Healthy Louisiana

Medicaid Managed Care Organizations System Companion Guide

Version 67
April 7, 2021

LDH will provide maintenance of all documentation changes to this Guide using the Change Control Table below.

Change Control Table

Author of Change	Section Changed	Description	Reason	Date
Susan Bryson	**Appendix G**	Provider Specialty/Provider Type Combinations	Validation of PS/PT combinations	**1/14/21**
Susan Bryson	**Appendix G**	Provider Specialty/Provider Type Combinations	Add: PT=20 (MD) to PS=67 (Oral and Maxilliofacial Surgery)	**1/25/21**
Susan Bryson	**Section 2**	**Additional Encounter Requirements**	Add: Special PA to bypass Ambulance Treatment in Place and Ambulance Transport same day edit '900'	**2/23/2021**
Susan Bryson	**Section 2**	**Additional Encounter Requirements**	Update: Dental Value Added Services in preparation for move from 837P to 837D	**3/10/2021**
Susan Bryson	**Appendix G**	**Provider Types**	Added: Verified PT table; PS = Peer Support; notes for those PTs no longer enrolled	**3/12/2021**
Susan Bryson	**Appendix G**	**Provider Specialties**	Corrected for formatting errors	**3/18/2021**
Susan Bryson	**Section 2**	Atypical Providers	Correct: Special PA to bypass Ambulance Treatment in Place and Ambulance Transport same day edit 900 – "9-digit PA number 000000900"	**4/7/2021**
Susan Bryson	**Section 2**	Atypical Providers	Correct: Non-Emergency Medical Transportation item 5 and remove items 6 10.	**4/7/2021**

Managed Care Policies & Procedures – Requests:

Policy/Procedure	**Date Posted**	**Public Comment Due By**	**Status**

General Disclaimer:

The Louisiana Department of Health (LDH) maintains this System Companion Guide. This is a service which is continually under development. Users of the SCG should do so in conjunction with other LDH guidance and regulations. LDH will make every effort to keep the SCG current and to correct errors brought to LDH's attention.

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20:00 Friday, February 14, 2020 1

Report: MW-W-06 *RUN DATE: 20200214*

State of Louisiana
Department of Health
Bureau of Health Services Financing
BAYOU HEALTH Plan
Report MW-W-06: Weekly Provider Registry Edit/Update Report

BAYOU_HEALTH_ID=

RECORD TYPE	PROV ID	NPI	NAME	TAXONOMY 1	ASSIGNED MEDICAID ID	ACC REJ	ERR1	ERR2	ERR3	ERR4	ERR5	ERR6	ERR7
N				3336C0003X	0000000	R	028	000	000	000	000	000	000
D				3336C0003X	0607555	A	035	000	000	000	000	000	000
D				3336C0003X	0523276	A	035	000	000	000	000	000	000
D				333600000X	0000000	R	029	035	000	000	000	000	000

