

BRULE Benefit Rules

*Rule ID : 05A10COPAY Type : 00 Short Desc : 10.00 COPAY AOD ONLY
 Med Def : 6000:7045
 Narrative :

Header section

Rule Attributes

COPAY RULE
 Copay Amount : 10.00

Apply only if : Quant >= 0.00 and Quant <= 0.00
 Min. qty. Max. qty.

Multiply by Quantity? (Y/N) : N
 Maximum Copay : 0.00

Count toward max :
 Reason code : CPPCP Primary Care Copayment
 Time Frame : L No. Years/Days : 1
 Carryover : N No. Years/Days : 0
 Files : P Member/Family : M
 Other Med Defs:

Attribute section

Security : e
 F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Special Functions
 UPDATE? (Y/N):

COPAY (Type 00)

Copay benefit rules are used to apply a flat co-payment to a service based on medical definitions.

The **header section** contains the rule ID, rule type, short description, medical definitions and a narrative.

The **attribute section** contains the specific fields that can be set depending on how the rule is to be applied.

- Copay amount – the dollar amount for the copay
- Apply only if: Quant >= and Quant <= – these fields tell Diamond when to apply the co-payment rule (ex., if office visits have a co-payment for the first 10 visits only, then the minimum quantity is 0 and the maximum quantity is 10) – default is 0.00.
- Multiply by quantity – if the copay should be multiplied by the quantity enter “Y” if not, enter “N” – default is “N”.
- Maximum copay – enter the dollar amount that once reached, no further co-payment is applied - default is 0.00.
- Count toward Max – Diamond assumes that all co-payment dollars in the member’s claim history are counted when determining if the copay maximum has been met. If only certain kinds of co-payments count toward the maximum use this field to identify them – default is blank.

- Reason Code – enter the applicable co-payment reason code. Diamond uses the Co-payment Reason Code to exclude claims when determining the copay maximum has been reached and if the claim falls within the quantity limit defined in Apply only if quantity field.
- Time frame – set the time frame for the rule:
 - Y-Calendar year (Jan. 1st through Dec. 31st)
 - C-Contract year (contract period on the GROUP record)
 - E-Elapsed years (include all history starting with X number of years prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
 - L-Life (include all claims with dates of service between 1/1/1900 through 12/31/2999)
 - D-Elapsed days (include all history starting with X number of days prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
- No. Years/Days - enter the number of years or days that are applicable to the Time frame of the rule. Not used for time frame code L-Life.
- Carryover - Enter either N-none, D-days or Y-years. Ex., a benefit package might require that a \$500.00 deductible be taken each calendar year and that any deductible taken in the last 60 days of the prior year be counted toward the next year's deductible. In this example Carry-over = D(days) and No. Years/Days = 60.
- No. Years/Days - enter the value that corresponds if you entered either a "D" or "Y" in the carryover field.
- Files - MACSIS only deals with professional services so a "P" should be entered here. (The are four choices: "P" for professional services, "I" for institutional services, "D" for dental services and "A" for authorizations.)
- Member/Family - "M" for member and "F" for family. MACSIS only deals with individuals so this value will always be an "M".
- Other Med Defs – used to specify any additional medical definitions that should be used when Diamond is reviewing the history. If you leave this blank, Diamond includes only those claims with medical definitions defined in the upper portion of the rule screen during is review of the member's claim history.
- Security – enter your board's security code.

BRULE		Benefit Rules	
Header section			
*Rule ID	: OH10SLIDE	Type : 10	Short Desc : 10% SLIDING SCALE
Med Def	: !1000:19ZZ;!5000:5ZZZ		
Narrative	:		
Attribute section			
Rule Attributes			
COINSURANCE RULE			
Coinsure % :	10.00		
Maximum Coins :	0.00		
Count toward Max :			
Reason code :	10%SF	10% SLIDING FEE SCALE	
Time Frame :	L	No. Years/Days :	1
Carryover :	N	No. Years/Days :	0
Files :	P	Member/Family :	M
Other Med Defs:			
Security :			
F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Special Functions			
UPDATE? (Y/N):			

Coinsurance (Type 10)

Coinsurance benefit rules are used to calculate the amount a member owes by taking a percentage of the allowed amount minus any deductible.

