/A	N/A	N/A	ACIP vaccine recommendations can be found on the Centers for Disease Control and Prevention Website at: www.cdc.gov/vaccines/hcp/acip-recs.
104	NC00	NC Healthy Blue Medicaid Adult Copay	VFCP	Vaccines for Children (VFC) Program	The Vaccines for Children (VFC) program provides free vaccinations to Medicaid-eligible children, Alaska Natives, American Indians, children who have no health insurance, and to privately insured children with no coverage for vaccinations (called underinsured children) who are served at a Rural Health Center (RHC) or Federally Qualified Health Center (FQHC).	Not Covered	N/A	This plan covers members 21 years of age and older only.	N/A	N/A

INFS: Infertility Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This Benefit Type may not be covered, but if it is then it will be diagnosis and procedure code driven, codes which the BA will provide.



	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
40	MN02	MN Medicaid MA-Children (Blue Advantage)	INFS	Infertility Services	- Infertility: not fertile; especially incapable of or unsuccessful in achieving pregnancy over a considerable period of time (as a year) in spite of determined attempts by heterosexual intercourse without contraception (an infertile male with a low sperm count or an infertile female with blocked fallopian tubes); failing to produce or incapable of producing offspring	Covered	N/A	N/A	Counseling and diagnosis of infertility and related services are covered for members who meet medical necessity guidelines.	The following services are not covered: - Fertility drugs when used to enhance fertility; - In vitro fertilization; - Artificial insemination; or - Reversal of a voluntary sterilization.	N/A	1) Counseling and diagnosis of infertility, including related services are open access service. 2) Treatment for medical conditions of infertility is not an open access service.

This Benefit Type may have overlap with others, so check if there is a difference based on POS for the procedure codes.

- ○ HMHC
- ○ IMVA
- ○ VFCP

SUBMIT

This Benefit Type may not be covered if the plan is only for Adults.

- ○ HMHC
- ○ VFCP
- ○ INFS

SUBMIT

CONTINUE

IPAC, All LTSS, LHDM, MOOP, NURH

IPAC: Inpatient Hospital Acute

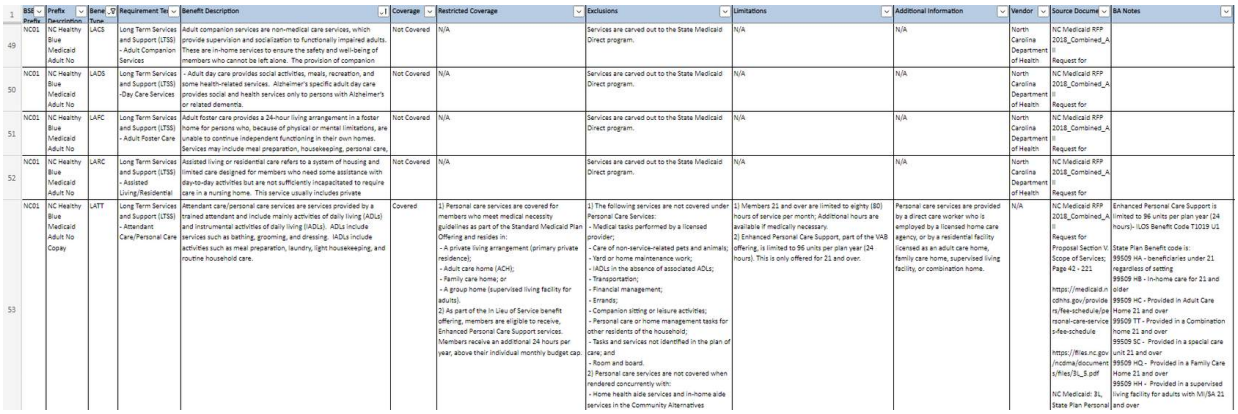
- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information.
- All inpatient care requires authorization.
- The Analyst will not get a whole list of procedure codes as this Benefit Type is POS/TOB driven.
- The Cost Share is on the Room and Board level; if the copay is listed as $0, be sure INPT isn't pulling any cost share.
- Review exclusions and limitations and configure any that should be handled by benefits. Exclusions for leave days or overnight leave of absence are revenue codes that BAs will catch and pass along.

	Prefix Description	Benefit Type	Requirement Text	Coverage	Cost-Share (In-Networ	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Informati
41	KY Medicaid-No Copay	IPAC	Inpatient Hospital Acute	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	1) Admissions for diagnostic purposes are covered only if the diagnostic procedures cannot be performed on an outpatient basis. 2) Readmissions within 14 days are covered only when an acute exacerbation of an existing condition occurs or when an entirely new condition develops.	1) Anesthesia services are not covered when provided by a Physician Assistant. 2) Anesthesia services, including conscious sedation, are not covered when provided by the physician performing the surgery, except for an anesthesia service provided by an oral surgeon. 3) The following inpatient hospital services are not covered:	Observation services may be covered for up to 48 hours.	N/A

LACS/LADS/LAFC/LARC/LATT/LCTS/LFIN/LFTS/ LHAB/LHEE/LHMS/LHOM/LNUH/LPEC/LSUP/ LTCH: All Long Term Services and Support (LTSS)

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information.

- Pay close attention as these can be complicated. Some are a part of the state program, some are covered by us.
- Exclusions or Not Covered will usually exist because it's carved out as part of the state program, so the BRD will show services are carved out to the state Medicaid program. Services are part of the fee for service state program, so would deny to the State, not just deny period.
- Codes would be provided.