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```
^N^3^^3336C0003X^0000000^R^028^000^000^000^0
^D^3^^3336C0003X^0607555^A^035^000^000^000^0
^D^2^^3336C0003X^0523276^A^035^000^000^000^0
^D^7^^333600000X^0000000^R^029^035^000^000^0
```

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Section 1

Overview

Introduction

This document provides further guidance to Managed Care Organizations (MCO), in addition to the Request for Proposal (RFP), regarding LDH requirements for storing, submitting and reporting Encounter Data.

Encounters include paid and denied services for Medicaid members. The MCO is required to submit encounters to the Fiscal Intermediary (FI) using HIPAA-compliant Provider-to Payer-to-Provider COB 837I (Institutional) and 837P (Professional) transactions.

Encounter Data

Encounters are defined as a distinct set of health care services provided to a Medicaid member enrolled with an MCO on the dates that services were delivered.

Health care encounter data includes:

- All data captured during the course of a single health care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter;
- The identification of the member receiving and the provider(s) delivering the health care services during the single encounter; and,
- A unique, i.e. unduplicated, identifier for the single encounter.

An encounter is comprised of the following components:

- Procedure(s) and/or services rendered during the contract
- Services paid as fee-for-service (FFS)
- Services paid under a capitated provider arrangement

The MCO must report all services (paid or denied), including services paid at $0, that are covered under the MCO Contract.

Purpose of Encounter Data Collection

Collecting complete and valid encounter data is vital to LDH, as it is utilized for the following purposes:

- Contract requirements compliance
- Rate Setting
- Quality Management and Improvement

LDH/Contractor Responsibilities

LDH Responsibilities

LDH is responsible for administering the State's MCO Program. Collection of encounter data is an instrumental tool in that administrative effort. Administration includes:

- Data analysis
- Productive feedback
- Comparative reports to MCOs
- Data confidentiality
- Maintaining the MCO System Companion Guide

Written questions or inquiries about the Guide must be directed to:

Mitzi Hochheiser	**Medicaid Deputy Director**
Telephone	(225) 342-8935
E-mail	Mitzi.Hochheiser@La.Gov

LDH is responsible for the oversight of the Contract and MCO activities. LDH Encounter responsibilities include:

- Production and dissemination of the System Companion Guide
- Initiation and ongoing discussion of data quality improvement with each MCO
- MCO training

Fiscal Intermediary Responsibilities

The FI is under contract with LDH to provide Louisiana Medicaid Management Information System (MMIS) services to the MCOs. The FIs responsibilities include:

Accepting and Storing Encounters

Accepting, editing, and storing encounter data in the 837 and NCPDP formats received from the MCO.

Technical Assistance

The FI is required to provide technical assistance to the MCO during the EDI 837 and NCPDP testing process. The testing process can be found in **Section 3**. Additionally, **Appendix H** of this Guide provides the FI's complete step-by-step process for testing.

X12 Reporting

- 999 – Files containing syntactical errors in segments and elements are reported in the 999 Functional Acknowledgements.
- TA1 – The TA1 report is generated and utilized to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

- 835 (Remittance Advice) - After encounter adjudication, an ANSI ASC X12N 835 (Remittance Advice) is delivered to the MCO, if requested. The MCO must prearrange for receipt of the 835 transactions.

Proprietary Reports and Files

The FI is required to provide MCOs with proprietary MMIS Reports. The following reports and file formats are located in **Appendix D** of this Guide:

- Encounter Claims Summary
- Encounter Edit Disposition Summary
- Edit Code Detail
- Claims Processing Flowchart
- Provider File
- Provider Rates File
- 820 File
- Prior Authorization File
- Diagnosis File for Pre-Admission Certification
- Procedure File for Prior Authorization
- Quality Profiles Submission File

Enrollment Broker Responsibilities

834 X12 Transaction File

On a daily, weekly, and monthly basis the Enrollment Broker is required to make available to MCOs, via 834 X12 transactions, updates on members newly enrolled, disenrolled, or with demographic changes. In addition, at the end of each month, the Enrollment Broker is required to reconcile enrollments and disenrollments with a full 834 X12 Transaction File.

Managed Care Organization (MCO) Responsibilities

Implementation

Within sixty (60) days of operation, the MCO's System shall be ready to submit encounter data to LDH's Fiscal Intermediary.

Encounter Submissions

- The MCO is responsible for ensuring accurate and complete encounter reporting from their providers.
- The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction.
- The MCO must investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified encounter data quality issue(s).
- As encounter data issues are discussed, the MCO must incorporate corrective action steps into

the Encounter Data Quality Improvement Plan. Any issues that are not fully addressed on a timely basis may be escalated into a Corrective Action Plan (CAP). The CAP will include the following:

- Listing of each outstanding issue(s)
- Name of responsible party
- Projected resolution date

File Exchanges

The MCO must be able to transmit, receive and process data in HIPAA-compliant or LDH specific formats and/or methods, including but not limited to, Secure File Transfer Protocol (sFTP) over a secure connection such as Virtual Private Network (VPN), that are in use at the start of the Systems Readiness Review activities.

Section 2

Encounter Data Instructions

Introduction

HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. Further, HIPAA has defined how each of these transactions is to be implemented. Instructions are provided in detail in Implementation Guides (IGs), which define how each loop, segment and data element in a specified transaction set is used.

- The formats used for LDH are the 837I (Institutional) and 837P (Professional) Provider-to-Payer-to Provider Coordination of Benefits (COB) Model as defined in the HIPAA IGs, and NCPDP Batch Pharmacy 1.1 D.0.
- Detailed instructions on how to map encounters from the MCO's System to the 837 transaction can be found in the 837 Implementation Guide (IGs).
- MCOs shall create their 837 transactions for LDH using the HIPAA IG for Version 5010.
- The ANSI ASC X12N 837 Healthcare Claim Transactions- Institutional(I) and Professional(P) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12 National Implementation Guide.

The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/content.

EDI Validation

LDH's FI provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 formats. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. The Guides may be accessed by selecting HIPAA Information Center from the left-hand menu of the site.

BHT06

The BHT06 is used to indicate the type of billed service being sent:

- Fee-for-Service (claim)
- Encounter

The ST-SE envelope must contain encounters only, and a value of "RP" must be used. If the "RP" value is not used when sending encounters, the entire batch of encounters will be rejected, or the batch will be processed as claims which will result in the denial of each claim.

Submission of 837s with TPL

- LDH requires the MCO to submit the Provider-to-Payer-to-Provider COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used

to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2330B (Other Payer information) and 2430 (Service Line Adjudication Information). In the first set of COB loops, the MCO will be required to include information about the MCO provider claim adjudication. In the first set of COB data, the MCO shall place their unique LDH carrier code in loop 2330B, NM109. If there is Medicare TPL, the MCO shall place Medicare's unique LDH carrier code, 999999, in the second set of COB loops. The MCO shall provide LDH with any third-party payments, in subsequent COB loops, the MCO must include the LDH carrier code of the other payer in loop 2330B NM109. There can be only one single subsequent loop per unique payer.

HLA Plan and Medicare Unique LDH Carrier Code Assignment

- Plan Name:
- ACLA Assigned Carrier Code: 999991
- AMG Assigned Carrier Code: 999992
- LHC Assigned Carrier Code 999993
- UHC Assigned Carrier Code 999994
- AETNA Assigned Carrier Code 999995

Medicare Assigned Carrier Code 999999

Identifying Encounters for Non-covered EPSDT Services

MCO must identify EPSDT services that may be authorized by the MCO, but is a non-covered service by Medicaid. When billing these services, MCO must bill via 837P v5010, Loop 2400. Service line SV1-11 (EPSDT-Indicator) value must be 'Y".

Batch File Limitations

The MCO may submit batch encounters up to 99 files per day (Monday through Sunday). The maximum number of encounters per file is 20,000. Daily batching concludes each day at 12 p.m. (noon).

The weekly deadline for NCPDP encounter submissions is Wednesdays at 10:00 p.m. (noon) on a normal processing week. The TA1 rejection code 505 would be applied after that time.

The FIs weekly deadline for accepting encounters is Thursday at 12:00 (noon) CDT. Encounters received after this deadline will be processed during the next week's cycle.

Provider Identifiers

The MCO is required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter. If the last four (4) digits of the zip code are unknown, then the MCO may substitute "9999".

Atypical Providers

Non-Emergency Medical Transportation (NEMT)

The MCO is required to follow the guidelines below for submitting encounters for NEMT claims:

5. Report trip ID/number from the transportation vendor/provider claim to Loop 2300 CLM01 segment of 837 NEMT encounter transaction – Trip ID is a required field.
    - MCO: Trip ID may not be all zeros (0), all nines (9s), or contain spaces nor special characters (effective 5/3/2021).
    - SETI FFS transportation vendor (submitter ID 4509620): Trip ID/number must be 2 chars (LA) and 4 byte integers (2 characters + 4 intergers).

6. Encounters for Electronic and Web-based claims submitted by an NEMT provider shall use the following guidelines:
    a. The Plan ICN length can be up to 30 characters.

    b. The first four Plan ICN characters shall use the following codes:
    Character 1: Claim Submission Media Type
    P = Paper Claim
    E = Electronic Claim
    W = Claim submitted over a web portal
    If other characters are submitted, the Plan shall provide a data dictionary.

    Character 2: Claim Status
    P = Paid Claim
    D = Denied Claim
    If any other characters are submitted, the Plan must provide a data dictionary.

    Characters 3-4: Vendor Information
    Each MCO must provide a data dictionary to indicate the vendor or organization that adjudicated the claim.

    c. A unique Plan ICN is to be populated for each service line in Loop 2400 REF*6R.

7. Modifiers Specific to NEMT Encounters
For NEMT service claims, the MCOs should report an origin and destination modifier for each NEMT trip. Origin and destination modifiers used for NEMT services are created by combining two alpha characters. Each alpha character represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
E = Residential, domiciliary, custodial facility (other than 1819 facility);
G = Hospital based ESRD facility;
H = Hospital;
J = Freestanding ESRD facility;

N = Skilled nursing facility

P = Physician's office;
R = Residence;

While combinations of these items may duplicate other HCPCS modifiers, when billed with a NEMT code, the reported modifiers can only indicate origin/destination.

8. Encounters for gas reimbursement services may use the transportation vendor's NPI as billing and rendering provider.

Billing Provider's Patient Control Number

The MCO is required to send the Patient Control Number value from the Billing Provider's Claim record as the Loop 2300 CLM01 value in the associated encounter record.

Echo the Provider Patient Control number in the claim to the CLM01 segment of the 837.

The following EDI Delimiters cannot be part of a Data Element (field) value. If any of the EDI Delimiters are part of a field value from a paper Claim record, the Encounter record value should substitute a <space> Character where the Delimiter Character was located.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element
~	Tilde	Separator Segment Terminator

File Naming Conventions

Encounter files must be submitted using the following file extensions:

Transaction	Claim Type	Name	File Extension	Sample File Name
837P	9	Durable Medical Equipment- Provider Type=40	DME	H4599999.DME
837P	4	Physician, Day Health Care Professional (Identify ALL 837P claims including EPSDT Services, and excluding Rehab)	PHY	H4599999.PHY
837P	5	Rehabilitation Provider Type=65, 59	REH	H4599999.REH
837P	7	Ambulance Transportation – NEAT, EMT: Provider Type 51	TRA	H4599999.TRA
837P	8	Non-emergency medical Transportation – NEMT: Provider Type = 42	NAM	H4599999.NAM
837I	01 & 03	Hospital IP/OP Inpatient: Identify by Place of Service – First 2 digits of Bill Type=11 or 12 Outpatient: Identify by Place of Service – First 2 digits of Bill Type=13, 14, or 72	UB9	H4599999.UB9
NCPDP Batch Pharmacy	12	NCPDP Batch Pharmacy – Provider Type=26 **Paid** Pharmacy Encounters	NCP	H4599999.NCP

NCPDP Batch Pharmacy	12	NCPDP Batch Pharmacy – Provider Type=26 **Denied** Pharmacy Encounters	NCD	H4599999.NCD
837I	6	Home Health – Identify by Place of Service – First 2 digits of Bill Type=32	HOM	H4599999.HOM

Encounters for Claims with Multiple Lines

The MCO is required to bill encounters with multiple claim lines at the document level. The following claim types billed for the same recipient, same billing provider, and same date of service must be billed as one encounter in Loop 2300. The FI's system assigns an ICN (Internal Control Number) including a 2-digit line item number at the header level. Subsequent lines will be assigned the same ICN with sequential line item numbers.

CLAIM TYPE DESCRIPTION	CLAIM TYPE
Outpatient Hospital	03
Professional	04
Rehab	05
Home Health	06
Transportation	07
Non-Emergency Transportation	08
DME	09

DXC ICN Format

The format of the DXC ICN is as follows:

- Digit 1 =Last digit of year of receipt
- Digit 2-4 =Julian date of the year of receipt
- Digit 5 =Media code
  - 0=Paper
  - 1=EDI or Electronic Claim
  - 2=Paper Adjustment
  - 3=System Void
  - 4=Void
  - 5=Paper Claim with Attachment
- Digits 6-8 =3-digit Batch Number

- Digits 9-11 =3-digit Sequential Number in Batch
- Digits 12-13=Claim Line Number

MCO ICN Format

The MCO's ICN must be populated in Loop 2400 REF*6R (Line Item Control Number) segment. The maximum number of characters that the FI can store is 30, which includes the 4-digit prefix. The ICN that the MCO transmits in this segment is echoed back to the submitter in the 835. This permits the MCO to use the value in this field as a key in their system to match the encounter back to the information returned in the 835 transaction.

LDH requires MCOs to modify their ICN to contain a 4-digit prefix as follows:

Character 1 - Claim Submission Media Type

- **"P"** to indicate submission of claim via paper form
- **"Q"** to indicate submission of a value added service via paper form
- **"E"** to indicate submission of claim via electronic submission
- **"F"** to indicate submission of value added service via electronic submission
- **"W"** to indicate the submission of claim via web portal
- **"V"** to indicate the submission of value added service submitted via web portal

The MCO must provide a Data Dictionary if other media types are submitted.

Character 2: Claim Status

The MCO, and/or sub-contractor, must indicate the status of the claim for this character position as follows:

- **"P"** for paid encounters
- **"D"** for denied encounters

Character 3-4: Vendor (Sub-contractor) Information

The MCO determines a two-character code for each of its vendors. The MCO must provide LDH with a Data Dictionary to identify the two-character code and the full name of the vendor it represents. As vendors are added or deleted, LDH must be furnished with an updated Data Dictionary.

Encounter Reporting of Financial Fields

LDH requires MCOs to report the following financial fields at the Header and Line Item:

Submitted Charge Amount

MCOs are required to report the provider's charge or billed amount; even when the amount is zero dollars.

MCO Paid Amount

If the MCO paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the MCO or was covered under a capitation arrangement, zero ("$0") is the appropriate paid amount. The MCO Paid Amount is sent in the first set of COB data.

Adjustment Amount

If the paid amount reflects any adjustments to the submitted line item Charge Amount, then 837 CAS segment data must be sent to fully explain the difference between the submitted charges and the amount paid. The CAS segment data must include monetary Adjustment Amount values along with associated Claim Adjustment Reason Code (CARC) values to account for the difference between the submitted charges and the amount paid; this is required even when the amount paid is zero and when the claim was denied. If the MCO Plan responded to the Billing Provider with proprietary reason codes, then the MCO Plan is required to convert those proprietary codes to standard CARC codes for reporting of encounter records.

Interest Paid Amount

Interest Paid by the MCO and the date of that Interest payment is required to be submitted in the Second or Third sets of COB data in the 837P and 837I Encounter Data.

In the Claim Interest set of COB Loops, a value in INT99X format will be used (instead of using the MCO's unique LDH Carrier Code – 99999x) where the last digit is the same last digit from the Plan's unique LDH Carrier Code value.

- For Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2320 using CAS02 value 225. The interest Paid Amount will also be sent in AMT02 of the Loop 2320 AMT*D segment. The Interest Paid Date will be sent in Loop 2330B DTP*573 Segment.
- For non-Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2430 using CAS02 value 225. The Interest Paid Amount will also be sent in Loop 2430 SVD02. The Interest Paid Date will be sent in the Loop 2430 DTP*573 Segment.

Claim Received Date

The MCO is required to submit the MCOs Claim Received Date in 837P and 837I encounter data. The Claim Received Date will be sent in Loop 2300 in the REF*D9 segment using date format **yyyymmdd**.

Historical Encounter Data

Below are the instructions for determining the receive date for historical encounter data:

1. Original Encounters
    - For original encounter records, the plan received date value should be the date that the MCO received the claim record from the billing provider.

2. Adjustment Encounters
    - For adjustment encounter records, if the adjustment was initiated by the billing provider, then the MCO receive date value should be the date that the MCO received the claim

adjustment record from the billing provider.

- If the adjustment was initiated by the MCO, then the plan receive date value should be the same as the MCO payment date of the adjustment.
- If an adjustment is requested by LDH or DXC, then the original MCO receive date value should be the MCO receive date.

3. Void Encounters
   - For void encounter records, if the void was initiated by the billing provider, then the MCO received date value should be the date that the MCO received the claim void record from the billing provider.
   - If the void was initiated by the MCO, then the MCO received date value should be the date that the MCO processed the void record.
   - If a void is request by LDH or DXC, then the original MCO receive date value should be the date MCO receive date.

The FI provides to the MCO a file of encounter records that are missing the MCO receive date. The MCO is required to retrieve the file, populate the records with the missing data, and return the file to the FI. The MCO may retrieve the file from the MCO's non-EDI "from_Molina" folder. The file name is: MCO_missing RecDate _DDMonYYYY.zip. The file layout can be found in Appendix V of this document.

Claim Paid Date