The **header section** contains the rule ID, rule type, short description, medical definitions and a narrative.

The **attribute section** contains the specific fields that can be set depending on how the rule is to be applied.

- Coinsurance % – the percentage to be applied.
- Maximum Coins – enter the dollar amount that once reached or exceeded, no further coinsurance will be calculated.
- Count toward Max – Diamond assumes that all co-payment dollars in the member’s claim history are counted when determining if the copay maximum has been met. If only certain types of co-payments are to be counted, use this field to identify them by entering the applicable co-payment reason code.
- Reason code – enter the correct coinsurance reason code.
- Time Frame – set the time frame for the rule:
 - Y-Calendar year (Jan. 1st through Dec. 31st)
 - C-Contract year (contract period on the GROUP record)
 - E-Elapsed years (include all history starting with X number of years prior to the date of service on the claim detail and ending with the claim detail)

date of service. The number of years is specified in the No. Days/Years: field).

- L-Life (include all claims with dates of service between 1/1/1900 through 12/31/2999)
- D-Elapsed days (include all history starting with X number of days prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
- No. Years/Days - enter the number of years or days that are applicable to the Time frame of the rule. Not used for time frame code L-Life.
- Carryover - Enter either N-none, D-days or Y-years. Ex., a benefit package might require that a \$500.00 deductible be taken each calendar year and that any deductible taken in the last 60 days of the prior year be counted toward the next year's deductible. In this example Carry-over = D(days) and No. Years/Days = 60.
- No. Years/Days - enter the value that corresponds if you entered either a "D" or "Y" in the carryover field.
- Files - MACSIS only deals with professional services so a "P" should be entered here. (The are four choices: "P" for professional services, "I" for institutional services, "D" for dental services and "A" for authorizations.)
- Member/Family - "M" for member and "F" for family. MACSIS only deals with individuals so this value will always be an "M".
- Other Med Defs – used to specify any additional medical definitions that should be used when Diamond is reviewing the history. If you leave this blank, Diamond includes only those claims with medical definitions defined in the upper portion of the rule screen during is review of the member's claim history.
- Security – enter your board's security code.

BRULE	Benefit Rules
Header section	<pre>*Rule ID : TESTAADM Type : 20 Short Desc : 15 MIN AND HOUR SVCS Med Def : 5010:5052;5080:5085 Narrative : AOD 15 MIN/HOURLY SVC LIMITS BY CALENDAR MONTH</pre>
Attribute section	<pre>-----Rule Attributes----- LIMITS Limit Type : Q Amount : 16.00 Count toward limit : LMBEN Not Covered Reason code : LMBEN Maximum Benefit For This Service Reached Hold reason code : Time Frame : M No. Years/Days : 1 Carryover : N No. Years/Days : 0 Files : P Member/Family : M Other Med Defs : Medicaid Rule? : Y -----Dental Specific Matches----- Dentist : Security : 0 -----F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Special Functions----- UPDATE? [Y/N]:</pre>

Limits (Type 20)

Limit benefit rules are used to limit the quantities and amounts of specific services.

The **header section** contains the rule ID, rule type, short description, medical definitions and a narrative.

The **attribute section** contains the specific fields that can be set depending on how the rule is to be applied.

- Limit type – enter the appropriate limit type
 - Q-quantity (sums the value in the quantity field)
 - B-billed (sums the billed amount)
 - A-allowed-not covered (sums the allowed amount – not covered amount)
 - N-net (sums the net amount)
 - D-days (sums the number of unique service dates)
 - X-x-ray (not used in MACSIS)
- Amount – enter either the maximum quantity, either an amount or number of days. If the total amount or quantity on file exceeds this maximum, then no further payment is calculated.
- Count toward limit – this field is not valued or used for this type of benefit rule.
- Not covered reason code – enter the appropriate reason code.