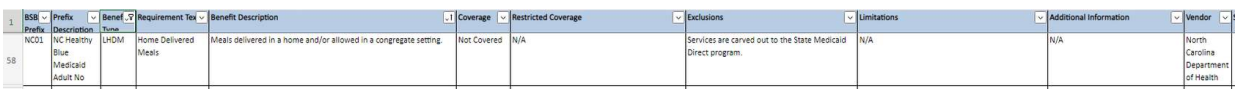
	BSE Prefix	Prefix Description	Bene Type	Requirement Tex	Benefit Description	Coverage	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor	Source Docume	BA Notes
49	NC01	NC Healthy Blue Medicaid Adult No	LACS	Long Term Services and Support (LTSS) - Adult Companion Services	Adult companion services are non-medical care services, which provide supervision and socialization to functionally impaired adults. These are in-home services to ensure the safety and well-being of members who cannot be left alone. The provision of companion	Not Covered	N/A	Services are carved out to the State Medicaid Direct program.	N/A	N/A	North Carolina Department of Health	NC Medicaid RFP 2018_Combined_A ll Request for	
50	NC01	NC Healthy Blue Medicaid Adult No	LADS	Long Term Services and Support (LTSS) -Day Care Services	- Adult day care provides social activities, meals, recreation, and some health-related services. Alzheimer's specific adult day care provides social and health services only to persons with Alzheimer's or related dementia.	Not Covered	N/A	Services are carved out to the State Medicaid Direct program.	N/A	N/A	North Carolina Department of Health	NC Medicaid RFP 2018_Combined_A ll Request for	
51	NC01	NC Healthy Blue Medicaid Adult No	LAFC	Long Term Services and Support (LTSS) - Adult Foster Care	Adult foster care provides a 24-hour living arrangement in a foster home for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care,	Not Covered	N/A	Services are carved out to the State Medicaid Direct program.	N/A	N/A	North Carolina Department of Health	NC Medicaid RFP 2018_Combined_A ll Request for	
52	NC01	NC Healthy Blue Medicaid Adult No	LARC	Long Term Services and Support (LTSS) - Assisted Living/Residential	Assisted living or residential care refers to a system of housing and limited care designed for members who need some assistance with day-to-day activities but are not sufficiently incapacitated to require care in a nursing home. This service usually includes private	Not Covered	N/A	Services are carved out to the State Medicaid Direct program.	N/A	N/A	North Carolina Department of Health	NC Medicaid RFP 2018_Combined_A ll Request for	
53	NC01	NC Healthy Blue Medicaid Adult No Copay	LATT	Long Term Services and Support (LTSS) - Attendant Care/Personal Care	Attendant care/personal care services are services provided by a trained attendant and include mainly activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include services such as bathing, grooming, and dressing. IADLs include activities such as meal preparation, laundry, light housekeeping, and routine household care.	Covered	1) Personal care services are covered for members who meet medical necessity guidelines as part of the Standard Medicaid Plan Offering and resides in: - A private living arrangement (primary private residence); - Adult care home (ACH); - Family care home; or - A group home (supervised living facility for adults). 2) As part of the In Lieu of Service benefit offering, members are eligible to receive, Enhanced Personal Care Support services. Members receive an additional 24 hours per year, above their individual monthly budget cap.	1) The following services are not covered under Personal Care Services: - Medical tasks performed by a licensed provider; - Care of non-service-related pets and animals; - Yard or home maintenance work; - IADLs in the absence of associated ADLs; - Transportation; - Financial management; - Errands; - Companion sitting or leisure activities; - Personal care or home management tasks for other residents of the household; - Tasks and services not identified in the plan of care; and - Room and board. 2) Personal care services are not covered when rendered concurrently with: - Home health aide services and in-home aide services in the Community Alternatives	1) Members 21 and over are limited to eighty (80) hours of service per month; Additional hours are available if medically necessary. 2) Enhanced Personal Care Support, part of the VAB offering, is limited to 96 units per plan year (24 hours). This is only offered for 21 and over.	Personal care services are provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home.	N/A	NC Medicaid RFP 2018_Combined_A ll Request for Proposal Section V: Scope of Services, Page 42 - 221 https://medicaid.ncdhhs.gov/providers/fee-schedule/personal-care-service-fee-schedule https://files.nc.gov/ncdma/documents/files/3i_S.pdf NC Medicaid: 3i_ State Plan Personal	Enhanced Personal Care Support is limited to 96 units per plan year (24 hours)- ILOS Benefit Code T1019 U1 State Plan Benefit code is: 99509 HA - beneficiaries under 21 regardless of setting 99509 HB - In-home care for 21 and older 99509 HC - Provided in Adult Care Home 21 and over 99509 TT - Provided in a Combination home 21 and over 99509 SC - Provided in a special care unit 21 and over 99509 HQ - Provided in a Family Care Home 21 and over 99509 HH - Provided in a supervised living facility for adults with MI/SA 21 and over

As can be seen from this sampling, there is a lot of information to review for LTSS and may be a mix of Covered/Not Covered Benefit Types.

LHDM: Home Delivered Meals

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This Benefit Type can be covered, part of LTSS or a Value-Added Benefit. As with other LTSS Types, it may be carved out to the State; codes would deny to be submitted to State.

Sometimes there is a vendor, i.e GA Foods, so it would be set up to deny to the vendor. In some markets GA Foods will be the vendor that submits the claims to us. In that case the services will be listed as covered. For these cases BA should be double-checking the vendor situation.



	BSE Prefix	Prefix Description	Bene Type	Requirement Tex	Benefit Description	Coverage	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
58	NC01	NC Healthy Blue Medicaid Adult No	LHDM	Home Delivered Meals	Meals delivered in a home and/or allowed in a congregate setting.	Not Covered	N/A	Services are carved out to the State Medicaid Direct program.	N/A	N/A	North Carolina Department of Health

MOOP: Maximum Out of Pocket

This is normally a Medicare item, but some states track the amounts for Medicaid as well. They can use the information to determine if a member needs to be moved to a different plan. If the state wants that wording in their contract, it will be on the BRD, but there may not be any Configuration needed.

	BSB Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
61	NY60	NY Essential Plan 2 Standard	MOOP	Maximum Out Of Pocket	The Maximum Out Of Pocket, or MOOP, is the maximum amount a member will pay out of their own pocket in a calendar year. This includes all out of pocket expenses (copayments, co-insurance, plan deductibles) that are associated with covered medical services that were paid for by the plan. (Note: This includes Part B drug cost sharing dispensed through a pharmacy but DOES NOT include Part D prescription drug copayments.) Any cost sharing paid for by another payer such as Medicaid is not included in the MOOP.	Covered	CO-PAY: $200 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $200 CO-INSURANCE: None DEDUCTIBLE: None	N/A	N/A	N/A	N/A	N/A

NURH: Nursing Hotline

No configuration is needed. A phone number may appear on the BRD, but that is being phased out as if the number is changed it doesn't always get communicated to Benefits and then Configuration. Customer Service is the team that really needs the information, and they have access to up-to-date Contact Lists.

	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
61	MN00	MN Medicaid MA-Copay (Blue Advantage)	NURH	Nursing Hotline	- Nurse Hotline is an after-hours triage service members can use if their PCP is not available. It is	Covered	N/A	N/A	N/A	N/A	N/A	N/A	Nurse Helpline at 1-855-658-9249. TTY users should call 711.

The Cost Share for this Benefit Type is on the Room & Board level.

- ◯ IPAC
- ◯ LTSS
- ◯ LHDM

SUBMIT

This Benefit Type may be a part of LTSS or be listed on its own.

- ◯ IPAC
- ◯ LADS
- ◯ LHDM

SUBMIT

Choose the TWO Benefit Types that should not require configuration.

- [ ] MOOP
- [ ] LSUP
- [ ] IPAC
- [ ] NURH

SUBMIT

CONTINUE

OCOA, OTRH, OUTP, PODS and PRDN

OCOA: Out of Area/Out of Country

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. However, this is handled through authorizations so there should not be anything to configure. Medicaid does NOT cover Out of Country care.

1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
62	MN00	MN Medicaid MA-Copay (Blue Advantage)	OCOA	Out of Area/Out of Country	- Out-of-area services are provided outside of the member's service area. This may be considered an area within or outside of the member's home state and plan location. - Out-of-country services are provided outside of the United States, or the U.S. territories of Guam, Puerto Rico, U.S. Virgin Islands, American Samoa and Northern Mariana Islands.	Covered	N/A	COPAY: 1) $3.50 non-emergent visit to a hospital emergency room, - Only one (1) copay per day per provider for non-emergency visits. 2) $3 per office visit, per provider for non-preventative services. - Copayment applies to urgent care centers.	Medically necessary Out-of-Area services are covered only for the following: - Medical Emergency Services - Post-Stabilization Care - Continuity of Care and Transition Services	Emergency, urgent, or other health care services delivered or items supplied from providers located outside of the United States (U.S.) are not covered.	N/A	Telemedicine services are covered.

OTRH: Other Alternative Medicinal Therapies

This is typically not sent over to Configuration. If codes are found that are deemed to be a part of this benefit as a part of the enterprise code mapping, then they will start sending them over. Additional information may come later.