The MCO is required to submit the Plan's Claim Paid Date in 837P and 837I encounter data.

- For Inpatient records, the Claim Paid Date must be sent in Loop 2330B in the DTP*573 segment.
- For non-Inpatient records, the Claim Paid Date must be sent in Loop 2430 in the DTP*573 segment.

Adjustment Process

In the case of encounter adjustments, the MCO is required to follow the detailed, payer-specific instructions provided in the FI's Companion Guides found at:

www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

To adjust an encounter with a line level denial, the MCO must make the correction(s) to the encounter and resubmit the corrected encounter using the instructions below:

Line Adjustment Process

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	**Claim Frequency Type Code** To adjust a previously submitted claim, submit a value of "7". See also 2300/REF02

2300	REF01	128	**Reference Identification Qualifier** To adjust a previously submitted claim, submit "F8" to identify the Original Reference Number
2300	REF02	127	**Original Reference Number** To adjust a previously submitted claim, submit the 13-digit FI's ICN assigned by the adjudication system and printed on the remittance advice for the previously submitted claim that is being adjusted

Additional Encounter Requirements

Newborn Birth Weight

The birth weight of a newborn is required on encounters for delivery services; and it must be reported in Value Code segments of the 837I Loop 2300 HI value Code 54 (Newborn Birth Weight in Grams). It may be necessary for the MCO to crosswalk the diagnosis code from deliveries to populate the patient information for the birth weight.

Billing for Newborns

The MCO is required to submit the baby's facility bill, for the newborn only at the time of delivery, using the baby's Medicaid ID. The baby's Medicaid ID is to be used on the following newborn claims:

- Well babies
- Babies with extended stays (sick babies) past the mother's stay
- All aftercare and professional encounters

The MCO is required to hold the encounter until the newborn Medicaid ID can be obtained and submitted on the encounter.

Category II CPT Codes

LDH requires the use of applicable Category II CPT Codes for performance measurement. These codes will facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures.

On the ASC X12N 837 Professional Health Care Claim Transaction, Category II CPT and HCPCS Level II Codes are submitted in the SV1 "Professional Service" segment of the 2400 "Service Line" loop. The data element for the procedure code SV101-2 "Product/Service ID".

NOTE: It is also necessary for the MCO to identify that a Category II CPT/HCPCS Level II G – code is being provided. This is done by submitting "HC" code in data element SV101-1.

Transformed Medicaid Statistical Information System (T-MSIS)

LDH, due to CMS mandates, will work with MCOs regarding required system changes for all Data Elements. MCOs are required to fully populate 837 transactions in accordance with the existing 5010 Implementation Guide and this System Companion Guide in order to ensure that their systems comply with this Federal mandate.

On a weekly basis, the MCO is required to submit a Provider Supplemental File. The layout for this file can be found in **Appendix J**.

Additional information and updates will be provided to MCOs via this Guide as approved by LDH.Value Added Services

Value Added Services

Dental

LDH requires the MCO to use ICD-9 diagnosis code V72.2 and ICD-10 diagnosis code Z01.20 when reporting value added dental services on the 837P encounter record. This code is ONLY required when the provider doesn't use a diagnosis on the value added dental claim.

In addition, tooth numbers, when used by the MCO, should be placed in the Procedure Code Modifier field of the 837P.

Procedure Code Modifier fields are 2 character fields; they must be 2 character values to pass 5010 validation. Therefore, for Tooth Numbers less than 10, use a zero (0) in front of the Tooth Number to make it 2 characters Tooth Number 8 would be reported as Modifier-1 value 08). The Tooth Number should be placed in SV101-3 (Procedure Modifier).

When Tooth Surface Codes are used by the MCO, the single character Tooth Surface Code values should be reported in Modifier-2 through Modifier-4 values, that's SV101-4, SV101-5 and SV101-6. Since the Procedure Code Modifier fields are 2 character fields, if only 1 or 3 or 5 Tooth Surface Codes are used, then place a dash (-) after the Tooth Surface Code value to complete the 2-character requirement. For example, if Tooth Surface Codes M, D and B are used, then the SV101-4 will be MD and the SV101-5 value will be B-.

Effective 07/01/2021 Managed Care Organizations should submit dental encounters via the 837 D as outlined in the Dental Systems Companion Guide. Pervious to this date MCOs should submit via the 837 P Guidance below. If an encounter was submitted via the 837 P format, any adjustments must also be submitted via 837 P or the MCO must void the original encounter and resubmit it as an 837 D.

Special PA to bypass Duplicate Ambulance Trip Edit 828

Same day Ambulance Claims can hit Encounter Deny Edit 828 (Exact Duplicate Ambulance Claim). A special Prior Authorization number '000000828', has been established to allow the MCO Plan to bypass Encounter Edit 828. After the MCO Plan has validated that the additional same day Ambulance trip is not a duplicate billing, then the MCO Plan can bypass Encounter Edit 828 by including the special PA number in the Encounter 837 data. The special PA number should be sent in the normal 837 Prior Authorization segment, that is at either Loop 2300 REF*G1 or Loop 2400 REF*G1.

Special PA to bypass Ambulance Treatment in Place and Ambulance Transport same day edit '900'

When ambulance treatment-in-place (A0427, A0429 (W second position of the destination modifier)) and emergency ambulance transport (A0427 or A0429) encounters are billed for the same DOS, same recipient and same billing provider, the last encounter processed will deny for edit 900 except when the MCO sends 9-digit PA number 000000900 in Loop 2300 REF*G1 or Loop 2400 REF*GR, certifying the services were rendered for unique occurrences within the same day.

Tracking of Evidence Based Practices (EBP)

The MCO is required to report the billing provider submitted EBP tracking code value in the encounter record submitted to MMIS in the 837-P's Loop 2400 SV101-7 data element.

The following table contains the current list of EBP tracking codes, associated cpt/hcpcs codes, as well as guidance on appropriate documentation of provider qualifications that should be linked to use of EBP tracking codes via credentialing. The MMIS adjudication system will be setup with Edits to deny MCO encounter records when an EBP tracking code is used with a mismatched cpt/hcpcs code.

Evidence-Based Practice	EBP Tracking Code	Valid CPT/HCPCS Codes	Credentialing documentation to provide the EBP
Functional Family Therapy-Child Welfare (FFT-CW)	EB01	H0036 with modifier HE	Agency FFT License with FFT-CW specialty from FFT, LLC.
Child-Parent Psychotherapy (CPP)	EB02	90837, 90834, 90832, 90847, 90846	Certificate stating that the clinician has fulfilled the requirements of an implementation level course in Child-Parent Psychotherapy, from a trainer endorsed by the University of California, San Francisco.
Parent-Child Interaction Therapy (PCIT)	EB03	90837, 90834, 90832, 90847, 90846	Certification from PCIT, International. http://www.pcit.org/united-states.html
Youth PTSD Treatment (YPT)	EB04	90837, 90834, 90832, 90847, 90846	Advanced Certificate from Tulane Psychiatry in Youth PTSD Treatment.

Preschool PTSD Treatment (PPT)	EB05	90837, 90834, 90832, 90847, 90846	Advanced Certificate from Tulane Psychiatry in Preschool PTSD Treatment.
Triple P-Standard Level 4	EB06	90837, 90834, 90832, 90847, 90846	Accreditation Certificate in Triple P – Standard Level 4, issued by Triple P America.
TF-CBT	EB07	90837, 90834, 90832, 90847, 90846	Documentation of certification through the TF-CBT National Therapist Certification Program. Certified TF-CBT therapists are listed on a national registry at https://tfcbt.org/members/
EMDR Therapy - Eye Movement Desensitization and Reprocessing	EB08	90837, 90834, 90832, 90839	Documentation of completion of EMDRIA Approved Basic Training. A directory of practitioners who have completed EMDIRA Approved Basic Training can be found at www.emdria.org.

Section 3

Electronic Data Interchange (EDI) Certification and Testing

Introduction

The intake of encounter data from each MCO is treated as HIPAA compliant transactions by LDH and its FI. As such, the MCO is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the MCO is required to send real transmission data. LDH requires a minimum set of encounters for each transaction type based on testing needs.

EDI Protocols

The Electronic Data Interchange (EDI) protocols are available at:

http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

MCO EDI Submitter Enrollment and Testing

Enrollment as an EDI submitter is achieved through the completion of the LDH/FI approval process and the successful testing of encounters by transaction type and claim type. Enrollment is processed through the following steps:

- Upon request from a LDH approved MCO, the FI will provide application and approval forms for completion by the MCO. Once complete, the forms must be mailed to the FI's Provider Enrollment Unit.
- During the authorization process, the MCO can call the EDI Department (225-216-6303) to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the submitter develops and tests application software to create EDI encounters.
- The FI requires the MCO to certify with a third-party vendor, EDIFECS, prior to submitting test encounters to the FI.
- When the submitter is ready to send a test file of encounters, the encounters are required to be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and format. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, the MCO is required to submit additional test encounters until an acceptable test run is completed.

NOTE: The test submitter Number (4509999) shall be used for TEST submission encounters ONLY.

When all forms have been received and approved by the FI's Provider Enrollment Unit, and the EDI Department has verified the test claims as successful, then the submitter will be notified that EDI encounters may be submitted to Production.

The encounter submitter process for approved MCO EDI submitters is as follows:

- Upon receipt of Production encounter submissions, the FI's EDI Department will log the submission and verify its completeness. Incomplete submissions are rejected and the submitter is notified of the reject reason(s) via electronic message or telephone call.
- The MCO is required to submit, annually, an EDI Certification Form. If the certification form has been completed, the EDI Department enters the submitted encounters into a pre-processor production run. The pre-processor generates the following items:
    - An encounter data file
    - The Claims Transmittal Summary Report
      The Claims Transmittal Summary Report lists the status (Accepted or Rejected) of a batch of encounters. Rejected encounters are identified and include the following information:
        - The provider number
        - The dollar ($) amount of the encounter
        - The number of encounters rejected

The MCO is required to submit to LDH and its FI a Test Plan with systematic plans for testing the ASC X12N837 COB. The three-tier (3) Test Plan is outlined and can be found in **Appendix H** of this Guide.

Timing

The MCO may initiate EDIFECS testing at any time. LDH's FI Business Support Analysts are available to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides for specific instructions at:
http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

Encounter Processing Flow

The Process Flow Chart depicting incoming transactions through the FI's Electronic Data Interchange (EDI) can be found in **Appendix N**.

Encounter Data Certification

The Balanced Budget Act (BBA) requires certification of data submitted by the MCO when State Payments are to be made to an MCO based on the data submitted by the MCO. The certification applies to:

- Enrollment Data
- Encounter Data
- Any other information specified by the State

Based on CFR §438.606 the certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the MCO which are used to create payments and/or capitated rates, must be certified by a complete, and signed Encounter Data Certification Form; and is required to be submitted concurrently with each encounter file submission. The MCO may submit one (1) Encounter Data Certification Form for all encounter files submitted in one (1) day. The form's "**For The Period Ending**" field value should use the same date as the "**Date File Sent**" field values. The same date value should be used in "**Date File Sent**" for all files listed on the form; the form shall not contain span-dates. The form should be sent to LDH no later than one (1) business day after the encounter files were submitted. The data must be certified by one of the following individuals:

- The MCO's Chief Executive Officer (CEO)
- The MCO's Chief Financial Officer (CFO), or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO

The Encounter Data Certification Form can be found in **Appendix O**.

Section 4

Data Management of File and Encounter Submissions

Introduction

Encounter Data is submitted through the FI's Electronic Data Interchange (EDI). Once received, the 837 transactions are subject to initial edits. Additional edits are applied during the FI's MMIS encounter process.

File Rejection and Encounter Denial

Incoming 837 files may be rejected during EDI Front-end processing. Once the 837 transactions successfully make it to the MMIS encounter processing level, then individual encounter records are independently adjudicated as either denied or accepted. At the FI's Electronic Data Interchange, there are four (4) Front-end levels at which edits are present:

- EDI File Encryption Level
- TA1 Level
- 999 Level
- Pre-processor Level

EDI File Encryption Level (Entire File)

EDI files sent to the FI must be encrypted and named according to the current sFTP guidelines established by the FI's EDI Department. If the EDI file is not properly encrypted or if the file is not properly named, then the entire EDI file is automatically deleted by the FI's system and no notification is sent back to the submitter.

If the EDI file is correctly encrypted and named, then the file will process through the TA1 level edits and either an accepted TA1 will be returned to the submitter or a rejected TA1 will be returned to the submitter. If the submitter does not receive either an accepted TA1 or a rejected TA1, then the submitter should look into whether the file was correctly encrypted and named; the EDI file will need to be

TA1 Level

Successfully received EDI files process through a set of TA1 edits that validate the file's Interchange format along with other LA Medicaid specific data content conventions. If there is a problem at the TA1 level, a rejected TA1 will be returned to the submitter and the entire EDI file is not processed any further. The rejected TA1 includes an error code for the problem with the file; a list of TA1 Edit (error) codes and descriptions are included in the EDI General Companion Guide found at http://www.lamedicaid.com/provweb1/HIPAABilling/5010_EDI_General_Companion.pdf. EDI files that receive a rejected TA1 will need to be resubmitted using a new Interchange Control Number (ISA13) value.

If the EDI file successfully passes the TA1 edits, then an accepted TA1 is returned to the submitter and the file will process through the 999 level edits.

999 Level (Entire File)

EDI files that receive an accepted TA1 are processed through a set of 999 edits that validate the Functional Group (GS-GE) format and data content. If there is a problem at the 999 level, a rejected 999 will be returned to the submitter and the entire EDI file is not processed any further. EDI file problems reported at the 999 level are reported in ASC X12 999 transaction set format. EDI files that receive a rejected 999 will need to be resubmitted using a new Interchange Control Number (ISA13) value.

If the EDI file successfully passes the 999 edits, then an accepted 999 is returned to the submitter and the file will process through the Pre-processor level edits.

Pre-processor Level (Entire File)

EDI files that receive an accepted 999 are processed through Pre-processor level edits that validate LA Medicaid specific data content. LA Medicaid data content specifications are listed in Companion Guides located on the LAMedicaid website: (http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm). If there is a problem at the Pre-processor level, the submitter is notified by the FI's EDI Department and the entire EDI file is not processed any further. EDI files that hit Pre-processor level edits will need to be resubmitted using a new Interchange Control Number (ISA13) value.

There is no notification sent back to the submitter when the EDI file successfully passes the Pre-processor edits. Once the EDI file passes the Pre-processor edits, each of the individual transaction records from the file are independently adjudicated.

A comprehensive list of encounter edits including the disposition; list of repairable edits and a list of non-repairable edits are located in **Appendix F**.

Correction of File and Encounter Errors

The MCO is required to correct all rejected files and repairable encounter edits applied to service line denials and resubmit corrected files and encounters to the FI as indicated below:

Entire File Rejection

When the entire file (batch) is rejected, the MCO will receive one of the following:

- For EDI File Encryption rejections, the absence of a TA1 is the notification of a problem at this level.
- For TA1 rejections, the TA1 transaction reports the details of the problem.
- For 999 rejections, the 999 transaction reports the details of the problem.
- For Pre-processor rejections, the FI's EDI Department will notify the MCO submitter either by phone or email.

The MCO is required to work with the FI's Business Support Analyst to determine the cause of the error.

The MCO will receive an X12 835 (RA) for header level rejects. The MCO is required to adhere to the implementation guide, code sets, and looping structures to correct these transactions, as well as to the LDH-specific data rules as defined in the FI's Companion Guide and **Section 2** of this Guide.

Individual Record Denial

The MCO will receive an X12N 835 for transaction claims that have processed through the MMIS.

EDI Resolution

If after implementing correction processes, there remain unresolved edits; the MCO may present the outstanding issue(s) to LDH and/or its FI for clarification and/or resolution. LDH and/or the FI will review and triage the issue(s) to the appropriate entity for resolution; and will respond to the MCO with their findings. If the outcome is not agreeable to the MCO then the MCO may resubmit the outstanding issue(s) with supporting documentation to LDH for reconsideration. The outcome as determined by LDH will prevail.

EDI Dispute Resolution

The MCO has the right to file a dispute regarding denied encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. An MCO may believe that a denied encounter is the result of an FI error. An FI error is defined as a denied encounter that:

- The FI acknowledges to be the result of its own error
- Requires a change to the FI's systems programming (i.e., an update to the MMIS reference tables, or further research by the FI) and therefore requires FI resolution.

The MCO must notify LDH in writing within thirty (30) calendar days if it believes that the resolution of a denied encounter rests on the FI rather than the MCO. The MCO must submit a memorandum describing the issue. The edit report(s) provided by the FI may be attached to the memorandum as part of the written request. Denied encounter(s) that require research must be highlighted or otherwise identified.

The FI, on behalf of LDH, will respond in writing within thirty (30) calendar days of receipt of such notification. The FI will review the MCO's written request, and if needed, may request additional substantiating documentation from the MCO. The FI's response will identify the disposition of each denied encounter issue in question. If the FI disagrees with the MCO's claim of an FI error because the documentation does not support the claim, then the MCO will be required to correct the encounter, if repairable, and resubmit during the next billing cycle.