- Hold reason code – if you want the claim to be put on hold, enter the appropriate reason code.
- Time frame – set the time frame for the rule:
 - Y-Calendar year (Jan. 1st through Dec. 31st)
 - C-Contract year (contract period on the GROUP record)
 - E-Elapsed years (include all history starting with X number of years prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
 - L-Life (include all claims with dates of service between 1/1/1900 through 12/31/2999)
 - D-Elapsed days (include all history starting with X number of days prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
 - W-Week (include all claims with dates of service in a seven day period that starts on Sunday and ends on a Saturday.)
 - M-Calendar Month (include all claims for a standard calendar month.)
- No. Years/Days - enter the number of years or days that are applicable to the Time frame of the rule. Not used for time frame code L-Life, W-Week or M-Calendar Month.
- Carryover - Enter either N-none, D-days or Y-years. Ex., a benefit package might require that a \$500.00 deductible be taken each calendar year and that any deductible taken in the last 60 days of the prior year be counted toward the next year's deductible. In this example Carry-over = D(days) and No. Years/Days = 60.
- No. Years/Days - enter the value that corresponds if you entered either a "D" or "Y" in the carryover field.
- Files - MACSIS only deals with professional services so a "P" should be entered here. (The are four choices: "P" for professional services, "I" for institutional services, "D" for dental services and "A" for authorizations.)
- Member/Family - "M" for member and "F" for family. MACSIS only deals with individuals so this value will always be an "M".
- Other Med Defs – used to specify any additional medical definitions that should be used when Diamond is reviewing the history. If you leave this blank, Diamond includes only those claims with medical definitions defined in the upper portion of the rule screen during is review of the member's claim history.
- Medicaid Rule: - used to flag this as a rule that should be used when tracking Medicaid service limitations for a client who moves/changes from one benefit package, plan or Board area to another.
- Dentist – not used in MACSIS.
- Security – enter your board's security code.

BRULE	Benefit Rules		
Header section	*Rule ID : TEST	Type : 30	Short Desc : ██████████
	Med Def :		
	Narrative :		
Attribute section	-----Rule Attributes-----		
	DEDUCTIBLE		
	Per Admit Deductible? [Y/N] :		
	Individual Deductible :		
	Family Deductible :		
	Children count individually? [Y/N] :		
	Count toward deduct :		
	Reason code :		
	Time Frame :	No. Years/Days :	
	Carryover :	No. Years/Days :	
	Files :		
	Other Med Defs :		
Security :			
-----F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Special Functions-----			
Short Description of this rule			

Deductible (Type 30)

Deductible benefit rules are used to define a claim deductible that is to be applied to a member.

The **header section** contains the rule ID, rule type, short description, medical definitions and a narrative.

The **attribute section** contains the specific fields that can be set depending on how the rule is to be applied.

- Per Admit Deductible? [Y/N] – This is only used for institutional claims.
- Individual Deductible – enter the individual deductible amount, if there is no individual deductible accept the default of 0.00.
- Family Deductible – not used in MACSIS.
- Children count individually? [Y/N] – Not used in MACSIS.
- Count toward deduct – Diamond assumes that all deductible dollars in a member’s claim history are counted when determining if the deductible has been met. If only certain types of deductibles count toward the maximum, use this field to identify them by entering the applicable deductible reason codes, otherwise leave it blank.
- Reason code – enter the appropriate reason code.
- Time Frame – set the time frame for the rule:
 - Y-Calendar year (Jan. 1st through Dec. 31st)
 - C-Contract year (contract period on the GROUP record)

- E-Elapsed years (include all history starting with X number of years prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
- L-Life (include all claims with dates of service between 1/1/1900 through 12/31/2999)
- D-Elapsed days (include all history starting with X number of days prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
- No. Years/Days - enter the number of years or days that are applicable to the Time frame of the rule. Not used for time frame code L-Life.
- Carryover - Enter either N-none, D-days or Y-years. Ex., a benefit package might require that a \$500.00 deductible be taken each calendar year and that any deductible taken in the last 60 days of the prior year be counted toward the next year's deductible. In this example Carry-over = D(days) and No. Years/Days = 60.
- No. Years/Days - enter the value that corresponds if you entered either a "D" or "Y" in the carryover field.
- Files - MACSIS only deals with professional services so a "P" should be entered here. (The are four choices: "P" for professional services, "I" for institutional services, "D" for dental services and "A" for authorizations.)
- Other Med Defs – used to specify any additional medical definitions that should be used when Diamond is reviewing the history. If you leave this blank, Diamond includes only those claims with medical definitions defined in the upper portion of the rule screen during is review of the member's claim history.
- Security – enter your board's security code.