	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
66	MN02	MN Medicaid MA-Children (Blue Advantage)	OTRH	Other Alternative Medical Therapies	- Other Alternative Medical Therapies: Encompass a broad category of treatment systems (e.g., herbal medicine, homeopathy, naturopathy, hypnosis, and spiritual devotions) or culturally based healing traditions such as Chinese, Ayurvedic, and Christian Science. Alternative medicine is also referred to as complementary medicine. Generally, it includes any medical practice or form of treatment not normally recognized as effective by the medical community at large. - Religious Non-Medical Health Care Institution (RNHCI): Previously known as Christian Science Sanatoria, these facilities provide health care furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a member, and the sole reliance on these religious tenets to fulfill a member's total health care needs.	Not covered - this benefit type is not utilized under this Medicaid plan	N/A	N/A	N/A	N/A	N/A	N/A

OUTP: Outpatient Hospital/Ambulatory Surgery Center Services

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information.

- Similarly to HCPS, anything and everything can be done in an outpatient setting, so the Analyst is not provided with a list of codes. Check if the service is or is not listed out in another Benefit Type.

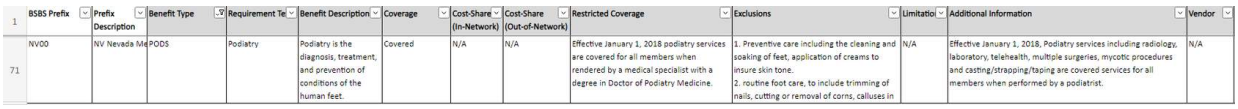
- The Ambulatory Surgical Center (ASC) often has a different copay, and if so then that layer would need to be mapped.

- Look at Exclusions. The Analyst should know how to run the appropriate queries to determine Places of Service, and then if there's still questions reach back out to the BA for clarification before moving on.

77	MO39	MO Medicaid Expansion	OUTP	Outpatient Hospital/Ambulatory Surgery Center Services	- Outpatient hospital services: Preventive, diagnostic, therapeutic, palliative care and other services provided to a member in the outpatient portion of a health facility. - Observation: Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate a patient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation is an outpatient service. - Ambulatory Surgical Centers: Also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.	Covered	N/A	N/A	Corneal transplants are covered in an outpatient or ambulatory surgical center (ASC) setting unless the provider is able to justify inpatient admission for the procedure.	1) Services may not be billed on the same date of service as a home visit, subsequent hospital visit, consultation, preventive medicine services, HCY screening, or nursing home visit. 2) Services may not be billed on the same date of service as psychotherapy visits. 3) The following services are not covered: - Residential treatment; and - Observation services are not covered when part of a diagnostic or therapeutic service for active monitoring as part of a procedure (e.g. colonoscopy, chemotherapy)	1) Outpatient services for illness care are limited to one (1) visit, per member, per day. Additional medically necessary visits on the same day may be allowed. 2) Observation services are covered up to twenty-four (24) hours.	1) The following services are covered: - Ambulatory surgical services; - Infusion services; - Maternity services; - Neurocognitive Rehabilitation Therapy; - Outpatient hospital services (including diagnostic and therapeutic); and - Psychiatric evaluation for Gastric Bypass surgery; 2) Services may be billed on the same date of service as a physical medicine modality or procedure. 3) The treatment of obesity is covered when the treatment is an integral and necessary course of treatment for a concurrent or complicating medical treatment.	N/A	1) Procedure codes 99201 -99215 may be used in the outpatient setting (POS 22) for the initial history and physical workup prior to outpatient surgery. 2) Charges for observation time must be submitted using rev code 0762 with procedure code G0378 and the actual number of hours the member was in observation as units billed (round to the nearest hour). Observation time is covered dUP TO 24 hours. 3) 13.33 J =Morbid Obesity Treatment and 13.55 Obesity The following are covered codes by MHD for patients if the above criteria are met, but do not require a prior authorization request. 43644, 43645, 43659, 43770, 43775, 43845, 43846, 43847, 43848, 43771, 43772, 43773 and 43774

PODS: Podiatry

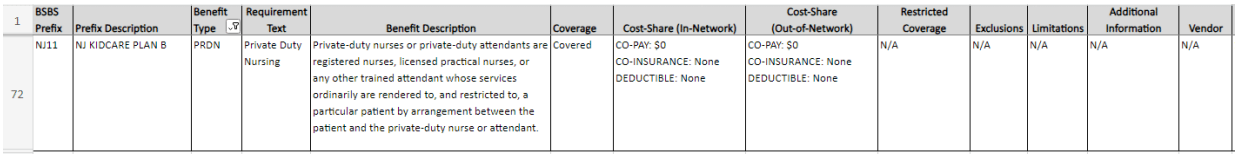
Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Similarly to Chiropractor/Acupuncture, it can rely on the provider specialty. Procedure and diagnosis codes for routine foot care should be provided.



1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Te	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitatio	Additional Information	Vendor
71	NV00	NV Nevada Me	PODS	Podiatry	Podiatry is the diagnosis, treatment, and prevention of conditions of the human feet.	Covered	N/A	N/A	Effective January 1, 2018 podiatry services are covered for all members when rendered by a medical specialist with a degree in Doctor of Podiatry Medicine.	1. Preventive care including the cleaning and soaking of feet, application of creams to insure skin tone. 2. routine foot care, to include trimming of nails, cutting or removal of corns, calluses in	N/A	Effective January 1, 2018, Podiatry services including radiology, laboratory, telehealth, multiple surgeries, mycotic procedures and casting/strapping/taping are covered services for all members when performed by a podiatrist.	N/A

PRDN: Private Duty Nursing

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Some items in this Benefit Type may be not be configurable. Some things may be at the provider contract level like the needed provider specialty (RN, LPN). Limitations are typically time-based, like 16 hours a day or 112 hours per week. Time increments have to be reviewed for clarification. For example, 15 minute increments might be considered one unit and will be determined by the BA before being sent over to configuration. Historically, Code editing has been handling per day limitations.



1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
72	NJ11	NJ KIDCARE PLAN B	PRDN	Private Duty Nursing	Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	N/A	N/A	N/A	N/A	N/A

T/F: Medicaid will cover care a member receives out of the United States or its territories.

○ True

- ◯ False

SUBMIT

This POS often has a different copay, so when configuring OUTP it is a possible layer that will need to be mapped.

- ◯ Ambulatory Surgical Center
- ◯ Home
- ◯ Rural Health Center

SUBMIT

Limitations for this Benefit Type are often time-based.

- ○ OUTP
- ○ PODS
- ○ PRDN

SUBMIT

CONTINUE

PREV, RESP, RSST, SCHL and SELF

PREV: Preventive Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This Benefit Type is typically covered 100%. Codes should be provided, but if not look in the Additional Information for descriptions of specific procedures. Some may already be captured under different Benefit Types like Immunizations/Vaccinations or Diagnostic Testing. Some procedures might be diagnosis code driven.

1	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restrictions	Exclusions	Limitations	Additional Information	Vendor
87	NE01	NE CAID Basic Adult No Copay Plan	PREV	Preventive Services	Routine health care that includes check-ups, patient counseling and screenings to prevent illness, disease, and other health-related problems.	Covered	N/A	N/A	N/A	N/A	1) One routine physical exam every 12 rolling months performed by your PCP. Health visits as needed. 2)Screening for • Pap test 1 per rolling year. • Women 35 years old Mammography Every 1 per calendar year. • Women starting at age 65 or starting at 60 for women at risk Osteoporosis (Bone Mass Measurement) Every two rolling years. • 65 years and older, or younger for those that have diabetes or other risk factors Vision including Glaucoma or Diabetic Retinal Exam 1 per rolling year.	Preventive services include but not limited to: a) Prostate Cancer Screening b) Pap Smear Exam c) Mammogram d) Blood Pressure, Height, Body Mass Index (BMI), Alcohol Use Check e) Cholesterol f) Members ages 50 and older Colorectal Cancer Screening and Hearing Screening g) Effective 01/01/21, mammography services for the screening digital breast tomosynthesis, bilateral is covered when billed with the primary mammogram procedure code	N/A

RESP: Respite

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Procedure codes for Respite Care should be provided to Configuration. Place of Service would be handled by Configuration, if the requirements indicate as such. Limitations on time, especially with the units to time equivalencies, should be handled by the BA first before sending to configuration.