Section 5

Denial Edit Codes and Descriptions

Introduction

LDH has modified edits specifically for Managed Care Organizations encounter processing. In order to ensure that LDH has the most complete data for rate setting and data analysis, the MCO is required to repair as many denial edit codes as possible.

Encounter Edit Reports

On a weekly basis, the FI will post to the MCOs sFTP site, encounter reports identified in **Appendix D**. The reports are produced one (1) day after the MMIS adjudication cycle. The MCO is required to correct and resubmit repairable encounters.

The following items/issues are required to be corrected and resubmitted:

- Service lines to which a repairable edit has been applied
- Encounters that deny its entirety

Section 6

Continuous Quality Improvement

Introduction

Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the MCO will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to assist LDH and the MCOs in developing MCO-specific Encounter Quality Improvement Plans as they become necessary. Interim monitoring and follow-up on identified quality problem areas is an integral component of LDH's encounter process.

The Encounter Quality Improvement Plan is designed to provide LDH and the MCO with a comprehensive list of data quality issues present in the data for a given period of time. LDH will meet with MCO's as needed. The MCO meeting attendees are to include, but not be limited to the following staff:

- Claims
- EDI Experts
- Clinical Quality Assurance Staff

Prior to meetings, the MCO is expected to have investigated any findings, and be prepared to explain the underlying reason(s) for the identified data quality issue(s). As data issues are discussed, the MCO must incorporate corrective action steps into a Quality Improvement Report. If issues are not resolved in a timely manner, LDH may request a Corrective Action Plan (CAP).

Minimum Standards

There are two (2) components to encounter data quality assessment:

- Repairable Denials
- Data Volume Assessment

Repairable Denials

Repairable denials must be for corrected and resubmitted in accordance with Section 17.8 of the RFP.

Data Volume Assessment

Data Volume Assessment is the evaluation to determine if key services meet expected rates of provision, as demonstrated in the data. The assessment is a core audit function; and allows LDH to determine the following:

- If the MCO is submitting data
- If all of the encounter data generated for a specified period has been received
- If the actual level of services are adequate to meet contractual requirements

The data is further used to justify capitation rates, and to provide appropriate access to care for the enrolled population.

Section 7

Medicare Recovery Process

On a monthly basis, the FI runs a query to identify Managed Care members who have retrospectively enrolled in Medicare (i.e., QMB, SLMB, & Part A/B). Once members have been identified, the FI generates and processes voids to recover the PMPM payments made on behalf of these members to an MCO. The FI will generate an 820 file with detailed information regarding the voids. The 820 file format is located in **Appendix D.** Only MCOs with impacted members will receive a CP-0-12D report which identifies the retrospectively enrolled members for which PMPM payments were made, and the 820 file which is placed on the MCO's sFTP site for retrieval.

Upon receipt of the 820 file, the MCO is required to contact the Enrollment Broker to request disenrollment information for the impacted members if they have not received it in a previous 834 file. In addition, the MCO must notify the provider of the disenrollment prior to recovery of payments made to the provider.

Section 8

Medicaid Administrative Retroactive Enrollment Correction Process

LDH has determined that in some instances, Administrative Retroactive Corrections to member linkages are necessary to ensure compliance with internal policies and the approved Medicaid state plan. These corrections, also known as retro, may address multiple months, and impact PMPMs.

Section 9

PMPM Payment Recovery for Duplicate Recipient Medicaid IDs

LDH identified instances in which Medicaid Members are assigned more than one Medicaid ID. Medicaid performs retrospective reviews to identify and invalidate duplicate member Medicaid ID(s).

The Fiscal Intermediary (FI) will effectively begin a monthly PMPM recovery process for duplicate PMPM payments paid for Member Medicaid IDs when the valid (current) Medicaid ID and invalidated Medicaid ID are made to the **same HLA Plan**.

The HLA Plan 820 has been modified to report valid (current) ID in Reference Information (8th occurrence). The HLA Plan should use the valid (current) ID reported in the 820 to crosswalk to the member invalidated ID from which the PMPM recovery is made.

The HLA Plans shall not recover provider claim payments for Invalidated ID(s) unless duplicate claim payments are identified (same claim paid to both Invalid and Valid ID).

Appendix A

Definition of Terms

The following terms shall be construed and interpreted as follows unless the context clearly requires otherwise.

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 (005010) file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc.).
CAS Segment	Used to report claims or line level adjustments.

Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under MCO rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility,after the member's insurance benefits are applied to a medical claim.
Coordination of Benefits (COB)	Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
Corrective Action Plan (CAP)	A plan developed by the MCO that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Covered Services	Those health care services/benefits to which an individual eligible for Medicaid or CHIP is entitled under the Louisiana Medicaid State Plan.

Data Certification	The Balanced Budget Act (BBA) requires that when State payments to an MCO are based on data that is submitted by the MCO, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Department (LDH)	The Louisiana Department of Health, referred to as LDH.
Dispute	An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter has denied. Other edit codes are educational only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.

Enrollee	Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.
Enrollment	The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of an MCO.
Enrollment Broker	The state's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an individual enrolled in Louisiana Medicaid.
File Transfer Protocol (sFTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI)	LDH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fraud	As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.
Implementation Date	The date LDH notifies the MCO that Network Adequacy has been certified by LDH; the MCO has successfully completed the Readiness Review and is approved to begin enrolling members.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.

Internal Control Number (ICN)	LDH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
Louisiana Department of Health (LDH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Managed Care Organization (MCO)	The private entity that contracts with LDH to provide core benefits and services to Louisiana Medicaid MCO Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22:1016 of the Louisiana Revised Statues, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by LDH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medicaid Management Information System (MMIS)	Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Enrollees.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which LDH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program**,** and on whose behalf payment is made.
Medical Vendor Administration (MVA)	Refers to the name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).
Member	As it relates to the Louisiana Medicaid Program and this RFP, refers to a Medicaid or CHIP eligible who enrolls in an MCO under the provisions of this RFP and also refers to "enrollee" as defined in 42 CFR §438.10(a).

National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Network	As utilized in the RFP, “network” may be defined as a group of participating providers linked through subcontractual arrangements to an MCO to supply a range of primary and acute health care services. Also referred to as Provider Network.
Newborn	A live infant born to an MCO member.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract or agreement with the MCO.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by an MCO member who has presentation of medical signs and symptoms, to a health care provider.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

Policies	The general principles by which LDH is guided in its management of the Title XIX program, and as further defined by LDH promulgations and by state and/or federal rules and regulations.
Primary Care Provider	An individual physician, nurse practitioner , or physician assistant who accepts primary responsibility for the management of a member's health care The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the MCO Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.
Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).

Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Readiness Review	Refers to LDH's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of MCO standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that LDH can make an informed assessment of the MCO's ability and readiness to render services.
Recipient	An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.
Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.

Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the MCO, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying edit code to indicate that the encounter is repairable.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Span of Control	Information systems and telecommunications capabilities that the MCO itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with LDH. The span of control also includes systems and telecommunications capabilities outsourced by the MCO.
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Surveillance and Utilization Review Subsystems (SURS) Reporting	Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.

Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Unavailability	Measured within the MCO's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 999. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and

	Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Appendix B

Frequently Asked Questions

What is HIPAA and how does it pertain to MCOs?

The Administrative Simplification provisions of HIPAA, Title II, include requirements that national standards be established for electronic health care transactions. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of EDI in health care. LDH has chosen to adopt these standards for MCO encounter data reporting.

Who is DXC and what is their role with the MCOs?

DXC is under contract as LDH's Fiscal Intermediary and responsible for providing functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients.

Is there more than one 837 format? Which shall I use?

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services, and one (1) HIPAA NCPDP Transaction set for Pharmacy. The transactions MCOs will use will depend upon the type of service being reported. Further instructions can be found in Section 2.

Whom do I contact if I have a question regarding the EDI Information Sheet or need technical assistance concerning electronic claim submission?

You may contact the DXC EDI Support Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. CDT, at 225-216-6303.

I am preparing for testing with EDIFECS. Whom do I contact for more information?

For answers to questions regarding specifications and testing, please contact DXC's EDI Business Support Analysts at 225-216-6303.

Will LDH provide us with a paper or electronic remittance advice?

LDH's FI will provide MCOs with an electronic 835 Health Care Claim Payment/Advice (ERA), if requested and arranged for in advance.

Where can I find HIPAA code lists, including the Claim Adjustment Reason Codes and Remittance Remark Codes, which appear in the 835 Health Care Claim?

The Claim Adjustment Reason Codes provide the "explanation" for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835.

The Remittance Remark Codes are used in the 835 to relay informational messages that cannot be expressed with a Claim Adjustment Reason Code. These codes are all nationally mandated codes that must be used by payers in conjunction with the 835.

Payers may no longer use the proprietary codes that they used prior to HIPAA, even if the proprietary codes give better details about how a claim was adjudicated.

HIPAA code lists can be found on the Washington Publishing Company's website at: http://www.wpc-edi.com/codes/.

We understand that LDH will require the NPI, taxonomy code and 9-digit zip of the provider to process the 837 COB. Is this correct?

Yes, that is correct. All providers are required to have an NPI and taxonomy. LDH will also require that a 9-digit zip code be placed on the encounter.

Does DXC have any payer-specific instructions for 837 COB transactions?

Yes, the DXC Companion Guides contain a number of payer-specific instructions for 837 transactions. The FI Companion Guides can be found at www.lamedicaid.com. Once on the LDH website, choose HIPAA Billing Instructions & Companion Guides from the left hand menu. There are separate companion guides for each of the 837 transactions.

What is a Trading Partner ID?

The Trading Partner ID is a number assigned by the FI for each submitter of encounter data. You are assigned this ID prior to testing.

Why must MCOs submit encounter data?

MCOs are required to submit encounter data based on requirements set forth in the RFP.

Appendix C

Code Sets

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. *Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

When conducting 837 transactions, LDH requires the MCO to adhere to HIPAA standards governing Medical data code sets. Specifically, the MCO must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. The MCO is also required to use the non-medical data code sets, as described in the Igs that are valid at the time the transaction is initiated.

LDH requires the MCO to adopt the following standards for Medical code sets and/or their successor code sets:

- International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:
  - Diseases;
  - Injuries;
  - Impairments;
  - Other health problems and their manifestations; and
  - Causes of injury, disease, impairment, or other health problems.
- ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:
  - Prevention;
  - Diagnosis;
  - Treatment; and
  - Management.
- National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:
  - Drugs; and
  - Biologics.
- The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or

service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:

- Physician services,
- Physical and occupational therapy services,
- Radiological procedures,
- Clinical laboratory tests,
- Other medical diagnostic procedures,
- Hearing and vision services, and
- Transportation services, including ambulance.

- In addition to the Category I codes described above, LDH requires that the MCOs submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

- The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

  - Medical supplies,
  - Orthotic and prosthetic devices, and
  - Durable medical equipment.

- Effective October 2015, the MCOs will be required to submit ICD-10 Diagnosis, HCPCS and Procedure Codes.

Appendix D

System Generated Files and Reports

The overarching purpose of these reports is to enhance the quality of the encounter data. They provide LDH and the submitting MCO with basic accuracy and completeness assessment of claims after each encounter cycle, so that preliminary corrections and repairs can be conducted and the encounter resubmitted to the FI. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the Fiscal Agent's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in Encounter Edit Disposition Summary Report. The report provides the repairable edit codes for the encounter data submitted; and can be found in this Section. The complete list of repairable edit codes are listed in **Appendix F**.

The following reports are generated by the FI's MMIS system and have been selected specifically to provide each MCO with useful information that, when compared with the 835 Remittance Advice for the specific encounter, will provide a complete explanation for the edit code. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These reports and the process for Data Quality Assessment are discussed in **Section 6.** These quality reports will also depict accuracy and completeness at a volume and utilization level.

Encounter Claims Summary

CCN-W-001 (weekly)

This report will serve as the high-level error report for the MCO as a summarization of the errors incurred. The format is by claim type. This report will be distributed to MCOs as a delimited text file and it will include the overall claim count, the disposition of MMIS paid or denied status occurrence, and overall percentage. The number and percent to be denied represent all denials, repairable or non-repairable.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by DXC.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is “Claims Summary”	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with	7	Numeric

Column(s)	Item	Notes	Length	Format
		the MCO.		
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number.	8	Numeric
22	Delimiter		1	Uses the ^ character value

23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation	2	Numeric
		08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services. 14=Medicare Crossover Instit. 15=Medicare Crossover Prof		
25	Delimiter		1	Uses the ^ character value
26-33	Number of claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Number of claim records denied		8	Numeric, no commas, decimal points.

43	Delimiter		1	Uses the ^ character value
44-51	Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

Column(s)	Item	Notes	Length	Format
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Character
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Not Used		8	Character value is spaces.
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value

26-33	Total Number of Claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Total Number of Claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Overall Percentage of		8	Numeric, with decimal point.

Column(s)	Item	Notes	Length	Format
	Denied Claims			For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

EDI TRANSMISSION RESEARCH REQUEST

PURPOSE

The EDI Transmission Research Request Form is for Medicaid Managed Care Plans to use when submitting a request to DXC for research regarding files and/or 835 responses. This form allows DXC and LDH to thoroughly review your request without having to go back to a plan with questions for more information. Complete all appropriate fields as delays may take place if we have to request additional information. Email the completed form to HipaaEDI@MolinaHealthCare.com and CC Erin Deville@la.gov and your MMIS Program Manager.

INSTRUCTIONS

Plan Name – Enter the name of your Managed Care Plan for Louisiana Medicaid.

Trading Partner ID – Enter the 7 digit Submitter ID assigned to you by DXC (450xxxx).

Date – Enter the date you complete the form.

Problem Description – Enter a thorough description of the problem with your claim file(s) or 835 Responses. Detailed information will assist staff in researching the issue.

Transmission Information – If you are inquiring about multiple claim files, either list this transmission information for all other files in the Problem Description box or else attach a list of each file providing the transmission information that applies to each file.

Name of the file you sent to DXC	Provide the file name as sent to DXC.
Date you sent the file to DXC	Provide month/date/year the file was sent.