- D-Elapsed days (include all history starting with X number of days prior to the date of service on the claim detail and ending with the claim detail date of service. The number of years is specified in the No. Days/Years field).
- No. Years/Days - enter the number of years or days that are applicable to the Time frame of the rule. Not used for time frame code L-Life.
- Carryover - Enter either N-none, D-days or Y-years. Ex., a benefit package might require that a \$500.00 deductible be taken each calendar year and that any deductible taken in the last 60 days of the prior year be counted toward the next year's deductible. In this example Carry-over = D(days) and No. Years/Days = 60.
- No. Years/Days - enter the value that corresponds if you entered either a "D" or "Y" in the carryover field.
- Files - MACSIS only deals with professional services so a "P" should be entered here. (The are four choices: "P" for professional services, "I" for institutional services, "D" for dental services and "A" for authorizations.)
- Member/Family - "M" for member and "F" for family. MACSIS only deals with individuals so this value will always be an "M".
- Other Med Defs – used to specify any additional medical definitions that should be used when Diamond is reviewing the history. If you leave this blank, Diamond includes only those claims with medical definitions defined in the upper portion of the rule screen during is review of the member's claim history.
- Security – enter your board's security code.

BRULE	Benefit Rules
<p>*Rule ID : 08BAODHOLD Type : 50 Short Desc : HOLD AOD TREATMENT Med Def : 6000:7505 Narrative : HOLD AOD TREATMENT SERVICES FOR CLIENTS IN INDIGENT DRIVER PROGRAM</p>	
<p>-----Rule Attributes----- MESSAGE AND HOLD</p>	
<p>Message : INDIGENT DRIVER CLIENT - SUBMIT TO COURT</p>	
<p>Hold Reason Code : CLMAN CLAIM MANUALLY PLACED ON HOLD</p>	
<p>Files : P;I;D;A</p>	
<p>Security : B</p>	
<p>-----F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Special Functions----- UPDATE? (Y/N):█</p>	

Header section

Attribute section

Message and Hold (Type 50)

Message and Hold benefit rules are used to display a warning message and put the claim detail line on hold. These held claims require manual intervention.

The **header section** contains the rule ID, rule type, short description, medical definitions and a narrative.

The **attribute section** contains the specific fields that can be set depending on how the rule is to be applied.

- Message – enter the message that should appear on the claims detail screen when this rule is applied.
- Hold Reason Code – enter the hold reason code.
- Files - MACSIS only deals with professional services so a “P” should be entered here. (The are four choices: “P” for professional services, “I” for institutional services, “D” for dental services and “A” for authorizations.)
- Security – enter your board’s security code.

BRULE	Benefit Rules
*Rule ID : 08BMHCREX	Type : 60 Short Desc : EXC NON CRISIS OC
Med Def : 1000:1999;2200:3580;3680;4000:5zzz;7000:7505	
Narrative : EXCLUDE ALL CLIENT SPECIFIC SERVICES EXCEPT CRISIS AND PRE HOSPITAL SCREENING TO NON MEDICAID OUT OF COUNTY CLIENTS	
Rule Attributes	
EXCLUSIONS	
Reason Code : NCSVC	Service/Supply Not Covered
Files : P;I;D;A	
Security : B	
F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Special Functions	
UPDATE? [Y/N]:	

Header section

Attribute section

Exclusions (Type 60)

Exclusions benefit rules are used to deny claims when the medical definition on the claim line matches the medical definitions listed in the header section. Diamond sets the not covered amount equal to the allowed amount on the claim detail line.

The **header section** contains the rule ID, rule type, short description, medical definitions and a narrative.

The **attribute section** contains the specific fields that can be set depending on how the rule is to be applied.

- Reason code – enter a valid not covered reason code.
- Files - MACSIS only deals with professional services so a “P” should be entered here. (The are four choices: “P” for professional services, “I” for institutional services, “D” for dental services and “A” for authorizations.)
- Security – enter your board’s security code.