	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
89	NC08	NC Healthy Blue Medicaid Child No Copay	RESP	Respite	Services provided on a short term basis to members unable to care for themselves due to the absence or need for relief of persons normally providing their care. Respite care does not substitute for the care usually provided by a registered nurse, LPN, or therapist.	Covered	N/A	N/A	As part of the In Lieu of Benefit Service benefit offering, members under the LTSS cohort, are eligible to receive In-Home Respite care services.	N/A	N/A	N/A	N/A

RSST: Rehabilitative Services for Medical Conditions - Short Term (OT, PT, RT, ST)

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The BA should provide codes.

	BSB Prefix	Prefix Description	Benef Type	Requirement Tex	Benefit Description	Coverag	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations
90	NC01	NC Healthy Blue Medicaid Adult No Copay	RSST	Rehabilitative Services for Medical Conditions – Short Term (OT, PT, RT, ST)	Performed in home or outpatient setting: - Occupational Therapy (OT) - Based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning. - Physical Therapy (PT) - The treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity) -- also called physiotherapy. It is a branch of treatment that uses physical means to relieve pain, regain range of movement, restore muscle strength, and return patients to normal activities of daily living. - Respiratory Therapy (RT) - Assessment and therapeutic treatment of respiratory diseases. May include but not limited to airway management, mechanical ventilation, blood acid/base balance, and critical care medicine.	Covered	N/A	N/A	1) Only Speech Therapy services are covered when provided in a group setting. 2) Outpatient Specialized Therapy, is covered only when provided by home health providers, hospital outpatient departments, and physician offices.	Members are not covered for therapy services when rendered by an Independent Practitioner Provider (IPP).	Outpatient Specialized Therapy is limited to twenty-seven (27) therapy treatment visits, per plan year across all therapy disciplines combined (occupational therapy, physical therapy, speech and language therapy).

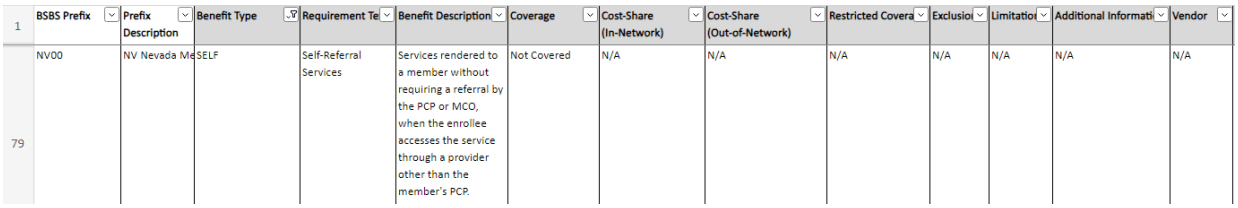
SCHL: School Based Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Every state/plan seems to handle it a little differently. What has been seen is if the school bills, it might not be covered, but if an independent provider bills with POS 3 for being in a school, then it is covered. Could be a lot of back and forth between the BA and the health plan to figure it out. If it's not covered at all, it might need to be handled by Claims Ops, so if it comes through to Configuration the Analyst should check with their Designated Buddy to see if it should be rejected back and go to Claims Operations instead.

	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
78	NJ MEDICAID PLAN A	SCHL	School Based Services	A Medicaid benefit that provides special education programs to medically needy children under the Individuals with Disabilities Education Act. Programs include audiology and other health-related programs provided by schools.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	Speech Therapy, Occupational Therapy and Physical Therapy are not covered, covered under Fee-for-Service.	N/A	N/A	AMERIGROUP shall identify and establish working relationships for coordinating care and services with external organizations that interact with its enrollees, including State agencies, schools, social services organizations, consumer organizations, and civic/community groups.	N/A

SELF: Self-Referral Services

This should not come over to Configuration as we do not configure for referrals.



	BSBS Prefix	Prefix Description	Benefit Type	Requirement Te	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Covera	Exclusio	Limitatio	Additional Informati	Vendor
1													
79	NV00	NV Nevada Me	SELF	Self-Referral Services	Services rendered to a member without requiring a referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the member's PCP.	Not Covered	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This Benefit Type is typically covered 100%, but may be captured under other categories such as Immunizations.

- ◯ RESP
- ◯ PREV
- ◯ RSST

SUBMIT

T/F: RESP, RSST and SCHL may all require some back-and-forth with the assigning BA or the Designated Buddy and the Configuration Analyst.

- ○ True
- ○ False

SUBMIT

CONTINUE

SMCS, SNFS, STRH, TCMS and TRNS

SMCS: Smoking Cessation Programs/Supplies

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. There could be a vendor for some items/procedures, so the BA will provide specific codes if necessary so the Analyst knows what to deny to the vendor vs what is covered by the Health Plan.

	F	G	H	I	J	K	L	M	N	O	P	Q
1	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverag	Cost-Sha (In-Networ k)	Cost-Sha (Out-Of-Ne twork)	Restricte Coverage	Exclusio	Limitatio	Additiona Information	Vendor
93	OH Child No BH	SMCS	Smoking Cessation Programs/ Supplies	Smoking cessation programs provide counseling and patient education as to the health risks of smoking and specific information related to the risks of specific diseases. Also includes items such as nicotine patches, gum or other non-smoking aids.	Covered	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SNFS: Skilled Nursing Facility

- Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The Analyst should look for Restrictions, Exclusions and Limitations that can be configured by Benefits.
- Something that may be in the BRD but Configuration does not handle would be, for example, if the plan has a 90 day limit in which the member gets disenrolled and put into another plan the first day of the month after the limit is reached.
- Any applicable codes will be provided.

	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor	Config Notes
81	SNFS	Skilled Nursing Facility (SNF)	A facility (which meets specific regulatory certification requirements) which primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a daily basis, i.e., on essentially a seven days a week basis. A patient whose inpatient stay is based solely on the need for skilled	Covered	N/A	N/A	Outpatient services for occupational therapy, physical therapy, and speech therapy (OT/PT/ST) are covered.	N/A	N/A	N/A	N/A	The CPT Codes listed below are covered for outpatient OT/PT/ST. Effective 8/22/2011 prior authorization is not required for members under the age of 21. Members age 21 and older require authorization. 64550 92614 97012 97112 97530 97762 92506 92616 97113 97532 97799 92507 97016 97116 97533 G0129 92508 97018 97124 97535 G0151 92520 95831 97022 97139 97537 G0152 92526 95832 97024 97140 97542 G0153 92597 95833 97026 97150 97597 G0159 92605 95834 97028 97161 97598 G0160 95851 97032 97162 G0161 92607 95852 97033 97163 97605 G0329 92608 95992 97034 97164 97606 92609 96105 97035 97165 97750 G0281 92610 96110 97036 97166 97755 G0283