Interchanged Control Number (ISA13)	Provide the ISA number you assigned to the file.
File Claim Count	Provide claim count on the file.

Transmission Acknowledgement Information

TA1	Indicate by circling Yes or No that you received a successful TA1
999	Indicate by circling Yes or No that you received a successful 999 Acknowledgement

Individual Claim Research Request – If your inquiry relates to only certain claims sent in on a file, provide the Transmission Information for that file and then provide the individual claim information in this area. You may not have the DXC ICN or Date of 835 which can be indicated by N/A in those fields. Attach a spread sheet if there are more than 7 claims to be listed. Please be sure your spreadsheet contains these same data fields.

EDI Transmission Research Request Form

DEPARTMENT OF HEALTH Medicaid

DXC.technology

EDI Transmission Research Request Form

Date: _____

Plan Name: _____
Trading Partner ID: _____

Problem Description:

Transmission Information	
Filename of the file you sent to DXC	
Date you sent the file to DXC	
Interchange Control Number [ISA13]	
File Claim Count	

Transmission Acknowledgement Information	
Did you receive a TA1 acknowledgement indicating your file was received successfully?	Yes / No
Did you receive a 999 acknowledgement indicating your file passed all EDI validation edits?	Yes / No

If you are requesting the DXC EDI department research individual claims in your transmission file please complete the chart below. Please complete this information if your request involves a small number of claims on a file (preferably less than 25). You may attach an Excel spreadsheet but it should contain the same columns as this chart.

Individual Claim Research Request								
DXC ICN	Date of 835	Patient Control Number [CLM01]	Billing Provider NPI	Recipient Name	Recipient Medicaid ID	Claim Date of Service	Procedure Code	Problem Description

Encounter Edit Disposition Summary

CCN-W-005 (weekly)

This report serves as the high-level edit report for the MCO as a summarization of the edit codes incurred. The format, as depicted below, is by claim type. This report will be distributed to MCOs as a delimited text file and it will produce the overall edit code disposition, edit code, and the number of edit codes from the submission.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by DXC.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is “EDIT Disposition Summary”	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the MCO.	7	Numeric
81	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number.	8	Numeric
22	Delimiter		1	Uses the ^ character value

23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation	2	Numeric

Column(s)	Item	Notes	Length	Format
		09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services 14=Medicare Crossover Instit. 15=Medicare Crossover Prof.		
25	Delimiter		1	Uses the ^ character value
26-29	Error Code		4	Numeric
30	Delimiter		1	Uses the ^ character value
31-38	Number of claim records having this error code		8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005”	10	Character

13	Delimiter		1	Uses the ^ character value
14-21	Total Detail	This is a number	8	Numeric

Column(s)	Item	Notes	Length	Format
	Lines in the file	that represents the total detail lines submitted in the file.		
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-29	Unused		4	Value is spaces
30	Delimiter		1	Uses the ^ character value
31-38	Total Number of Claim records denied	This value should match that of the CCN-W-001 file. It may not equal the total of all detail lines in the CCN-W-005 file because one claim may have several edits.	8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.

Edit Code Detail

CCN-W-010 (weekly)

This report lists all encounters and their error codes, including denied error codes. Some of the denied edits are repairable. Refer to **Appendix F** for a listing of repairable edits. This report will be distributed to MCOs as a delimited text file and it is a detailed listing by header and line item of the edits applied to the encounter data. Claims history includes behavioral health encounters.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by DXC.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is “Claim Detail”	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the MCO.	7	Numeric
81	Delimiter		1	Uses the ^ character value
82	End of Record		1	Value is spaces.
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail	8	Numeric

Column(s)	Item	Notes	Length	Format
		portion of the file is sorted by this number		
22	Delimiter		1	Uses the ^ character value
23-35	Claim ICN	Internal Claim Number, assigned by DXC. Unique per claim line.	13	Numeric
36	Delimiter		1	Uses the ^ character value
37-66	Medical Record Number	Submitted on the claim by the MCO.	30	Character
67	Delimiter		1	Uses the ^ character value
68-87	Patient Control Number	Submitted on the claim by the MCO	20	Character
88	Delimiter		1	Uses the ^ character value
89-118	Line Control Number	Submitted on the claim by the MCO	30	Character
119	Delimiter		1	Uses the ^ character value
120-128	Remittance Advice Number	Assigned by DXC	9	Numeric
129	Delimiter		1	Uses the ^ character value
130-133	Error Code 1	First error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
134	Delimiter		1	Uses the ^ character value
135-138	Error Code 2 (if necessary)	2nd error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric

Column(s)	Item	Notes	Length	Format
139	Delimiter		1	Uses the ^ character value
140-143	Error Code 3 (if necessary)	3rd error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
144	Delimiter		1	Uses the ^ character value
145-148	Error Code 4 (if necessary)	4th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
149	Delimiter		1	Uses the ^
				character value
150-153	Error Code 5 (if necessary)	5th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
154	Delimiter		1	Uses the ^ character value
155-158	Error Code 6 (if necessary)	6th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
159	Delimiter		1	Uses the ^ character value
160-163	Error Code 7 (if necessary)	7th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
164	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
165-168	Error Code 8 (if necessary)	8th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	4	Numeric
169	Delimiter		1	Uses the ^ character value
170-173	Error Code 9 (if necessary)	9th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none		
174	Delimiter		1	Uses the ^ character value
175-178	Error Code 10 (if necessary)	10th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none		
179	Delimiter		1	Uses the ^ character value
180	Type of Admission		1	Character
181	Delimiter		1	Uses the ^ character value
182-191	Medicaid Paid Units		10	Numeric with decimal point, left zero-fill.
192	Delimiter		1	Uses the ^ character value.
193-195	Patient Status		3	Character
196	Delimiter		1	Uses the ^ character value.
197-204	DOS-From		8	Numeric, YYYYMMDD
205	Delimiter		1	Uses the ^ character value.
206-213	DOS-Through		8	Numeric, YYYYMMDD
214	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
215-227	Medicaid Recipient ID	Recipient's current Medicaid ID number	13	Character
228	Delimiter		1	Uses the ^ character value.
229-242	Provider Billed Charges	Billed charges from provider as submitted by Provider on claim	14	Numeric with decimal point, left zero-fill.
243	Delimiter		1	Uses the ^ character value.
244-248	Procedure Code	As submitted by Provider on claim, for all claim types except inpatient hospital.		Character
249	Delimiter		1	Uses the ^ character value.
250-259	Provider Billed Units	As submitted by Provider on claim	10	Numeric with decimal point, left zero-fill.
260	Delimiter		1	Uses the ^ character value.
261-274	Medicaid Payment	Amount Louisiana Medicaid paid on the claim	14	Numeric with decimal point, left zero-fill.
275	Delimiter		1	Uses the ^ character value.
276-286	NDC	If Rx claim, then this is the NDC on the claim	11	
287	Delimiter		1	Uses the ^ character value.
288-290	Therapeutic Class	If Rx claim	3	
291	Delimiter		1	Uses the ^ character value.
292	Rx refill code	If Rx claim: 0=1st script, 1-5=refill number	1	
293	Delimiter		1	Uses the ^ character value.
294-298	Diagnosis Code	ICD-9-CM diag. code, if available	5	Character, does not include the decimal.
299	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
300	Admit Date		8	Numeric, YYYYMMDD For inpatient hospital claims
308	Delimiter		1	Uses the ^ character value.
309-316	Discharge Date		8	Numeric, YYYYMMDD For inpatient hospital claims
317	Delimiter		1	Uses the ^ character value.
318-319	Servicing Provider Specialty		2	Numeric with leading zero if necessary.
320	Delimiter		1	Uses the ^ character value.
321-330	Prior Authorization Number		10	Numeric, 9 or 10 digits
331	Delimiter		1	Uses the ^ character value.
332-334	Bill Type		3	Claim Bill Type (inpatient and institutional)
335	Delimiter		1	Uses the ^ character value.
336-337	Type of Service		2	See Type of Service values in Appendix J
338	Delimiter		1	Uses the ^ character value.
339-340	Category of Service		2	See Category of Service values in Appendix J
341	Delimiter		1	Uses the ^ character value.
342-351	Billing Provider NPI		10	
352	Delimiter		1	Uses the ^ character value.
353-362	Servicing/ Attending Provider NPI		10	
363	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
364-365	Billing Provider Type		2	See Provider Type values in Appendix J
366	Delimiter		1	Uses the ^ character value.
367-368	Servicing/ Attending Provider Type		2	See Provider Type values in Appendix J
369	Delimiter		1	Uses the ^ character value.
370	Claim Status		1	Numeric: 1=Paid Original 2=Adjustment/Void 3=Denied
371	Delimiter		1	Uses the ^ character value.
372	Claim Status Modifier		1	Numeric: 1=Paid Original 2=Adjustment 3=Void (for adjustment) 4=Void (from provider)
373	Delimiter		1	Uses the ^ character value.
374	Claim Type		2	01=Inpatient Hosp 02=LTC/ICF/NH 03=Outpatient Hosp 04=Professional 05=Rehab 06=Home Health 07=EMT 08=NEMT 09=DME 10=Dental EPSDT 11=Dental Adult 12=Pharmacy 13=EPSDT 14=Medicare Institutional Crossover 15=Medicare Professional Crossover 16=ADHC
376	Delimiter		1	Uses the ^ character value.
377	Claim or Encounter Indicator	1=claim 2=encounter	1	Identifies FFS claim vs. pre-paid encounter.
378	Delimiter		1	Uses the ^ character value.
379-380	Not populated		2	Spaces.
381	Delimiter		1	Uses the ^ character value.
382-383	Procedure Modifier 1		2	Character
384	Delimiter		1	Uses the ^ character value.
385-386	Procedure Modifier		2	Character

Column(s)	Item	Notes	Length	Format
	2			
387	Delimiter		1	Uses the ^ character value.
388-389	Procedure Modifier 3		2	Character
390	Delimiter		1	Uses the ^ character value.
The following items represent revenue codes, HCPCS, units and charges associated with institutional claims. There are 23 occurrences.				
391-394	Revenue Code 1		4	Numeric
395	Delimiter		1	Uses the ^ character value.
396-400	Revenue HCPCS 1		5	Character
401	Delimiter		1	Uses the ^ character value.
402-406	Revenue Units 1		5	Numeric
407	Delimiter		1	Uses the ^ character value.
408-421	Revenue Charges 1		14	Numeric with decimal point, left zero-fill.
422	Delimiter		1	Uses the ^ character value.
There are 23 occurrences of the revenue items, with each occurrence being 32 bytes in length (consisting of code, HCPCS, Units and Charges, with delimiters).				
1127-1134	Claim Payment Date		8	Numeric data format in the format YYYYMMDD
1135	Delimiter		1	Uses the ^ character value.
1136-1140	Diagnosis Code 2	ICD-9-CM diag code, if available (this represents the secondary diagnosis)	5	Character, does not include the decimal.
1141	Delimiter		1	Uses the ^ character value.
1142-43	Place of Service	Uses the CMS 1500 standard Place of Service code values	1	2-digit numeric value. Only applicable to professional services claims.
1144	Delimiter		1	Uses the ^ character value.
1145-1152	Rx Prescription Date	Only populated on Pharmacy claims; otherwise, will have 0 value	8	Numeric, YYYYMMDD
1153	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
1154-1157	Rx Days Supply	Only populated on Pharmacy claims; otherwise, will have 0 value	4	Numeric, left fill with zero.
1158	Delimiter		1	Uses the ^ character value.
1159-1169	Rx Quantity	Only populated on Pharmacy claims; otherwise, will have 0 value	11	Numeric with decimal point, left zero-fill.
1170	Delimiter		1	Uses the ^ character value.
1171-1180	Prescribing Provider NPI	Only populated on Pharmacy claims; otherwise, will have BLANK value	10	Numeric left zero fill.
1181	Delimiter		1	Uses the ^ character
1182	ICD Indicator	Used to identify whether ICFD-9 or ICD-10 CM codes were submitted on claim/encounter	1	0=ICD-10 9= ICD-9
1183	Delimiter		1	Uses the ^ character
1184-1190	ICD-10 CM primary diagnosis code		7	Will contain spaces if only ICD-9 code is submitted. If ICD-10 code was submitted, it will not contain the period.
1191	Delimiter		1	Uses the ^ character
1192-1198	ICD-10 CM		7	Will contain spaces if only ICD-9 code is submitted. If ICFD-10 code was submitted, it will not contain the period.
1199	Delimiter		1	Uses the ^ character
1200	End of Record		1	Character, value is space.

Column(s)	Item	Notes	Length	Format

TRAILER (TOTALS)		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file. It is equivalent to the total number of claim lines that denied.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of claim records denied.	This value represents the count of unique claim lines that appear in the detail portion of this file and have been denied.	8	Numeric
34	Delimiter		1	Uses the ^ character value
35	End of Record		1	Value is space.

Provider File

FI to MCO

This file is sent to MCOs on a weekly basis.

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number. This is the internal Louisiana Medicaid provider ID	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit. This is the external Louisiana Medicaid provider ID (the one known by providers)	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-46	Provider Name (Servicing)		30	Character
47	Delimiter		1	Uses the ^ character value
48-57	Provider NPI		10	Character
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character

Column(s)	Item	Notes	Length	Format
69	Delimiter		1	Uses the ^ character value
70-71	Provider Type		2	See Provider Type codes in Appendix J
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix G
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-123	Provider Street Address (Servicing)		30	
124	Delimiter		1	Uses the ^ character value
125-154	Provider City (Servicing)		30	
155	Delimiter		1	Uses the ^ character value
156-157	Provider State	USPS abbreviation	2	

Column(s)	Item	Notes	Length	Format
158	Delimiter		1	Uses the ^ character value
159-168	Provider Phone		10	Numeric
169	Delimiter		1	Uses the ^ character value
170-171	Provider Parish		2	See parish code values in Appendix J
172	Delimiter		1	Uses the ^ character value
173-181	Provider Zip Code		9	Numeric
182	Delimiter		1	Uses the ^ character value
183	Urban-Rural Indicator (applicable to hospitals only)		1	Character: 0=not applicable 1=urban 2=rural 3=sole community hospital
184	Delimiter		1	Uses the ^ character value
185-214	Provider Street Address (Pay-To)		30	
215	Delimiter		1	Uses the ^ character value
216-245	Provider City (Pay-To)		30	

Column(s)	Item	Notes	Length	Format
246	Delimiter		1	Uses the ^ character value
247-248	Provider State (Pay-To)	USPS abbreviation	2	
249	Delimiter		1	Uses the ^ character value
250-258	Provider Zip (Pay-To)	USPS ZIP code+4, if available	9	Numeric
259	Delimiter		1	Uses the ^ character value
260	Tax ID number (TIN) or SSN		9	Numeric, left fill with zeros
269	Delimiter		1	Uses the ^ character value
270	Medicare-registered or other LLC NPI number First occurrence		10	Numeric if present, otherwise spaces
280	Delimiter		1	
281	Medicare-registered or other LLC NPI number 2nd occurrence		10	Numeric if present, otherwise spaces
291	Delimiter		1	
292	Medicare- registered or other LLC NPI number 3rd occurrence		10	Numeric if present, otherwise spaces
302	Delimiter		1	

Column(s)	Item	Notes	Length	Format
303	Medicare-registered or other LLC NPI number 4th occurrence		10	Numeric if present, otherwise spaces
313	Delimiter		1	
314	Medicare-registered or other LLC NPI number 5th occurrence		10	Numeric if present, otherwise spaces
324	Delimiter		1	
325	Medicare-registered or other LLC NPI number 6th occurrence		10	Numeric if present, otherwise spaces
335	Delimiter		1	
336	Medicare-registered or other LLC NPI number 7th occurrence		10	Numeric if present, otherwise spaces
346	Delimiter		1	
347	Medicare-registered or other LLC NPI number 8th occurrence		10	Numeric if present, otherwise spaces
357	Delimiter		1	
358	Medicare-registered or other LLC NPI number 9th occurrence		10	Numeric if present, otherwise spaces
368	Delimiter		1	

Column(s)	Item	Notes	Length	Format
369	Medicare-registered or other LLC NPI number 10th occurrence		10	Numeric if present, otherwise spaces
379	Delimiter		1	
380	Medicare-registered or other LLC NPI number 11th occurrence		10	Numeric if present, otherwise spaces
390	Delimiter		1	
391	Medicare-registered or other LLC NPI number 12th occurrence		10	Numeric if present, otherwise spaces
401	Delimiter		1	
402	Medicare-registered or other LLC NPI number 13th occurrence		10	Numeric if present, otherwise spaces
412	Delimiter		1	
413	Medicare-registered or other LLC NPI number 14th occurrence		10	Numeric if present, otherwise spaces
423	Delimiter		1	
424	Medicare-registered or other LLC NPI number 15th occurrence		10	Numeric if present, otherwise spaces
434	Delimiter		1	

Column(s)	Item	Notes	Length	Format
435	Medicare-registered or other LLC NPI number 16th occurrence		10	Numeric if present, otherwise spaces
445	Delimiter		1	
446	Medicare-registered or other LLC NPI number 17th occurrence		10	Numeric if present, otherwise spaces
456	Delimiter		1	
457	Medicare-registered or other LLC NPI number 18th occurrence		10	Numeric if present, otherwise spaces
467	Delimiter		1	
468	Medicare-registered or other LLC NPI number 19th occurrence		10	Numeric if present, otherwise spaces
478	Delimiter		1	
479	Medicare-registered or other LLC NPI number 20th occurrence		10	Numeric if present, otherwise spaces
489	Delimiter		1	

Column(s)	Item	Notes	Length	Format
490	Prescriber Indicator		1	Character with this value set: Blank = not applicable or no prescriptive authority. 0 = Full Rx Authority. 1 = Resident with Rx authority. 2 = Limited Rx authority (PA, NP, Medical Psychologist). 3 =Sanctioned. 4 = Full Rx authority plus ability to Rx Suboxone (opioid dependents). 5 = Pharmacist who can Rx Immunizations. 6 = CCN Prescriber (see PT=56) 7 =EHR Incentive Program 8 = No Prescriptive Authority
491	End of Record		1	Value is spaces.

Provider Rates File

FI to MCO

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-46	Provider Name (Servicing)		30	Character
47	Delimiter		1	Uses the ^ character value
48-57	Provider NPI		10	Character
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character
69	Delimiter		1	Uses the ^ character value
70-71	Provider Type		2	See Provider Type codes in Appendix J
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix G

Column(s)	Item	Notes	Length	Format
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-101	Rate 1	Inpatient General LOC Per-diem	8	Numeric with decimal and left-fill with zeros
102	Delimiter		1	Uses the ^ character value
103-110	Effective Date 1		8	Numeric, date value in the format YYYYMMDD
111	Delimiter		1	Uses the ^ character value
112-119	Rate 2	Other Inpatient (usually not applicable)	8	Numeric with decimal and left-fill with zeros
120	Delimiter		1	Uses the ^ character value
121-128	Effective Date 2		8	Numeric, date value in the format YYYYMMDD

129	Delimiter		1	Uses the ^ character value
130-137	Rate 9	Outpatient Cost-to-Charge Ratio	8	Numeric with decimal and left-fill with zeros
138	Delimiter		1	Uses the ^ character value
139-146	Effective Date 9		8	Numeric, date value in the format YYYYMMDD
147	Delimiter		1	Uses the ^ character value
The next 40 items depict rates associated with specific revenue codes And/or procedure codes. There are 5 parts to each item: Code Value, Type of Service, Effective Begin Date, Rate and Location. Each item is 30 bytes in length and there are 40 occurrences. Not all 40 items may be populated… some may contain spaces.				
148-152	Procedure or Revenue Code		5	Character
153	Delimiter		1	Uses the ^ character value
154-155	Type of Service		2	Character, see Type of Service values in Appendix J.