STRH: Sterilization and Reversal/Hysterectomy

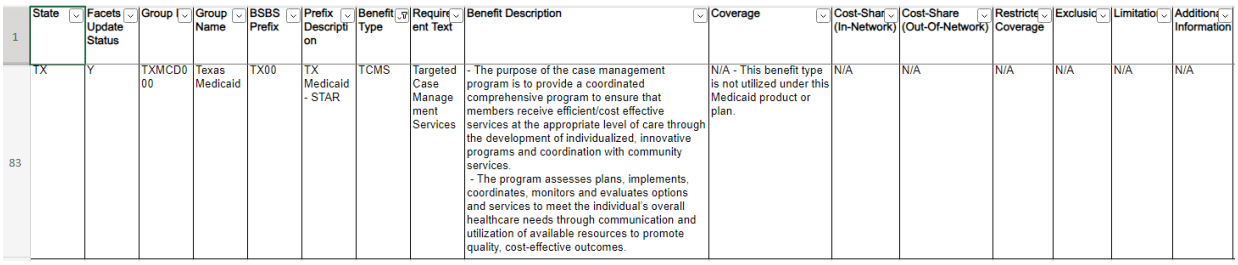
Check Coverage and Cost Share, most of the Restrictions and Limitations will be handled either through authorizations or by Claims Operations. The ASH Committee (Abortion/Sterilization/Hysterectomy) finds out if the Health Plan will follow our standard code list. The ASH list has all the procedure, diagnosis codes and exclusions that get configured by Claims Operations. Configuration will need to ensure if there is any Cost Share that needs to be configured. The BA will already have reached out to Janet Partin who owns/maintains the ASH standard code list before it comes to the Configuration team. If sterilization and reversal/hysterectomy is NOT covered, then that should come through to the Configuration team with the needed codes that go along to have them set up as Non-Covered.

	BSBS Pro	BSBS Description	Benefit_Type	Requirement Text	Benefit Description	Covera	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitation	Additional Information
95	OH96	OH ACT	STRH	Sterilization and Reversal/Hysterectomy	- Sterilization surgery is called a tubal ligation in women and a vasectomy in men. Even though either procedure can occasionally be reversed, tubal ligation and vasectomy must be considered a permanent form of birth control. - Hysterectomy is the surgical removal of the uterus resulting in inability to become pregnant (sterility). The uterus may be removed through the abdominal wall or the vagina.	Covered	N/A	N/A	1) Sterilization of a member aged 21 or over is covered when the consent form is signed and the member is not legally mentally incompetent or institutionalized. The member must give "informed consent" at least 30 days, but not more than 180 days, before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs. Exceptions are approved when medical criteria has been met. 2) Hysterectomies are covered when medically necessary and performed for the purpose of removing the uterus.	1) Sterilization is not covered for the following: - Sterilized members electing artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; and fertility drugs); - Reversal of voluntary sterilization; - Sterilization of a mentally incompetent recipient; - Sterilization of a recipient institutionalized; - When the informed consent was obtained while the member is: - Labor or childbirth; - Seeking to obtain or obtaining an abortion; or - Under the influence of alcohol or other substance; and - When the Sterilization consent form is signed by a guardian, conservator, or anyone other than the person to be sterilized. 2) Hysterectomy performed solely for the purpose of making a recipient sterile. The following services are excluded: - Infertility treatment, including but not limited to the following modalities: (a) Assisted reproductive technologies (ART);	N/A	Covered Sterilization Services include: - Management and evaluation (office) visits and consultations; - Health education and counseling visits; - Laboratory tests and procedures with the provision of sterilization services; - Drug Administration, and - Supplies associated with the sterilization.

TCMS: Targeted Case Management Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. The BA will send over affected codes with ticket, probably only 2 or 3, along with diagnosis codes if there are limits on something like HIV Case Management. This hasn't always

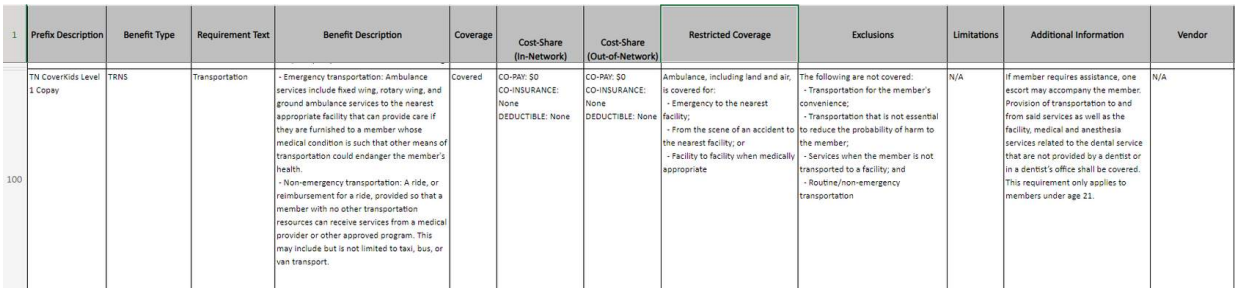
been a Medicaid Benefit Type, so it may be listed as not covered or not utilized for this program but it's still captured under HCPS or BHOP. Case management usually means UM is involved.



	State	Facets Update Status	Group	Group Name	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-Of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information
1																
83	TX	Y	TXMCD000	Texas Medicaid	TX00	TX Medicaid - STAR	TCMS	Targeted Case Management Services	- The purpose of the case management program is to provide a coordinated comprehensive program to ensure that members receive efficient/cost effective services at the appropriate level of care through the development of individualized, innovative programs and coordination with community services. - The program assesses plans, implements, coordinates, monitors and evaluates options and services to meet the individual's overall healthcare needs through communication and utilization of available resources to promote quality, cost-effective outcomes.	N/A - This benefit type is not utilized under this Medicaid product or plan.	N/A	N/A	N/A	N/A	N/A	N/A

TRNS: Transportation

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. There is usually a standard set of procedure codes, but there may be a 2 or 3 code deviation from one market to another. There is usually a vendor involved for non-emergent transport, and the BA sits in on the vendor calls to clarify the codes that will then get sent to Configuration to ensure those codes deny to the vendor. Any services that are covered by the vendor would be handled by that vendor. For example, if there is a Cost Share but there is a vendor, the Analyst will not have to configure the copay because it will deny to the vendor. Same thing with limitations, as the vendor will be handling the ride limit.



	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
100	TN CoverKids Level 1 Copay	TRNS	Transportation	- Emergency transportation: Ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the member's health. - Non-emergency transportation: A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider or other approved program. This may include but is not limited to taxi, bus, or van transport.	Covered	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	CO-PAY: $0 CO-INSURANCE: None DEDUCTIBLE: None	Ambulance, including land and air, is covered for: - Emergency to the nearest facility; - From the scene of an accident to the nearest facility; or - Facility to facility when medically appropriate	The following are not covered: - Transportation for the member's convenience; - Transportation that is not essential to reduce the probability of harm to the member; - Services when the member is not transported to a facility; and - Routine/non-emergency transportation	N/A	If member requires assistance, one escort may accompany the member. Provision of transportation to and from said services as well as the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered. This requirement only applies to members under age 21.	N/A

T/F: SMCS may be covered on a Kid's Plan.

- ◯ True
- ◯ False

SUBMIT

T/F: Configuration is able to handle the 90 day limit for SNFS.

- ◯ True
- ◯ False

SUBMIT

This Benefit Type usually has a standard set of procedure codes, and the BA sits in on vendor calls to learn which of those codes the vendor uses.

- SNFS
- TRNS
- TCMS

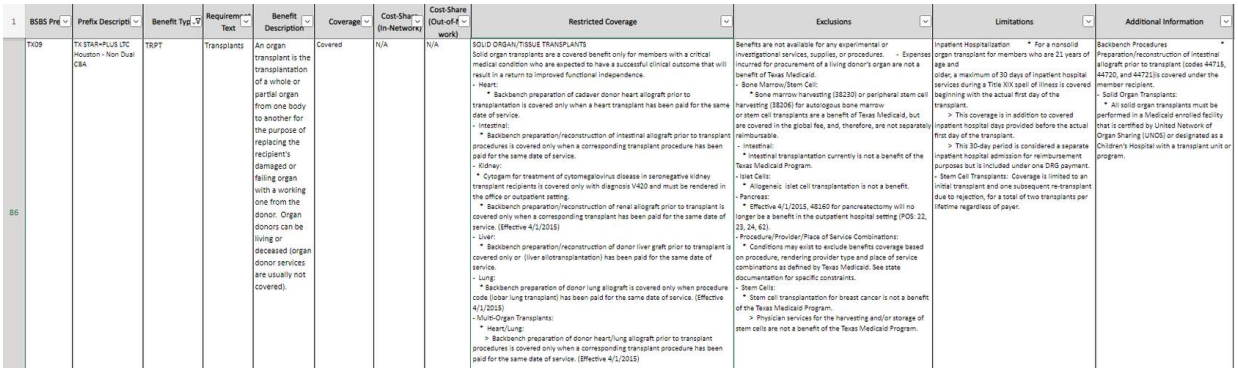
SUBMIT

CONTINUE

TRPT, VABS, VISN, WEBT and WEIT

TRPT: Transplants

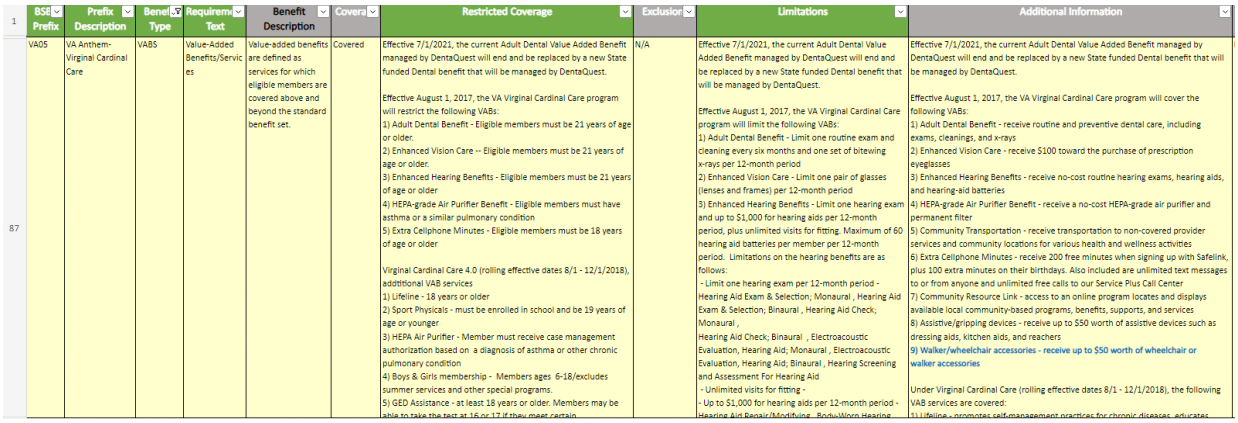
Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Procedure codes will be provided. These services commonly require an authorization, so the Analyst may see information about medical necessity within the requirements.



	BSBS Pre	Prefix Descripti	Benefit Typ	Requirem Text	Benefit Description	Coverage	Cost-Shar (In-Network)	Cost-Share (Out-of-N work)	Restricted Coverage	Exclusions	Limitations	Additional Information
86	TX09	TX STAR+PLUS LTC Houston - Non Dual CBA	TRPT	Transplants	An organ transplant is the transplantation of a whole or partial organ from one body to another for the purpose of replacing the recipient's damaged or failing organ with a working one from the donor. Organ donors can be living or deceased (organ donor services are usually not covered).	Covered	N/A	N/A	SOLID ORGAN/TISSUE TRANSPLANTS Solid organ transplants are a covered benefit only for members with a critical medical condition who are expected to have a successful clinical outcome that will result in a return to improved functional independence. - Heart: * Backbench preparation of cadaver donor heart allograft prior to transplantation is covered only when a heart transplant has been paid for the same date of service. - Intestinal: * Backbench preparation/reconstruction of intestinal allograft prior to transplant procedures is covered only when a corresponding transplant procedure has been paid for the same date of service. - Kidney: * Cytogam for treatment of cytomegalovirus disease in seronegative kidney transplant recipients is covered only with diagnosis V420 and must be rendered in the office or outpatient setting. * Backbench preparation/reconstruction of renal allograft prior to transplant is covered only when a corresponding transplant has been paid for the same date of service. (Effective 4/1/2015) - Liver: * Backbench preparation/reconstruction of donor liver graft prior to transplant is covered only or (liver allotransplantation) has been paid for the same date of service. - Lung: * Backbench preparation of donor lung allograft is covered only when procedure code (lobar lung transplant) has been paid for the same date of service. (Effective 4/1/2015) - Multi-Organ Transplants: * Heart/Lung: > Backbench preparation of donor heart/lung allograft prior to transplant procedures is covered only when a corresponding transplant procedure has been paid for the same date of service. (Effective 4/1/2015)	Benefits are not available for any experimental or investigational services, supplies, or procedures. - Expenses incurred for procurement of a living donor's organ are not a benefit of Texas Medicaid. - Bone Marrow/Stem Cell: * Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid, but are covered in the global fee, and, therefore, are not separately reimbursable. - Intestinal: * Intestinal transplantation currently is not a benefit of the Texas Medicaid Program. - Islet Cells: * Allogeneic islet cell transplantation is not a benefit. - Pancreas: * Effective 4/1/2015, 48160 for pancreatectomy will no longer be a benefit in the outpatient hospital setting (POS: 22, 23, 24, 62). - Procedure/Provider/Place of Service Combinations: * Conditions may exist to exclude benefits coverage based on procedure, rendering provider type and place of service combinations as defined by Texas Medicaid. See state documentation for specific constraints. - Stem Cells: * Stem cell transplantation for breast cancer is not a benefit of the Texas Medicaid Program. > Physician services for the harvesting and/or storage of stem cells are not a benefit of the Texas Medicaid Program.	Inpatient Hospitalization * For a nonsolid organ transplant for members who are 21 years of age and older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness is covered beginning with the actual first day of the transplant. > This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. > This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes but is included under one DRG payment. - Stem Cell Transplants: Coverage is limited to an initial transplant and one subsequent re-transplant due to rejection, for a total of two transplants per lifetime regardless of payer.	Backbench Procedures * Preparation/reconstruction of intestinal allograft prior to transplant (codes 44715, 44720, and 44721)is covered under the member recipient. - Solid Organ Transplants: * All solid organ transplants must be performed in a Medicaid enrolled facility that is certified by United Network of Organ Sharing (UNOS) or designated as a Children's Hospital with a transplant unit or program.