156	Delimiter		1	Uses the ^ character value
157-164	Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
165	Delimiter		1	Uses the ^ character value

166-173	Rate	8	Numeric with decimal and left-fill with zeros
174	Delimiter	1	Uses the ^ character value
175-176	Location	2	Character
177	Delimiter	1	Uses the ^ character value
1348	End of Record	1	Value is spaces.

820 File FI to CCN

On a monthly basis the MCO receives from the Fiscal Intermediary, the following 820 files as established by and as deemed necessary by LDH:

- Per Member Per Month (PMPM)
- Maternity Kick Payments
- Date of Death Recoupments (DOD)
- Medicare Recoveries
- Department of Corrections Recoveries (DOC)
- Retro Baby Per Member Per Month
- Other
    - Special Adjustments
    - Payments
    - Recoupments
- PMPM Payment Recovery for Duplicate Recipient Medicaid IDs

The format for the 820 Files can be found on the following pages.

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		D
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					
		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.					
BPR=Financial Information					
Sample: BPR*I*12345678.90*C*NON******1234567890******20150315~					

	BPR	BPR01	Transaction Handling Code	I=Remittance Information	S
				Only	
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON=Non-payment 820	S
		BPR05	Payment Format Code	NOT USED	
		BPR06	(DFI) ID Number Qualifier	NOT USED	
		BPR07	(DFI) Identification Number	NOT USED	
		BPR08	Account Number Qualifier	NOT USED	
		BPR09	Account Number	NOT USED	
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	NOT USED	
		BPR13	(DFI) Identification Number	NOT USED	
		BRP14	Account Number Qualifier	NOT USED	
		BPR15	Account Number	NOT USED	
		BPR16	EFT Effective Date	Expressed CCYYMMDD	D

TRN=Re-association Trace Number					
Sample: TRN*3*1123456789*1234567890*~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver's Identification Key					
Sample: REF*18*123456789*CCN Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	D
		REF03	Description	'CCN Fee Payment' or	S

				'CCN Kick Payment'	
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	D
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	D
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-	D
				CCYYMMDD	

1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*CCN-S of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	S
	1000A	N102	Name	Information Receiver Last or Organization Name	D
	1000A	N103	Identification Code Qualifier	"FI" – Federal	S
	1000A	N104	Identification Code	Receiver Identifier	D
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*LA-DHH-MEDICAID*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	S
	1000B	N102	Name	Premium Payer Name	S
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	S

	1000B	N104	Identification Code	Premium Payer ID	S
2000B INDIVIDUAL REMITTANCE					
ENT=Individual Remittance					
Sample: ENT*1*2J*34*123456789~					
	2000B	ENT01	Assigned Number	Sequential Number assigned for differentiation within a transaction set	D
	2000B	ENT02	Entity Identifier Code	“2J” – Individual	S
	2000B	ENT03	Identification Code Qualifier	“34” – Social Security Number	S
	2000B	ENT04	Identification Code	Individual Identifier – SSN	D
2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	“QE” – Policyholder (Recipient Name)	S
	2100B	NM102	Policyholder	“1” – Person	S
	2100B	NM103	Name Last	Individual Last Name	D

	2100B	NM104	Name First	Individual First Name	D
	2100B	NM105	Name Middle	Individual Middle Initial	D
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Individual Identifier	S
	2100B	NM109	Identification Code	Individual Identifier – Recipient ID number	D
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*11*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	S
	2300B	RMR02	Reference Identification	Claim ICN (DXC internal claims number).	D
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	D
REF=Reference Information (1st occurrence)					
Sample: REF*ZZ*0101C~					

	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Capitation Code	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (2nd occurrence)					
Sample: REF*ZZ*01~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Recipient Region code: Values 01 to 09.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (3rd occurrence)					
Sample: REF*ZZ*01~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Recipient Category of Assistance (aka Aid Category) – 2-digit number.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		

REF=Reference Information (4th occurrence)					
Sample: REF*ZZ*001~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Recipient Type Case (aka Case Type) – 3-digit number	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (5th occurrence)					
Sample: REF*ZZ*00000.00~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	FMP amount (Hospital), numeric value in the format numeric (5.2), for a total length of eight bytes.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (6th occurrence)					
Sample: REF*ZZ*00000.00~					

	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	FMP amount (Physician), numeric value in the format numeric (5.2), for a total length of eight bytes.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (7th occurrence)					
Sample: REF*ZZ*00000.00~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	FMP amount (AMBULANCE), numeric value in the format numeric (5.2), for a total length of eight bytes.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (8th occurrence) – used only for duplicate recipient recoveries					
Sample: REF*ZZ*1234567890123~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S

	2300B	REF02	Reference Identification	**Current Recipient ID of the correct record (used only for duplicate recipient recoveries)**	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" – Report Period	S
	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	"RD8" – Range of Dates	S
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	D
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" – Report Period	S

	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	“RD8” – Range of Dates	S
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	D
Transaction Set Trailer					
Sample: SE*39*0001~					
	SE	SE01	Transaction Segment Count		D
		SE02	Transaction Set Control Number		D
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					

An adjustment of a previous original administrative fee payment will be shown as two (2) 2300B sets:

- A void of the previous payment; and
- A record showing the new adjusted amount

The void record will have RMR and ADX segments, where the RMR will have the original claim ICN in RMR02 and the original payment amount in RMR05. The ADX will have a negative amount (equal to the original payment) in ADX01 and the value '52' in ADX01. The record showing the new adjusted amount will behave in the same manner as an original payment (RMR). An example of an adjustment set is provided below:

Void sequence (reversal of prior payment):

ENT*107*2J*ZZ*7787998022222~

NM1*QE*1*DOE*JOHN*D***N*1234567890123~

RMR*AZ*1059610021800***500~

ADX*-500*52~

Adjusted Amount sequence:

ENT*107*2J*ZZ*7787998022222~

NM1*QE*1*DOE*JOHN*D***N*1234567890123~

RMR*AZ*1067610041100**600~

REF*ZZ*0101C~ (added to comply with HIPAA standard)

REF*ZZ*01~ (added to provide recipient region)

DTM*582****RD8*20120201-20120229~

Prior Authorization File

FI TO MCO

This file is a weekly file that contains a 2-year history of prior authorization and Pre-Admission Certification (Pre-cert) authorization transactions performed by the Louisiana Medicaid MMIS. Modifications to include ICD-10 coding (Columns 148-149) and Chronic Needs Indicator.

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number	7	Numeric, non-check-digit.
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-29	Recipient ID (Original)		13	Numeric
30	Delimiter		1	Uses the ^ character value
31-43	Recipient ID (Current)		13	Numeric
44	Delimiter		1	Uses the ^ character value
45-54	NPI		10	Character
55	Delimiter		1	Uses the ^ character value
56-65	Taxonomy		10	Character
66	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
67-71	Procedure Code		5	Character, CPT or HCPCS value
72	Delimiter		1	Uses the ^ character value
73	Authorized Units/Amount		10	Numeric, with decimal and left-zero fill
83	Delimiter		1	Uses the ^ character value
84-91	Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
92	Delimiter		1	Uses the ^ character value
93-100	Effective End Date		8	Numeric, date value in the format YYYYMMDD
101	Delimiter		1	Uses the ^ character value
102-106	Admitting Diagnosis Code (for Inpatient Pre- Admission Certification) or Diagnosis code if required on the PA		5	ICD-9-CM
107	Delimiter		1	Uses the ^ character value
108-111	Length of Stay in Days (for Inpatient Pre-Admission Certification)		4	Numeric, left zero-fill
112	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
113	PA or Pre-cert Type	1=PA 2=Pre-cert 3=RxPA	1	Character
114	Delimiter		1	Uses the ^ character value
115-116	PA Type Or Pre-cert Type	**Pre-cert**: 03=Inpatient Acute **PA**: 04=Waiver 05=Rehab 06=HH 07=Air EMT 09=DME 10=Dental 11=Dental 14=EPSDT-PCS 16=PDHC 17=PDD or ASD 35=ROW 40=RUM 50=LT-PCS 60=Early Steps CM 66=RxPA 67=NEMT 88=Hospice 99=Misc	2	
117	Delimiter		1	Uses the ^ character value
118-119	PA or Precert Status	02=Approved 03=Denied	2	Character
120	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
121-125	Precert Level of Care (this field should be blank for Medical PA transactions, but it will contain the Therapeutic Class for RxPA transactions)	GEN ICU NICU REHAB PICU CCU TU=Telemetry LT=LTAC	5	Character
126	Delimiter		1	Uses the ^ character value
127-136	PA Line Amount Used	For an approved PA or Precert line item, this field contains any amount used as a result of claims processing. For an approved RxPA line item, this field contains the HICL in the first 6 characters.	10	Numeric, with decimal and left-zero fill.
137	Delimiter		1	Uses the ^ character value
138-147	PA or Precert Number assigned by DXC		10	9- or 10-digit number
148	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
149	ICD indicator	Blank=no diag 0=icd10 9=icd9	1	Identifies if ICD-9 or ICD-10 code was submitted: 0=ICD-10 9=ICD-9
150	Delimiter		1	Uses the ^ character value
151-157	ICD-10 CM Diagnosis. Admitting Diagnosis Code (for Inpatient Pre- Admission Certification) or Diagnosis code if required on the PA		7	Will contain spaces if ICD-9 code was submitted. If ICD-10 code was submitted, it will not contain the period. May contain spaces.
158	Delimiter		1	Uses the ^ character value
159	Chronic Needs Indicator	O=unknown 1=has chronic needs	1	Numeric
160	Delimiter		1	Uses the ^ character value
161	End of Record		1	Value is spaces

Diagnosis File for Pre-Admission Certification

FI to MCO

This file shows all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Pre-cert) operation with Louisiana Medicaid MMIS. Modifications for ICD-10 have been made to Columns 7; 27-35.

Column(s)	Item	Notes	Length	Format
1-5	Diagnosis Code		5	Character, does not include the period
6	Delimiter		1	Uses the ^ character value
7	Pre-Cert Status	1=Applicable 2=Not applicable/Not valid for Precert, 3=Not a valid diagnosis	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27-33	ICD-10 Diagnosis Code		7	Character, does not include the period.
34	Delimiter		1	Uses the ^ character value
35	End of Record		1	Value is spaces.

Procedure File for Prior Authorization

FI to MCO

This file shows all procedure codes applicable to the Prior Authorization (PA) operation with Louisiana Medicaid MMIS.

Column(s)	Item	Notes	Length	Format
1-5	Procedure Code		5	Character
6	Delimiter		1	Uses the ^ character value
7	PA Status	1=Applicable 2=Not applicable	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27-28	Type of Service		2	Character. See Appendix J for code values
29	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
30-39	Maximum Amount		10	Numeric, with decimal and left-fill with zeros, will be zero if not applicable
40	Delimiter		1	Uses the ^ character value
41-43	Minimum Age		3	Numeric, left-fill with zeros. Will be zero if not applicable.
44	Delimiter		1	Uses the ^ character value
45-47	Maximum Age		3	Numeric, left-fill with zeros. Will be zero if not applicable.
48	Delimiter		1	Uses the ^ character value
49	Sex Restriction Indicator	0=n/a 1=Male only 2=Female only	1	Character
50	Delimiter		1	Uses the ^ character value
51-53	Pricing Action Code		3	Character See Appendix J for Code values
54	Delimiter		1	Uses the ^ character value
55	End of Record		1	Value is spaces.

CLIA File

FI to MCO

This file shows all CLIA (clinical laboratory improvements amendment) registrations associated with laboratory providers enrolled with the Louisiana Medicaid MMIS.

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	Non-check digit Medicaid Provider ID	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider ID (check-digit)	Check-digit Medicaid Provider ID	7	
16	Delimiter		1	Uses the ^ character value
17-26	Provider NPI	NPI	10	
27	Delimiter		1	Uses the ^ character value
CLIA numbers with effective dates, there are up to 15 occurrences of these items per CLIA number. Each occurrence is 31 bytes				
28-37	CLIA number		10	Character
38	Delimiter		1	Uses the ^ character value
39-46	CLIA Effective Begin Date		8	Numeric in date format YYYYMMDD
47	Delimiter		1	Uses the ^ character value
48-55	CLIA Effective End Date		8	Numeric in date format YYYYMMDD

Column(s)	Item	Notes	Length	Format
56	Delimiter		1	Uses the ^ character value
57	CLIA Type		1	Space=not avail. 1 = Registration 2 = Regular Certificate 3 = Accreditation 4 = Waiver 5 = Microscopy
58	Delimiter		1	Uses the ^ character value
493	End of Record		1	Value is spaces.

Quality Profiles Submission File

MCO to FI

There will be 1 single file, formatted as a text, CSV (comma-separated value) file.

There will be 4 record types on the file as shown in the grid below, so the file will have exactly 4 records.

Record Type 1: Performance Standards Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=1	1
Delimiter	2	Character, value='^'	1
QPS_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QPS_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QPS_PHONE_ACCESS_24X7_PERCENT	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QPS_SERVICE_AUTH_PERCENT	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QPS_PRE_PROCESS_CLAIMS_PERCENT	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QPS_REJECTED_CLAIMS_TO_PROV_PERCENT	38-43	Numeric in the format NNN.NN, with the decimal	6

		included.	
Delimiter	44	Character, value='^'	1
QPS_CALL_CENTER_CALLS_PERCENT	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QPS_CALL_CENTER_AVERAGE_CALL_ANSWER_TIME	52-57	Numeric, 6 digits, no comma, no decimal, left fill with zeroes. Expressed in seconds.	6
Delimiter	58	Character, value='^'	1
QPS_CALL_CENTER_ABANDON_RATE	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QPS_GRIEVANCES_RESOLVED_RATE	66-71	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	72	Character, value='E'	1

Record Type 2: Incentive-Based Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=2	1
Delimiter	2	Character, value='^'	1
QIB _CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QIB _TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QIB_ADULT_ACCESS_TO_PREV_AMB_SERVICES	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QIB_COMPREHENSIVE_DIABETES_CARE_HGBA1C	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QIB_CHLAMYDIA_SCREENING	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QIB_WELL_CHILD_VISITS_THIRD_YEAR	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1
QIB_WELL_CHILD_VISITS_FOURTH_YEAR	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1

QIB_WELL_CHILD_VISITS_FIFTH_YEAR	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QIB_WELL_CHILD_VISITS_SIXTH_YEAR	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QIB_ADOLESCENT_WELL_VISITS	66-71	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	72	Character, value='E'	1

Record Type 3: Level I Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=3	1
Delimiter	2	Character, value='^'	1
QLI_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QLI_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QLI_CHILD_AND_ADOL_ACCESS_TO_PCP	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QLI_TIMELINESS_OF_PRENATAL_AND_POSTPARTUM_CARE	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QLI_CHILDHOOD_IMMUN_STATUS	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QLI_IMMUNIZATIONS_FOR_ADOL	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1
QLI_LEAD_SCREENING_CHILDREN	45-50	Numeric in the format NNN.NN, with the decimal included.	6

Delimiter	51	Character, value='^'	1
QLI_CERVICAL_CANCER_SCREENING	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QLI_PERCENT_LIVE_BIRTHS_WEIGHT_LT_2500G	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QLI_WEIGHT_ASSESSMENT_CHILDREN_ADOL	66-71	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	72	Character, value='^'	1
QLI_MEDICATIONS_FOR_PERSONS_WITH_ASTHMA	73-78	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	79	Character, value='^'	1
QLI_COMPREHENSIVE_DIABETES_CARE	80-85	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	86	Character, value='^'	1
QLI_BREAST_CANCER_SCREENING	87-92	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	93	Character, value='^'	1
QLI_EPSDT_SCREENING_RATE	94-99	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	100	Character, value='^'	1
QLI_ADULT_ASTHMA_ADMISSION_RATE	101-106	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	107	Character, value='^'	1
QLI_CHF_ADMISSION_RATE	108-113	Numeric in the format NNN.NN, with the decimal included.	6

Delimiter	114	Character, value='^'	1
QLI_UNCONTROLLED_DIABETES_ADMISSION_RATE	115-120	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	121	Character, value='^'	1
QLI_INPATIENT_HOSP_READMISSION_RATE	122-127	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	128	Character, value='^'	1
QLI_WELL_CHILD_VISITS_IN_FIRST_15_MONTHS	129-134	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	135	Character, value='^'	1
QLI_AMBULATORY_CARE_ER_UTILIZATION	136-141	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	142	Character, value='E'	1

Record Type 4: Level II Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=4	1
Delimiter	2	Character, value='^'	1
QLII_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QLII_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QLII_FOLLOWUP_CARE_CHILD_WITH_ADHD	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QLII_OTITIS_MEDIA_EFFUSION	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QLII_DEVEL_SCREENING_IN_FIRST_3_YEARS	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QLII_PED_CENTRAL_LINE_ASSOC_BLOODSTREAM	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1

QLII_CESAREAN_RATE_FOR_LOW_RISK_FIRST_BIRTH_WOMEN	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QLII_APPROP_TESTING_FOR_CHILDREN_WITH_PHARYNGITIS	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QLII_PERCENT_PREG_WOMEN_TOBACCO_SCREEN	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QLII_TOTAL_NUMBER_ELIG_WOMEN_WITH_17OH_PROGESTERONE	66-71	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	72	Character, value='^'	1
QLII_EMER_UTIL_AVG_ED_VISITS_PER_MEMBER	73-78	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	79	Character, value='^'	1
QLII_ANNUAL_NUMBER_ASTHMA_PATIENTS_WITH_1_ER_VISIT	80-85	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	86	Character, value='^'	1
QLII_FREQ_OF_ONGOING_PRENATAL_CARE	87-92	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	93	Character, value='^'	1
QLII_CAHPS_HEALTH_PLAN_SURVEY40_ADULT	94-99	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	100	Character, value='^'	1
QLII_CAHPS_HEALTH_PLAN_SURVEY40_CHILD	101-106	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	107	Character, value='^'	1

QLII_PROVIDER_SATISFACTION	108-113	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	114	Character, value='E'	1

Denied Encounter Error Analysis – E-CP-O-90-D

On a weekly basis LDH provides to the MCO the Denied Encounter Error Analysis (E-CP-O-90-D) via the MCO's sFTP site. The report provides a list of encounter denials by error code, description, and the number of denials for each claim type. MCO is required to retrieve the report, and review for encounters with correctable errors; and resubmit the corrected encounter according to the RFP guidelines.