VABS: Value-Added Benefits/Services

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Depending on the BRD the Analyst might see a multitude of things. Older markets had everything called out. In new markets the only parts shown are those benefits that truly have a claim or benefit impact. These will primarily fall under other Benefit Types, such as Transportation or Home Delivered Meals. A ticket would only be submitted to Configuration if there is a benefit impact that does not fall under another Benefit Type.



	BSE Prefix	Prefix Description	Benef Type	Requirem Text	Benefit Description	Covera	Restricted Coverage	Exclusion	Limitations	Additional Information
1										
87	VA05	VA Anthem-Virginal Cardinal Care	VABS	Value-Added Benefits/Services	Value-added benefits are defined as services for which eligible members are covered above and beyond the standard benefit set.	Covered	Effective 7/1/2021, the current Adult Dental Value Added Benefit managed by DentaQuest will end and be replaced by a new State funded Dental benefit that will be managed by DentaQuest. Effective August 1, 2017, the VA Virginal Cardinal Care program will restrict the following VABs: 1) Adult Dental Benefit - Eligible members must be 21 years of age or older. 2) Enhanced Vision Care -- Eligible members must be 21 years of age or older. 3) Enhanced Hearing Benefits - Eligible members must be 21 years of age or older 4) HEPA-grade Air Purifier Benefit - Eligible members must have asthma or a similar pulmonary condition 5) Extra Cellphone Minutes - Eligible members must be 18 years of age or older Virginal Cardinal Care 4.0 (rolling effective dates 8/1 - 12/1/2018), additional VAB services 1) Lifeline - 18 years or older 2) Sport Physicals - must be enrolled in school and be 19 years of age or younger 3) HEPA Air Purifier - Member must receive case management authorization based on a diagnosis of asthma or other chronic pulmonary condition 4) Boys & Girls membership - Members ages 6-18/excludes summer services and other special programs. 5) GED Assistance - at least 18 years or older. Members may be	N/A	Effective 7/1/2021, the current Adult Dental Value Added Benefit managed by DentaQuest will end and be replaced by a new State funded Dental benefit that will be managed by DentaQuest. Effective August 1, 2017, the VA Virginal Cardinal Care program will limit the following VABs: 1) Adult Dental Benefit - Limit one routine exam and cleaning every six months and one set of bitewing x-rays per 12-month period 2) Enhanced Vision Care - Limit one pair of glasses (lenses and frames) per 12-month period 3) Enhanced Hearing Benefits - Limit one hearing exam and up to $1,000 for hearing aids per 12-month period, plus unlimited visits for fitting. Maximum of 60 hearing aid batteries per member per 12-month period. Limitations on the hearing benefits are as follows: - Limit one hearing exam per 12-month period - Hearing Aid Exam & Selection; Monaural , Hearing Aid Exam & Selection; Binaural , Hearing Aid Check; Monaural , Hearing Aid Check; Binaural , Electroacoustic Evaluation, Hearing Aid; Monaural , Electroacoustic Evaluation, Hearing Aid; Binaural , Hearing Screening and Assessment For Hearing Aid - Unlimited visits for fitting - - Up to $1,000 for hearing aids per 12-month period -	Effective 7/1/2021, the current Adult Dental Value Added Benefit managed by DentaQuest will end and be replaced by a new State funded Dental benefit that will be managed by DentaQuest. Effective August 1, 2017, the VA Virginal Cardinal Care program will cover the following VABs: 1) Adult Dental Benefit - receive routine and preventive dental care, including exams, cleanings, and x-rays 2) Enhanced Vision Care - receive $100 toward the purchase of prescription eyeglasses 3) Enhanced Hearing Benefits - receive no-cost routine hearing exams, hearing aids, and hearing-aid batteries 4) HEPA-grade Air Purifier Benefit - receive a no-cost HEPA-grade air purifier and permanent filter 5) Community Transportation - receive transportation to non-covered provider services and community locations for various health and wellness activities 6) Extra Cellphone Minutes - receive 200 free minutes when signing up with Safelink, plus 100 extra minutes on their birthdays. Also included are unlimited text messages to or from anyone and unlimited free calls to our Service Plus Call Center 7) Community Resource Link - access to an online program locates and displays available local community-based programs, benefits, supports, and services 8) Assistive/gripping devices - receive up to $50 worth of assistive devices such as dressing aids, kitchen aids, and reachers 9) Walker/wheelchair accessories - receive up to $50 worth of wheelchair or walker accessories Under Virginal Cardinal Care (rolling effective dates 8/1 - 12/1/2018), the following VAB services are covered: 1) Lifeline - promotes self-management practices for chronic diseases, educates

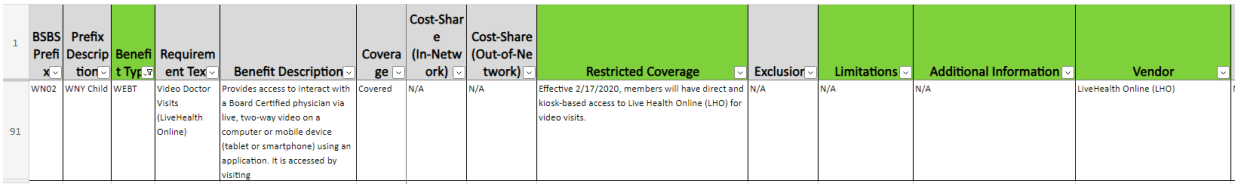
VISN: Vision

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Much like Dental, the routine services are typically carved out to a vendor. The BA will work with a vendor contact and define the contract, then provide codes and other criteria for services that stay with us and thus can be configured versus deny to the vendor.

	Prefix Description	Benefit Type	Requiren nt Text	Benefit Description	Coverag	Cost-Sha (In-Networ k)	Cost-Sha (Out-Of-Ne twork)	Restricted Coverage	Exclusions	Limitations	Additional Information	Vendor
1												
89	WA Medicaid FIMC	VISN	Vision	Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the eye. - Ophthalmology is the branch of medicine which deals with the diseases and surgery of the visual pathways, including the eye, brain, and areas surrounding the eye, such as the lachrymal system and eyelids. - Optometry is a health care profession concerned with examination, diagnosis, and treatment of the eyes and related structures and with determination and correction of vision problems using lenses and other optical aids. - Routine vision services include visual examination, fitting, dispensing and adjustment of eyeglasses, follow-up examinations, and contact lenses.	Covered	N/A	N/A	1) Routine medical/surgical vision services are covered through Amerigroup's vendor contract with EyeQuest. - Fundus photography ocular screening, interpretation and report (procedure 92250) is covered when submitted with TC modifier, and not denied to vendor. 2) Examinations and refraction services are only covered outside the specified Limitations if: - The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease; - The client is on medication that affects vision; or, - The service is necessary due to lost or broken eyeglasses/contacts when the eyeglasses or	1) Eyeglass frames, lenses, contact lenses, and fabrication services and associated fitting and dispensing services are covered under HCA's fee-for-service program. HCA's vision hardware contractor is Airway Optical, which is part of the Washington State Department of Correctional Industries. Providers must obtain all hardware through Airway Optical. HCA does not pay any other optical manufacturer or provider for frames, lens, or contact lenses. 2) Group vision screening for eyeglasses is not covered. 3) Vision-related services for cosmetic purposes only are not covered. 4) Refractive surgery of any type that changes the eye's refractive error is not covered when the intent of the	1) Eye examinations and refraction and fitting services are covered with the following limitations: - Once every 24 months for clients 21 years of age or older; and, - Once every 12 months for clients 20 years of age or younger. 2) Repair and adjustment of spectacles (92370 and 92371) is limited to clients 20 years of age and younger. 3) Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve (92133) is limited to one (1) per calendar year. 4) Scanning computerized ophthalmic diagnostic imaging, posterior	The vendor contractor is EyeQuest.	EyeQuest

WEBT: Video Doctor Visits (LiveHealth Online)

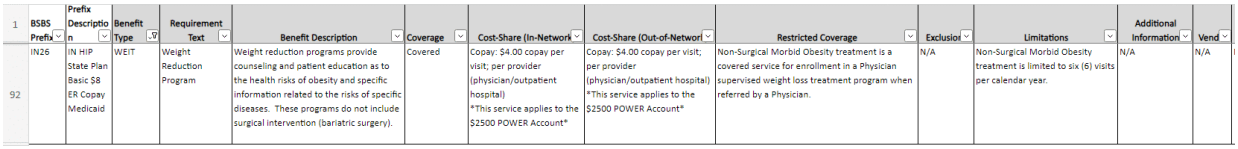
Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. Procedure codes, modifiers and place of service criteria will be given. If Cost Share is different from the plan's standard office visits and/or behavioral services then cost share benefits would need to be configured.



	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network)	Cost-Share (Out-of-Network)	Restricted Coverage	Exclusion	Limitations	Additional Information	Vendor
91	WN02	WNY Child	WEBT	Video Doctor Visits (LiveHealth Online)	Provides access to interact with a Board Certified physician via live, two-way video on a computer or mobile device (tablet or smartphone) using an application. It is accessed by visiting	Covered	N/A	N/A	Effective 2/17/2020, members will have direct and kiosk-based access to Live Health Online (LHO) for video visits.	N/A	N/A	N/A	LiveHealth Online (LHO)

WEIT: Weight Reduction Program

Look at Coverage, Cost Share, Exclusions, Limitations and Additional Information. This Benefit Type may be a Value-Added Benefit, in which case the BA will have worked with the Health Plan to determine if it needs to be configured to be covered by us or not. If there will be claims, the BA will supply the codes to be configured.



	BSBS Prefix	Prefix Description	Benefit Type	Requirement Text	Benefit Description	Coverage	Cost-Share (In-Network	Cost-Share (Out-of-Networ	Restricted Coverage	Exclusio	Limitations	Additional Information	Vend
92	IN26	IN HIP State Plan Basic $8 ER Copay Medicaid	WEIT	Weight Reduction Program	Weight reduction programs provide counseling and patient education as to the health risks of obesity and specific information related to the risks of specific diseases. These programs do not include surgical intervention (bariatric surgery).	Covered	Copay: $4.00 copay per visit; per provider (physician/outpatient hospital) *This service applies to the $2500 POWER Account*	Copay: $4.00 copay per visit; per provider (physician/outpatient hospital) *This service applies to the $2500 POWER Account*	Non-Surgical Morbid Obesity treatment is a covered service for enrollment in a Physician supervised weight loss treatment program when referred by a Physician.	N/A	Non-Surgical Morbid Obesity treatment is limited to six (6) visits per calendar year.	N/A	N/A

This Benefit Type is primarily captured in other categories, but older BRDs still call out everything, whether or not it has a distinct claim or benefit impact.

○ TRPT

- ○ VABS
- ○ WEBT

SUBMIT

The routine services under this Benefit Type are typically carved out to a vendor.

- ○ WEBT
- ○ TRPT
- ○ VISN

SUBMIT

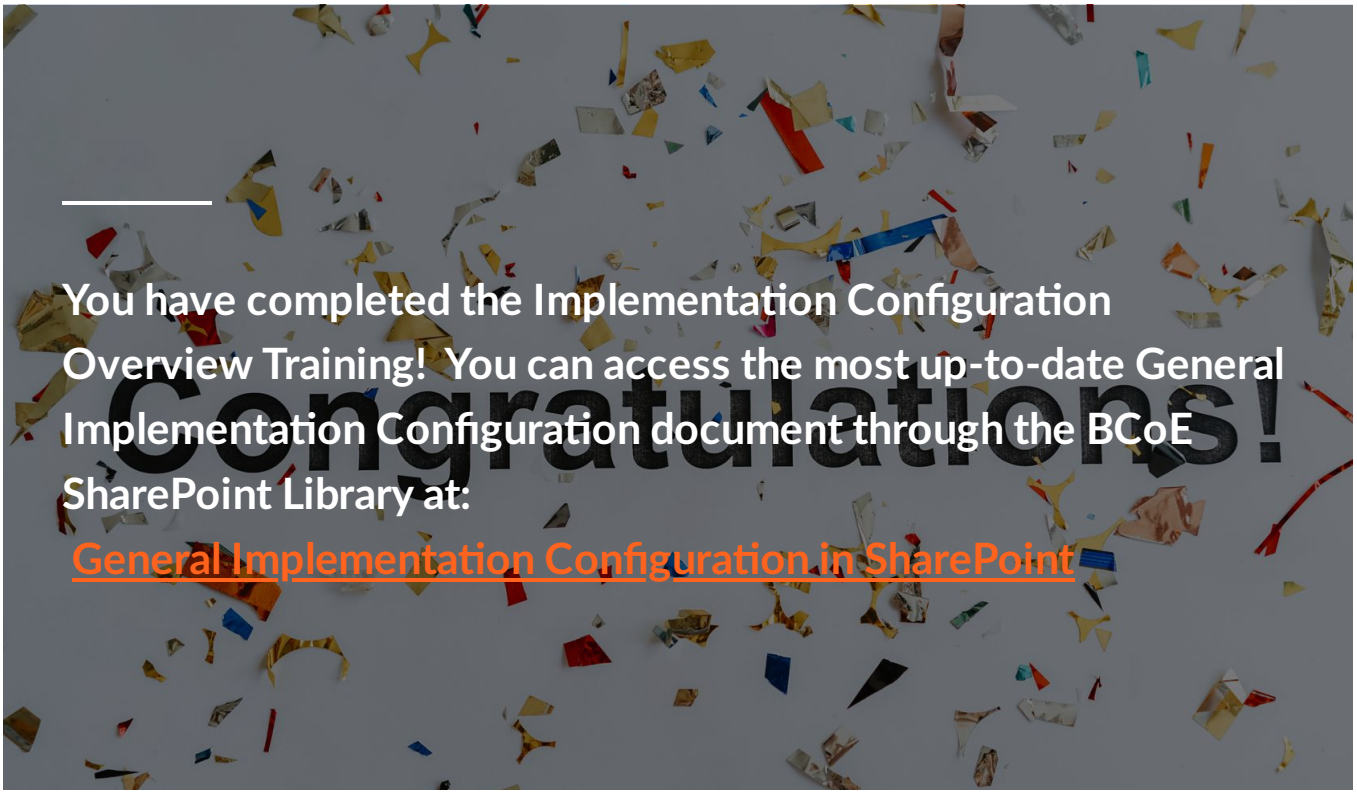
This Benefit Type may fall under Value Added, so the BA will have worked with the Health Plan to determine if any configuration needs to happen in-house.

- ○ WEIT
- ○ WEBT
- ○ VABS

SUBMIT

CONTINUE

CONGRATULATIONS!



You have completed the Implementation Configuration Overview Training! You can access the most up-to-date General Implementation Configuration document through the BCoE SharePoint Library at:

General Implementation Configuration in SharePoint

FINISHED!