An example of the E-CP-O-90-D can be found on the following page.

LAM2D070 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: E-CP-0-90-D
RUN: 12/12/14 15:30:48 LOUSIANA DEPARTMENT OF HEALTH - MEDICAL (BHSF) PAGE: 1
CYCLE: 12/16/14 DENIED ENCOUNTER ERROR ANALYSIS
45XXXXX MCO

ERROR CODE	ERROR DESCRIPTION	HOSP 01	LTC 02	OPAT 03	PHY 04	RHAB 05	HH 06	AMBL 07	NAMB 08	DME 09	DNTLE 10	DNTL 11	RX 12	EPSDT 13	18-I 14	18-P 15	ADC 16	HAB 17	HMKR 18	TOTAL
022	INVALID BILLED CHRGS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
114	INV/MISSING HCPCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
123	RX > SERVICE DATE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
127	MISSING NDC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
130	DENY PROV. 9999999	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
134	ENC DENIED BY PLAN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
185	REQ NONCOVRD CHARGES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
215	RECIPIENT NOT ON FIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
216	RECIPIENT NOT ELIG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
313	SUBMIT TO FI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
364	RECIP INELIG/DECEASE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
545	REV CODE INVALID NDC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
796	ORIG/ADJ PROV DIFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
797	DUP ADJ. RECORD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
798	HIST ALREADY ADJSTED	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
799	NO ADJ HISTORY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
805	EXACT DUPE 03 TO 03	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
843	EXACT DUPE 12 TO 12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
849	PD SAME ATTEN/DIF BL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	***** TOTAL *****	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Encounter EOB Analysis – E-CP-O-90-E

On a weekly basis, LDH provides to the MCO, thru the Fiscal Intermediary, the Encounter EOB Analysis Report (E-CP-O-90-E) via the MCO's sFTP site. The report is broken down by EOB codes that are set to "Educational" disposition, the description, and the number of edits for each claim type. The report is INFORMATIONAL ONLY, therefore, no action is required on the part of the MCO.

An example of the Encounter EOB Analysis (e-cp-o-90-E) can be found on the following page.

LAM2D070 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: E-CP-0-90-E
RUN: 12/12/14 15:30:48 LOUSIANA DEPARTMENT OF HEALTH - MEDICAL (BHSF) PAGE: 1
CYCLE: 12/16/14 ENCOUNTER EOB ANALYSIS
45XXXXX MCO

ERROR CODE	ERROR DESCRIPTION	HOSP 01	LTC 02	OPAT 03	PHY 04	RHAB 05	HH 06	AMBL 07	NAMB 08	DME 09	DNTLE 10	DNTL 11	RX 12	EPSDT 13	18-I 14	18-P 15	ADC 16	HAB 17	HMKR 18	TOTAL
030	SERV THRU DT TOO OLD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
115	HCPC CD NOT ON FILE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
132	SECONDARY DX NOF____	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201	PROVIDER NOT ELIG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
202	PROV CLAIM TYP CONFL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
210	PROV PROC CONFLICT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
212	PROV MUST BE INDIV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
231	NDC NOT ON P/F FILE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
232	PROCEDURE CODE NOF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
234	P/F AGE RESTRICTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
254	DIAG AGE RESTRICTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
272	CLAIM OVER 1 YEAR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
299	PROC/DRUG NOTCOVERED	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
416	ENC RCV DT ERROR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
813	EXACT DUPE 04 TO 04	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
855	SUSPCT DUPE 03 TO 03	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
863	SUSPCT DUPE 04 TO 04	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	***** TOTAL *****	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix E

MCO Generated Reports

The overarching purpose of this set of reports is to supplement information that is reported through the encounter process. Once the encounter process has stabilized, LDH may use encounters as the basis for these reports.

Denied Claims Report

LDH requires that health plans submit a monthly report showing **all** denied claims. Spreadsheet should be populated with records where **date of processing (date denied**) falls within the reporting period.

The report shall be submitted to the LDH Health Plan Manager in an Excel Spreadsheet by the 15th of the month following the end of the reporting period. The Excel Spreadsheet shall include one tab each for Medical Summary, Medical Detail, Pharmacy Summary, Pharmacy Detail, CARC Dictionary, RARC Dictionary, NCPDP Dictionary, and Definitions Page.
Any instructions or definitions not followed will result in rejected reports.

DETAILED DENIED CLAIMS REPORT

At a minimum, the **Medical Detail Denied Claims** reports shall include:

- Report heading, which includes
  - Health Plan ID:
  - Health Plan Name:
  - Health Plan Contact:
  - Contact Email:
  - Report Period Start Date:
  - Report Period End Date:
  - Submission Date of Report:
- Medicaid ID (13-digit Medicaid ID number);
- Billing Provider NPI - (National Provider Identifier);
- Servicing Provider NPI (National Provider Identifier);

- Plan Internal Control Number (ICN) for the claim;
- Billing Provider Type;
- Billing Provider Taxonomy code (if applicable)
- Servicing Provider Type;
- Servicing Provider Taxonomy code (if applicable)
- Claim type (LDH 2 digit code);
- ER = 0 Non-ER = 1: ER/Non-ER = Emergency service or Non-Emergency Service adjudicated during the reporting period; reported as 0 or 1 only. Emergency services are defined as claim type 03 with revenue codes 450, 459 or 981 (outpatient hospital) and claim type 04 with procedure codes 99281 through 99285 (professional).
- Date of service (The discharge or end date of service);
- Provider billed amount (include decimal point followed by 2 digits);
- Date Received- Date of receipt by the Health Plan;
- Date Denied;
- Primary diagnosis code
- CPT Procedure/HCPCS code(s) (if applicable)
- Revenue code(s) (if applicable): For Inpatient records, the Revenue Code field can be blank or can be the first Service-Line's Revenue Code value, but do not send more than 1 Revenue Code per Inpatient record and do not list the same Inpatient record on more than 1 row of the report.
- CARC code 1 : Claims Adjustment Reason Code as per CARC dictionary tab. Shall be at least one per denied claim/encounter

- CARC code 2 (if applicable)
- CARC code 3 (if applicable)
- CARC code 4 (if applicable)
- CARC code 5 (if applicable)
- RARC code 1 : Remittance Advice Remark Code as per RARC dictionary tab (if applicable according to CARC directive)

- RARC code 2 (if applicable according to CARC directive)
- RARC code 3 (if applicable according to CARC directive)

Note: Inpatient claims (claim type 01) are counted at the header level. Professional and Outpatient claims are counted at the line level (includes claims types: 03, 04, 05, 06, 07, 08, 09).

Please note that some fields are to be populated only if applicable. If not applicable, **leave field blank and do not enter N/A, NULL, or other entry.** All other fields are required and must be populated by the health plans and/or the health plan subcontractors.

At a minimum, the **Pharmacy Detail Denied Claims** reports shall include:

- Report heading, which includes:
  - Health Plan ID:
  - Health Plan Name:
  - Health Plan Contact:
  - Contact Email:
  - Report Period Start Date:
  - Report Period End Date:
  - Submission Date of Report:
- Medicaid ID (13-digit Medicaid ID number);
- Prescribing Provider NPI - (National Provider Identifier);
- Pharmacy Provider NPI (National Provider Identifier for dispensing pharmacist)
- Plan Internal Control Number (ICN) for the claim;
- Claim type (LDH 2 digit code): should be claim type 12 only for pharmacy
- ER = 0 Non-ER = 1: ER/Non-ER = Emergency service or Non-Emergency Service adjudicated during the reporting period; reported as 0 or 1 only. Emergency pharmaceutical services are defined as claim type 12 with a NCPDP field 418-DI with a value of 3. Non-emergency pharmaceutical services are defined as all other claims under claim type 12.
- Date of service (Point of Sale);
- Provider billed amount (include decimal point followed by 2 digits);
- Date Received- Date of receipt by the Health Plan;
- Date Denied;
- NDC Code
- NCPDP reject code 1 (up to 5 submitted on encounter per claim)
- NCPDP reject code 2 (if applicable)
- NCPDP reject code 3 (if applicable)
- NCPDP reject code 4 (if applicable)
- NCPDP reject code 5 (if applicable)

NOTE: The pharmacy detail tab should exclude true duplicates for the same claim with multiple denials on the same date of service and the same denial reason code, but shall include any duplicate claim if the denial reason changed.

- Professional and Outpatient claims are counted at the line level (includes claims type 12).
- Please note that some fields are to be populated only if applicable. If not applicable, **leave field blank and do not enter N/A, NULL, or other entry**. All other fields are required and must be populated by the health plans and/or the health plan subcontractors.

- Reports submitted by the health plan subcontractors (e.g. pharmacy) must have all required fields populated. It is the health plans responsibility to ensure that these reports contain all required data as outlined here.

Appendix F

Encounter Edit Codes

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the FI's MMIS are subject to edits. Edits may post at the line or at the header level. If an encounter denies at the header level, the encounter must be corrected and resubmitted. Instructions for correcting line level denials are found in **Section 4**.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS
- Encounter contains a fatal error that results in its denial

The MCO is required to correct repairable edits and resubmit the encounter to the FI for processing.

Encounter Edits Listing, Comprehensive

Disposition values: D=Deny, E=Education ONLY, O=Off

Edit Code	Disposition	Long Description
002	D	PROVIDER NUMBER MISSING OR NOT NUMERIC
003	D	RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
005	D	SERVICE FROM DATE MISSING/INVALID
006	D	INVALID OR MISSING THRU DATE
007	D	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	D	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	D	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
011	E	TPL INDICATOR NOT Y N OR SPACE
020	D	INVALID OR MISSING DIAGNOSIS CODE
021	D	FORMER REFERENCE NUMBER MISSING OR INVALID
022	D	BILLED CHARGES MISSING OR NOT NUMERIC
023	D	RECIPIENT NAME IS MISSING
024	D	BILLING PROVIDER NUMBER NOT NUMERIC
026	D	TOTAL DOC CHARGE MISSING OR NOT NUMBERIC
028	D	INVALID OR MISSING PROCEDURE CODE
030	E	SERV THRU DATE MORE THAN TWO YEARS OLD
035	D	ASC,OP FAC/PHYS.BILLED DIFF CODE;REBILL CORRECT HC
040	D	ADMISSION DATE MISSING OR INVALID
041	E	ADMISSION DATE GREATER THAN SERVICE FROM DATE

042	D	INVALID UB92 TYPE BILL CODE (LOGIC CHANGE NEEDED: bump bill type in encounter against list of valid BILL TYPES)
044	E	NATURE OF ADMISSION MISSING OR INVALID
045	D	PATIENT STATUS CODE INVALID OR MISSING
047	D	PATIENT STATUS DATE GREATER THAN THRU DATE
048	D	INVALID OR MISSING PROCEDURE CODE
049	D	INVALID/CONFLICT SURGICAL DATE
053	D	ACCOMODATION DAYS MISSING OR INVALID
055	D	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID
060	D	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING
064	E	THE NET BILLED AMOUNT IS NOT NUMERIC
067	E	NON COVERED HOSP DAYS NOT NUMERIC OR MISSING
068	D	INVALID POINT OF ORIGIN
069	D	INVALID OCCURRENCE DATE
071	D	STATEMENT COVERS FROM DATE INVALID
072	D	STATEMENT COVERS THRU DATE INVALID
073	D	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM
074	D	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE
077	D	ATTENDING PROV MUST EQUAL BILLING
081	D	INVALID OR MISSING PATIENT STATUS DATE
082	D	INVALID PATIENT STATUS CODE

084	D	INVALID OR MISSING PLACE OF TREATMENT
085	D	INVALID OR MISSING UNITS VISITS AND STUDIES
087	D	MISSING OR INVALID COINSURANCE DAYS
089	D	MISSING OR INVALID INCENTIVE AMOUNT
092	E	INVALID OR MISSING MODIFIER
093	D	REVENUE CODE MISSING/INVALID
094	D	MISSING PINTS BLOOD
095	D	CONDITION CODE 40 FROM THRU NOT EQUAL
097	D	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	D	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
112	D	PROCEDURE CODE - PROVIDER TYPE CONFLICT
113	D	ONLY ONE ER REVENUE (450/
114	E	INVALID OR MISSING HCPCS
115	D	HCPC CODE NOT ON FILE
120	D	QUANTITY INVALID/MISSING
127	D	NDC CODE MISSING OR INCORRECT
130	D	ALL PROVIDERS 9999999 TO BE DENY
131	O	PRIMARY DIAGNOSIS NOT ON FILE

132	D	SECONDARY DIAGNOSIS NOT ON FILE
134	D	DENIED ENCOUNTER SUBMITTED BY PLAN
136	D	NO ELIGIBLE SERVICE PAID – ENCOUNTER DENIED
141	O	REFILL NOT FILLED WITHIN 12 MONTHS
149	D	DESI INEFFECTIVE-NOT PAYABLE
151	D	CLAIM CONTAIN MIXED ICD CODE SETS
152	D	INVALID ICD CODE SET FOR CLAIM DATES OF SERVICE
180	D	THE ADMISSION DATE WAS NOT A VALID DATE
182	E	PROCEDURE CLAIM TYPE CONFLICT
183	D	SURGICAL PROCEDURE NOT ON FILE
185	O	NON-COVERED CHARGES REQUIRED OR USED FOR PAYMENT
186	D	CRNA'S MUST BILL CORRECT MODIFIER
191	D	PROCEDURE REQUIRES PRIOR AUTHORIZATION
200	D	PROVIDER/ATTENDING PROVIDER NOT ON FILE
201	E	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
202	E O	PROVIDER CANNOT SUBMIT THIS TYPE CLAIM
203	E	PROVIDER ON REVIEW
206	D	BILLING PROVIDER NOT ON FILE
210	E	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
211	D	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	D	RECIPIENT NOT ON FILE
216	D	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE

217	D	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RE
222	D	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATES
231	D	NDC CODE NOT ON FILE
232	E	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
234	D	P/F AGE RESTRICTION
235	D	P/F SEX RESTRICTION
236	D	P/F PLACE RESTRICTION
237	E	P/F PROVIDER SPECIALTY RESTRICTION
252	D	DIAGNOSIS NOT ON FILE
254	E	DIAGNOSIS AGE RESTRICTION
255	D	DIAG SEX RESTRICTION
258	D	DIFFERENCE BETWEEN SERVICE DATES AND QUANT
263	D	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
266	D	REV CODE INVALID FOR AMBULATORY SURG PROC.
267	D	REVENUE CODE 490 REQUIRES VALID ICD SURGICAL PROC
268	D	TREATMENT PLACE IS INCORRECT
272	E	CLAIM EXCEEDS 1 YEAR FILING LIMIT

275	D	RECIPIENT IS MEDICARE ELIGIBLE
279	E	INVALID PLACE OF TREATMENT FOR PROF COMP
289	D	INVALID PROVIDER NUMBER WHEN DENY APPLIED
299	E	PROC/DRUG NOT COVERED BY MEDICAID
303	E	INPATIENT RESPITE DAYS GREATER THAN FIVE
306	E	BABY ONLY / PENDING FOR REVIEW.
307	D	SURGICAL PROCEDURE MISSING
309	D	DATE OF SURGERY MISSING
310	D	DATE OF SURGERY LESS THAN SERVICE FROM DATE
313	D	SUBMIT CLAIM TO FISCAL INTERMEDIARY, NOT HLA NOR LBH
316	O	COVERED DAYS DO NOT EQUAL ACCOMODATION DAYS
317	E	STATEMENT DATES CONFLICT WITH ACCOMODATION DAYS
328	D	NOT COVERED FOR RECIPIENT IN NH/ICF
329	E	CLIA # DOES NOT COVER DATE OF SERVICE
330	E	QMB NOT MEDICAID ELIGIBLE_____
332	D	STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 2
334	D	CONSENT MUST BE AT LEAST 30 BUT NO MORE THAN 180 D
336	D	ABORTION REQUIRES REVIEW
337	E	STERILIZATION OFS FORM 96 REQUIRES REVIEW
338	E	ACKNOWLEDGEMENT REQUIRES REVIEW
339	D	OCCUR CODES/DATES CONFLICT
340	E	SPAN DAYS/NON COVERED DAYS CONFLICT
349	D	RECIPIENT NOT COVERED FOR THIS SERVICE

351	D	SPAN DATE NOT ALLOWED MUST BILL PER DAY_____
364	D	RECIPIENT INELIGIBLE/DECEASED
386	E	NOT PAYABLE WITH CLIA CERT TYPE
387	D	NO CLIA # ON OUR FILE
390	E	SERVICE EXCEEDS MAXIMUM ALLOWABLE OF 1 PER MONTH
400	E	REFERRING/ATTENDING PHYSICIAN REQUIRED
401	E	CONCURRENT CARE IS NOT COVERED BY THE PROGRAM
402	E	NUMBER OF SERVICES EXCEEDS STATE MAX/ CUTBACK APPL
405	E	OUTSIDE LABORATORY SERVICES NOT COVERED
408	D	INVALID POA INDICATOR
410	D	LICN PREFIX ON ENCOUNTER IS MISSING OR INVALID
414	D	PLAN PAYMENT DATE ON ENCOUNTER IS MISSING OR INVALID
416	D	PLAN RECEIVE DATE ON ENCOUNTER IS MISSING OR INVALID
417	D	INTEREST PAYMENT ON PLAN ENCOUNTER IS INVALID
429	E	NOT PAYABLE FOR MED NEEDY PROGRAM_____
433	D	MISSING/INVALID DIAGNOSIS CODE
444	D	MISSING/INVALID SERVICE PROVIDER
456	D	SUBMIT CLAIM TO CSOC PROVIDER (MAGELLAN)
472	O	Manufacturer not in federal rebate agreement
475	E	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE
490	E	MUST UTILIZE HMO SERVICES_____
492	E	HMO EOB REQUIRES REVIEW_____
505	O	CLAIM DID NOT RECEIVE CLAIMCHECK EDITS
513	D	HCPCS REQUIRED

522	D	MOTHER/NEWBORN MUST BE BILLED SEPARATE_____
523	D	ADJUSTMENT IS INVALID, VOID AND REBILL_____
532	E	OUT OF STATE SERVICES REQUIRE LDHDHH APPROVAL LETTER
539	D	CLAIM REQUIRES DETAILED BILLING_____
545	D	REVENUE CODE INVALID FOR REPORTING NDC INFO
550	D	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	E	ATTENDING/SERVICING PROVIDER NOT LINKED TO HLA PLA
615	E	MUST BE BILLED WITH APPROPRIATE PRIMARY CODE
622	D	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
644	D	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
675	D	VACC & ADM MUST PAY/AGREE;IF ONLY ONE PAYS TOTAL D
676	D	PAYABLE ONLY IF PRIMARY CODE IS PAID
678	E	GLOBAL CODE PD THIS DOS THIS RECIP
680	E	ABORTION PAID MOTHERS LIFE ENDANGERED
695	D	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
702	D	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
704	D	ER VISIT ON DATE OF INP HOS SERVICES
705	D	AIDE/RN/PT VISIT SAME DAY NOT ALLOWED/H. HEALTH
706	D	FOLLOWUP NB CARE BILLED SEPARATELY
712	D	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER AD
715	E	FOUND DUPLICATE VISIT SAME DAY
716	D	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT
720	D	MUST BE BILLED BY PROVIDER OF SERVICE
727	E	EXCEEDS DAILY SERVICE MAXIMUM

740	E	ONLY ONE PROCEDURE V2630 V2631 V2632 ALLOWED PER RECIP
746	D	SAME ATTENDING PROV PAID INPT CONSULTATION SAME ST
748	D	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN
749	D	DELIVERY BILLED AFTER HYSTERECTOMY/STERLIZ WAS DON
750	E	FOUND PROC. 2 X INDICATES STERILIZATION
755	D	THIS SHOULD BE BILLED AS ADJUST.FOR CNT STAY
774	E	INCLUDED IN RELATED SERVICE
777	E	ABORTION DUE TO RAPE PAID
781	E	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL
789	E	ABORTION DUE TO INCEST PAID
794	D	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING
796	D	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
797	D	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	D	HISTORY RECORD ALREADY ADJUSTED
799	D	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
800	D	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	D	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
805	D	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	D	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVIC
807	D	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
808	D	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE
810	D	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUI
813	D	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
815	D	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CL

816	D	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEA
817	D	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANC
818	D	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBU
819	D	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE
822	D	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIM
823	D	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
828	D	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
830	D	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP
833	D	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLA
837	D	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLA
843	D	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
849	D	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROV
851	D	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	E	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIM
857	E	SUSPCT DUPLICATE ERROR: OUTPATIENT AND HOME-HEALTH
859	E	SUSPCT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULAN
860	D	INVALID DATA IN FIRST COB LOOP
863	E	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
865	E	SUSPEC DUPLICATE ERROR: IDENTICAL REHAB-SERVICES C
866	E	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND HOME HE
867	E	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND AMBULAN
868	E	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMB
869	E	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND DME
872	E	SUSPCT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAI

873	E	SUSPCT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
874	E	SUSPCT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULA
878	E	SUSPCT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
879	E	SUSPCT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANC
883	E	SUSPECT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE C
884	E	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND DME CLA
887	E	SUSPECT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP C
893	E	SUSPECT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
898	D	EXACT DUPE SAME ICN – DROPPED
900	D	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED
906	E	EXCEEDS MAMIMUM ALLOWED
917	D	LIFETIME LIMITS FOR THIS SERVICE HAVE BEEN EXCEEDE
924	E	EFF 11/5/10 PAS FOR THIS HCPC REQUIRES CORRECT NDC
983	D	SYSTEM CALCULATED TOTAL – NET BILLED NOT IN BALANC

Repairable Edits

EDIT CODE	**EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1]** **EDIT DESCRIPTION**
049	INVALID-CONFLICT-SURG-DATE
200	PROVIDER-NOT-ON-FILE
216	RECIPIENT-NOT-ELIGIBLE
258	SPANNING-DATES-QUANT-DIFF
339	CODES-DATE-CONFLICT
364	RECIPIENT-INELIGIBLE-DECEASED
545	REV-NDC-INVALID

556	ATTENDING/SERVICING PROVIDER NOT LINKED TO HEALTHY LOUISIANA PLAN

[1] These denials may be corrected only in some instances

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
002	INVALID-PROV-NO
003	INVALID-RECIP-NO
005	INVALID-STMT-FROM-DTE
006	INVALID-STMT-THRU-DTE
007	SERV THRU LT SERV FM
008	SERV FRM GT ENTR DTE
009	SRV-THRU-GT-ENTRY
015	INVALID ACCIDENT IND
016	INVALID ACCID IND
017	INVALID EPSDT IND
020	DIAG-MISSING
021	INVALID FORMER REFNO
022	BILLING CHARGES MISSING OR NOT NUMERIC
023	INV PARTIAL RECIP
024	INV BILLING PROV NO
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMBERIC
028	INVALID OR MISSING PROCEDURE CODE
040	INVALID-ADMISSION-DTE-ERR
041	ADMISSION DATE GREATER THAN SERVICE FROM DATE
042	INVALID UB92 TYPE BILL CODE (LOGIC CHANGE NEEDED: bump bill type in encounter against list of valid BILL TYPES)
045	INV PATIENT STATUS
046	INV PATIENT STAT DTE
047	PAT STAT DTE GT THRU
053	ACCOMODATION DAYS MISSING OR INVALID
055	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
060	COVERED HOSPITAL DAYS NOT NUMBERIC OR MISSING
068	INVALID POINT OF ORIGIN
069	INVALID-OCUR-DATE
071	INV STMT COVERS FROM
072	INV STMT COVER THRU
073	STMT FRM LT SERV FRM
074	STMT THRU GT SRV THR
077	ATTENDIN PROV MUST EQUAL BILLING
081	INVALID STATUS DATE
082	INVALID STATUS CODE
084	INVALID OR MISSING PLACE OF TREATMENT
085	INVALID OR MISSING UNITS VISITS AND STUDIES
087	MISSING OR INVALID COINSURANCE DAYS
093	REVENUE CODE MISSING/INVALID
094	MISSING-PTS-BLOOD
095	CONDITION CODE 40 FROM THRU NOT EQUAL
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
114	INVALID OR MISSING HCPCS
115	HCPC CODE NOT ON FILE
120	QTY-INVALID-MISSING
126	REFILL CODE MISSING NOT NUMERIC OR GREATER THAN 11
130	DENY-PROV-9999999
132	SECONDARY DIAGNOSIS NOT ON FILE
149	DESI INEFFECTIVE-NOT PAYABLE

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
180	INVALID ADMIT DATE
186	CRNA-MUST-BILL-CORRECT-MOD
206	BILL PROV NOT ON FIL
211	DOS-LESS-THAN-DOB
212	ATTENDING PROVIDER MUST BE INDIVIDUAL
215	RECIPIENT-NOT-ON-FILE
217	NAME AND/ORNUMBER O CLAIM DOES NOT MATCH FILE RECORD
266	INVALID-AMB-SURG-REV
267	REQ-ICD9-SURGICAL-CD
268	TREATMENT PLACE IS INCORRECT
289	REJ-DENY-INV-PROV
307	SURG PROC MISSING
309	SURG DATE MISSING
310	SURG DTE LT SRV FROM
318	SUSP-COND-MISS-REF2
319	SUSP-COND-MISS-REF3
400	REFER-PHYS-REQD
444	M/I SERVICE PROVIDER
513	HCPCS-REQUIRED
563	ADJ-ADD-ON-WITH-51
676	PRIMARY CODE DENIED
702	NEW PT/EST PT CD CON
706	FOLLOW-UP-NB-CARE-BILLED
720	TO BE BILLED BY PROV
753	REBILL-DELIVERY
755	BILL AS ADJ/CNT STAY

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
757	ADJ PD LINE 51 MOD
796	ORIG/ADJ PROV DIFF
799	NO ADJ HISTORY
970	INAPPROPRIATE CODE
983	TOTAL-CHRG-CHANGED
TBD	PROV-NOT-CCN

Non-Repairable Edits

Below is a list of encounter edit codes set to deny. These codes are considered non-repairable and are not correctable.

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
035	REBILL CORRECT HCPC
113	ONLY ONE ER REVENUE (450/459) CODE PER VISIT
115	HCPC CODE NOT ON FILE
133	BEHAVIORAL HEALTH CROSSOVER SENT TO SMO (MAGELLAN)
141	REFILL NOT FILLED WITHIN 12 MONTHS
149	DESI INEFFECTIVE-NOT PAYABLE
222	RECIP-ELIG-DATE-OVERLAP
231	NDC CODE NOT ON FILE
234	P/F AGE RESTRICTION
235	P/F SEX RESTRICTION
236	P/F PLACE RESTRICTION
254	DIAGNOSIS AGE RESTRICTION
255	DIAG SEX RESTRICTION
263	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
425	BEHAVIORAL HEALTH CROSSOVER SENT TO HLA PLAN
426	SUBMIT CLAIM TO HLA
456	SUBMIT CLAIM TO CSoC PLAN – MAGELLA
507	SUBMIT CLAIM TO HLA PLAN
555	SUBMIT CLAIM TO LBHP SMO
631	EPSDT-AGE-ERROR
644	VISIT CODE PD/DOS
673	EVAL & MGT PD DOS
695	HOSP DISCHARGE PAID

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
704	ER VISIT/INP HOS SER
712	INITIAL HOSP INPT PD
716	PROC-INCLUDED-IN-OV
735	PREV PD ANES-SAME RE
746	SAME ATTD PD IP CONS
748	1 DEL.ALLOW. 6MTH.SP
749	DEL HYST/STER CONFLI
758	FND DUP SERV SM DAY
794	INPT SER PD SAME ATT
797	DUP ADJ. RECORD
798	HIST ALREADY ADJSTED
800	ON-LINE DUPE DENY
801	EXACT DUPE 01 TO 01
805	EXACT DUPE 03 TO 03
806	EXACT DUPE 03 TO 05
807	EXACT DUPE 03 TO 06
808	EXACT DUPE 03 TO 07
810	EXACT DUPE 03 TO 09
816	EXACT DUPE 05 TO 06
817	EXACT DUPE 05 TO 07
818	EXACT DUPE 05 TO 08
819	EXACT DUPE 05 TO 09
822	EXACT DUPE 06 TO 06
823	EXACT DUPE 06 TO 07
828	EXACT DUPE 07 TO 07
830	EXACT DUPE 07 TO 09
833	EXACT DUPE 08 TO 08

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
837	EXACT DUPE 09 TO 09
843	EXACT DUPE 12 TO 12
849	PD SAME ATTEN/DIF BL
898	EXACT DUPE SAME ICN
900	LIFETIME LIMITS-ONE
917	OVER LIFETIME LIMIT

Pharmacy Encounter Edits

Edit #	Description	Disposition
002	PROVIDER NUMBER MISSING OR NOT NUMERIC	D
003	RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS	D
005	SERVICE FROM DATE MISSING/INVALID	D
006	INVALID OR MISSING THRU DATE	D
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE	D
008	SERVICE FROM DATE LATER THAN DATE PROCESSED	D
011	TPL INDICATOR NOT Y, N, OR SPACE	E
021	FORMER REFERENCE NUMBER MISSING OR INVALID	D
022	BILLED CHARGES MISSING OR NOT NUMERIC	D
024	BILLING PROVIDER NUMBER NOT NUMERIC	D
030	SERV THRU DATE MORE THAN TWO YEARS OLD	D
120	QUANTITY INVALID/MISSING	D
121	A PRESCRIBING PHYSICIAN NPI OR MEDICAID ID REQUIRE	E
122	RX DATE MISSING OR INVALID	D
123	RX DATE WAS AFTER DATE FILLED	D
124	DAYS SUPPLY MISSING,NOT NUMERIC, OR ZERO	D
125	PRESCRIPTION NUMBER MISSING	D
126	REFILL CODE MISSING NOT NUMERIC OR GREATER THAN 11	D
127	NDC CODE MISSING OR INCORRECT.	D
129	PRESCRIBING PROV NPI MISSING/NOT ON FILE____	E
130	ALL PROVIDERS 9999999 TO BE DENY.	D
141	REFILL NOT FILLED WITHIN 12 MONTHS	D
142	BILLING PROVIDER NPI MISSING/NOT ON FILE____	D
149	DESI INEFFECTIVE-NOT PAYABLE_____	D
151	CLAIM CONTAIN MIXED ICD CODE SETS	D
152	INVALID ICD CODE SET FOR CLAIM DATES OF SERVICE	D
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE	E

Edit #	Description	Disposition
211	DATE OF SERVICE LESS THAN DATE OF BIRTH	D
215	RECIPIENT NOT ON FILE	D
216	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	D
217	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RE	D
231	NDC CODE NOT ON FILE	D
262	PROVIDER'S ADJUSTMENTS ON REVIEW	E
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT	E
273	3RD PARTY CARRIER CODE MISSING-REFER TO CARRIER CD	D
275	RECIPIENT IS MEDICARE ELIGIBLE	D
299	PROC/DRUG NOT COVERED BY MEDICAID	E
311	C-II EXPIRED-GREATER THAN 90 DAYS	D
315	NEGATIVE TPL AMOUNT NOT ALLOWED	D
330	QMB NOT MEDICAID ELIGIBLE_____	D
346	BILL MEDICARE B FOR QUALIFIED SERVICE OTHERWISE PA	D
364	RECIPIENT INELIGIBLE/DECEASED	D
393	MISSING/INVALID RECIPIENT COPAY IN 1ST COB OCCURRE	D
414	PLAN PAYMENT DATE ON ENCOUNTER IS MISSING OR INVAL	D
421	PROVIDER FEE MUST BE SUBMITTED AS $0.10	E
422	NEW PRESCRIPTION NOT FILLED WITHIN 12 MO OF DATE P	D
434	BILL MEDICARE NEBULIZER MED	D
436	DAYS SUPPLY >100 EXCEEDS PROGRAM MAXIMUM____	E
438	MANUFACTURER NOTIFIED US THAT NDC IS OBSOLETE	D
448	TRANSPLANT DISCHARGE DATE OR OTHER DX NEEDED	D
452	SCHEDULE 2 NARCOTIC CANNOT BE REFILLED	D
454	NEW PRESCRIPTION NOT FILLED WITHIN 6 MOS. OF DATE	D
455	REFILL NOT FILLED WITHIN 6 MONTHS	D
462	CMS NOTIFIED US THAT NDC IS TERMINATED	D
465	INVALID NDC - NOT AVAILABLE	D
472	MANUFACTURER HAS NOT ENTERED INTO HCFA REBATE AGRE	D
489	PROVIDER TYPE NOT AUTHORIZED TO PRESCRIBE___	E
491	PRESCRIBER NUMBER NOT FOR INDIVIDUAL PRESCRIBER	D
521	PRESCRIBING PRVI BILLED IS GROUP USE INDIVIDUAL PR	D
535	BILL MEDICARE PART D_____	D
536	BILL MEDICARE PART B_____	D
537	OBRA 90 EXCUDED DRUG PAID BY MEDICAID_____	E
556	BILLING/ATTENDING/SERVICING/PROVIDER NOT LINKED TO	E
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT	D
797	DUPLICATE ADJUSTMENT RECORDS ENTERED	D
798	HISTORY RECORD ALREADY ADJUSTED	D
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT	D
831	MISSING/INVALID PRODUCT/SERVICE ID QUALIFIER IN 43	D
843	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS	D
860	INVALID COB-1 ID COB-1 PAYER ID MUST BE PLAN ID	D
861	MISSING/INVALID UNIT OF MEASURE IN NCPDP FIELD 600	D

Edit #	Description	Disposition
898	EXACT DUPE SAME ICN - DROPPED	D
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURAN	E
939	CUTBACK PER SURS GUIDELINES	D
988	ITEM COVERED BY MEDICARE	D

Appendix G

Provider Directory/Network and Subcontractor Registry

MCOs are required to provide an adequate network of providers including but not limited to PCPs, specialists, hospitals and auxiliary services needed to ensure member access to covered services that meets standards for distance, timeliness, amount, duration and scope as defined in the contract with LDH. Plans are required to provide LDH with a listing of all contracted providers. Providers in an MCO network are not required to be enrolled in Louisiana Medicaid, but all are required to be included in the listing submitted to LDH.

At the onset of the contract and periodically as changes are necessary, LDH shall publish a list of NPIs of Medicaid providers that will include provider types, specialty, and sub-specialty coding schemes to the MCO and/or its contractor. The MCO and/or its contractor shall utilize these codes within their provider file record, at the individual provider level.* The objective is to coordinate the provider enrollment records of the MCO with the same provider type, specialty and sub-specialty codes as those used by LDH and the Enrollment Broker.

The MCO listing of contracted providers is to be submitted electronically through the state's Fiscal Intermediary (FI). Only one unique record per combined NPI and Taxonomy should be submitted in the master Provider Registry. If a provider practices at multiple sites the MCO should submit only the primary site in the Provider Registry. Secondary sites for PCPs and specialist can be submitted through the "Provider Registry Site" file, described in this Appendix. Providers that are no longer accepting patients must be clearly identified.

Many of the data elements are publicly available from NPPES through the Freedom of Information Act (FOIA). The complete listing of data elements and file specifications are also detailed in this Appendix.

In addition, the file layout for the Magellan Provider Registry can be found in Appendix Y of this guide.

The MCO is responsible for:

- Ensuring the completeness and accuracy of the data submitted
- Timely submission of all updates to the registry to the FI on a weekly basis (each Friday by close of business 5 PM CST).

Provider Types

The MCO is required to populate the Provider Type field to a LDH valid provider type code as shown in the list below:

Provider Type	Name
01	FISCAL AGENT (WVR)
02	TRANSITIONAL SUPPORT (WVR)
03	CHILDREN'S CHOICE (WVR)(IN-ST)
04	PEDI DAY HLTH CARE (IN-ST)
05	MANAGED CARE ORG - PREPAID
06	NOW PROFESSIONAL SERVICES
07	CASE MGMT-INFT & TODD (IN-ST)
08	OAAS CASE MGMT (IN-ST)
09	HOSPICE SERVICES (IN-ST)
10	COMPREHENSIVE COMM SUPPORT SRV
11	SHARED LIVING (WVR) (IN-ST)
12	MULTI-SYSTEMIC THER (IN-ST)
13	PREVOC REHAB (WVR) (IN-ST)
14	DAY HABILITAT (WVR) (IN-ST)
15	ENVIR ACC ADAP (WVR) (IN-ST)
16	PERS EMERG RESP SYS (WVR)
17	ASSISTIVE DEVICES (WVR)
18	COMM MENTAL HLTH CTR/PART HOSP
19	DR OF OSTEOPATH MED (IND & GP)
20	PHYSICIAN (IND & GP)
21	THIRD PARTY BILL AGT/SUBMITTER
22	PERSONAL CARE ATTENDANT (WVR)
23	INDEPENDENT LAB
24	PERSONAL CARE SERVICES (IN-ST)
25	MOBILE XRAY/RADIATION THRPY CT
26	PHARMACY

Provider Type	Name
27	DENTIST (IND & GP)
28	OPTOMETRIST (IND & GP)
29	EARLYSTEPS (IND & GP) (IN-ST)
30	CHIROPRACTOR (IND & GP)
31	PSYCHOLOGIST (LIC/MED) (IN-ST)
32	PODIATRIST (IND & GP)
33	PRESCRIBING ONLY PROVIDER
34	AUDIOLOGIST (IN-ST)
35	PHYSICAL THERAPIST (IN-ST)
36	NOT ASSIGNED
37	OCCUPATIONAL THERAPIST (IN-ST)
38	SCHOOL BSED HEALTH CTR (IN-ST)
39	SPEECH/LANGUAGE THERAP (IN-ST)
40	DME
41	REGISTERED DIETICIAN (IN-ST)
42	NON-EMER MED TRANSPORT (IN-ST)
43	CASE MGT - NHV/FTM (IN-ST)
44	HOME HEALTH AGENCY (IN-ST)
45	CASE MGMT - CONTRACTOR (IN-ST)
46	CASE MGMT - HIV
47	CASE MGMT - CMI - no longer enrolled
48	CASE MGMT - PREGNANT WOMEN - no longer enrolled
49	CASE MGMT - DEVELOP DISABLED - no longer enrolled
50	PACE (ALL-INCLUSIVE CARE-ELD)
51	AMBULANCE TRANSPORTATION
52	CO-ORDIN CARE NETWORK-SHARED
53	SELF DIRECTED/DIRECT SUPPORT
54	AMBULATORY SURGI CTR (IN-ST)
55	EMERG ACCESS HOSPITAL (IN-ST)
56	PRESCRIBER ONLY FOR MCO
57	OPH REGISTERED NURSE (IN-ST)

Provider Type	Name
59	NEURO REHAB HOSPITAL (IN-ST)
60	HOSPITAL
61	VENERIAL DISEASE CL (IN-ST)
62	TUBERCULOSIS CLINIC
63	TUBERCULOSIS INPT HOSPITAL - no longer enrolled
64	MENTAL HLTH HOSP (FREE-STAND)
65	REHABILITATION CENTER (IN-ST)
66	KIDMED - no longer used since 2016
67	PRENATAL HLTH CARE CL (IN-ST)
68	SUBS/ALCOH ABSE CTR (X-OVERS)
69	DIST PART PSYCH HOSP (IN-ST)
70	EPSDT HEALTH SERVICES (IN-ST) - LEA = Licensed Educational Agency
71	FMLY PLANNING CLINIC (IN-ST)
72	FED QUALIFIED HLTH CTR (IN-ST)
73	LIC CL SOCIAL WORKER (IN-ST)
74	MENTAL HEALTH CLINIC (IN-ST) - LGE = Local Government Entity
75	OPTICAL SUPPLIER
76	HEMODIALYSIS CENTER (IN-ST)
77	MENTAL REHAB AGENCY (IN-ST)
78	NURSE PRACTITIONER (IND & GP) - APRN
79	RURAL HLTH CL(PROV-BSE)(IN-ST)
80	NURSING FACILITY (IN-ST)
81	CASE MGMT - VENT ASSTD CARE - no longer enrolled
82	PERS CARE ATTEND (WVR) (IN-ST) - also used for CSoC
83	CTR BASED RESPITE CARE (IN-ST)
84	SUBSTIT FMLY CARE (WVR)(IN-ST)
85	ADLT DAY HLTH CA (WVR) (IN-ST)
86	ICF/DD REHABILITATION - no longer enrolled
87	RURAL HLTH CL(INDEPEND)(IN-ST)
88	ICF/DD - GROUP HOME (IN-ST)
89	SPRVISE INDEP LIV (WVR)(IN-ST)

Provider Type	Name
90	CERTIFIED NURSE MIDWIFE - APRN
91	CERT REG NURS ANEST (IND & GP) - APRN
92	PRIVATE DUTY NURSE - no longer enrolled
93	CLINICAL NURSE SPECIALIST - APRN
94	PHYSICIAN ASSISTANT
95	AMERICAN INDIAN/638 FACILITY
96	PSYCH RESID TREAT FACILITY
97	ADULT RESIDENTIAL CARE FAC
98	SUPPORTED EMPLYMENT (IN-ST)
99	GREAT NO COMM HLTH CONN(IN-ST)
AA	ASSERTIVE COMM TREAT TEAM
AB	PREPAID INPATIENT HLTH PLAN
AC	FAMILY SUPPORT ORGANIZATION
AD	TRANSITION COORDINATION
AE	RESPITE CARE SERVICE AGENCY
AF	CRISIS RECEIVING CENTER
AG	BEHAVIORAL HLTH REHAB AGENCY
AH	LIC MARRIAGE & FAMILY THERAPY
AJ	LICENSED ADDICTION COUNSELOR
AK	LICENSED PROFESSION COUNSELOR
AL	COMMUNITY CHOICE WAIVER-NURS
AM	HOME DELIVERED MEALS
AN	CAREGIVER TEMPORARY SUPPORT
AQ	NON-MEDICAL GROUP HOME
AR	THERAPEUTIC FOSTER CARE
AS	OPH CLINIC
AT	THERAPEUTIC GROUP HOME
AU	OPH REGISTERED DIETITIAN
AV	EXTENDED DUTY DENTAL ASSISTANT
AW	PERMANENT SUPPOR HOUSING AGENT

Provider Type	Name
AX	CERTIFIED BEHAVIOR ANALYST
AY	DENTAL BENEFIT PLAN MANAGER
AZ	SUBST USE RESIDENT TX FAC
BC	BIRTH CENTER (FREE-STANDING)
BI	BEHAVIOR INTERVENTION
DC	DCFS TARGETED CASE MANAGEMENT
IP	EHR INCENTIVE PROGRAM
MI	MONITORED IN-HOME CAREGIVING
MW	LICENSED MID-WIFE
NB	NON-LICENSED BEHAVIORAL HEALTH INDIVIDUAL
PO	OPR (ORDERING, PRESCRIBING AND REFERRING)
PS	**Peer Support Specialist**
PO	OPR (ORDERING, PRESCRIBING AND REFERRING)
SP	SUPER PROVIDER/OHCDS
TH	THERAPEUTIC HORSEBACK RIDING
TM	TRANSPORTATION MANAGEMENT CONTRACTOR
TS	TRANSPORTATION SUBCONTRACTOR
WA	Wrap Around Agencies
XX	ERROR PROVIDER

Provider Specialty Types

For providers registered as individual practitioners, LDH requires the MCO to assign a LDH provider specialty code from the LDH valid list of specialties found below:

Specialty Code	Name	Description	Associated Provider Types
00	All Specialties	Specialty	
01	General Practice	Both Specialty and Sub-specialty	19, 20, 33, 93, PO
02	General Surgery	Both Specialty and Sub-specialty	19, 20, 33, 93
03	Allergy	Both Specialty and Sub-specialty	19, 20, 33
04	Otology, Laryngology, Rhinology	Both Specialty and Sub-specialty	20, 33
05	Anesthesiology	Both Specialty and Sub-specialty	19, 20, 33, 91, PO
06	Cardiovascular Disease	Both Specialty and Sub-specialty	19, 20, 33, 93
07	Dermatology	Both Specialty and Sub-specialty	19, 20, 33
08	Family Practice	Both Specialty and Sub-specialty	19, 20, 33, 78, 93
09	Gynecology (DO only)	Specialty	19
10	Gastroenterology	Both Specialty and Sub-specialty	19, 20, 33
11	**Not in use**		
12	Manipulative Therapy (DO only)	Specialty	19
13	Neurology	Both Specialty and Sub-specialty	20, 33
14	Neurological Surgery	Both Specialty and Sub-specialty	19, 20, 33
15	Obstetrics (DO only)	Specialty	19
16	OB/GYN	Both Specialty and Sub-specialty	20, 33, 90, IP, PO
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	Specialty	19
18	Ophthalmology	Both Specialty and Sub-specialty	20, 33
19	Orthodontist	Specialty	27, 33
1A	Adolescent Medicine	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1B	Diagnostic Lab Immunology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33

Specialty Code	Name	Description	Associated Provider Types
1C	Neonatal Perinatal Medicine	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33, 93
1D	Pediatric Cardiology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1E	Pediatric Critical Care Medicine	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33, 93
1F	Pediatric Emergency Medicine	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1G	Pediatric Endocrinology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1H	Pediatric Gastroenterology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1I	Pediatric Hematology - Oncology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1J	Pediatric Infectious Disease	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1K	Pediatric Nephrology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1L	Pediatric Pulmonology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1M	Pediatric Rheumatology	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1N	Pediatric Sports Medicine	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1P	Pediatric Surgery	Both Specialty and Sub-specialty. If Specialty, then 37 must be specified as the Sub-specialty.	19, 20, 33
1Q	Pediatric Neurology	Sub-specialty	19, 20, 33
1R	Pediatric Genetics	Sub-specialty	19, 20, 33
1S	BRG - Med School	Sub-specialty	19, 20, 33

Specialty Code	Name	Description	Associated Provider Types
1T	Emergency Medicine	Both Specialty and Sub-specialty	19, 20, 33
1U	Pediatric Developmental Behavioral Health	Sub-specialty	20
1Z	Pediatric Day Health Care	Specialty	04
20	Orthopedic Surgery	Both Specialty and Sub-specialty	19, 20, 33
21	Pathologic Anatomy; Clinical Pathology (DO only)	Specialty	19
22	Pathology	Both Specialty and Sub-specialty	20, 33
23	Peripheral Vascular Disease or Surgery (DO only)	Specialty	19
24	Plastic Surgery	Both Specialty and Sub-specialty	19, 20, 33
25	Physical Medicine Rehabilitation	Both Specialty and Sub-specialty	19, 20, 33
26	Psychiatry	Both Specialty and Sub-specialty	19, 20, 33, 78, 93, 94, PO
27	Psychiatry; Neurology (DO only)	Specialty	19, PO
28	Proctology	Both Specialty and Sub-specialty	19, 20, 33
29	Pulmonary Diseases	Both Specialty and Sub-specialty	19, 20, 33
2A	Cardiac Electrophysiology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2B	Cardiovascular Disease	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	Only used as a subspecialty secondary to specialty 41 for PT 19, 20, 33
2C	Critical Care Medicine	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	Only used as a subspecialty secondary to specialty 41 for PT 19, 20, 33, and for any PT **93**
2D	Diagnostic Laboratory Immunology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2E	Endocrinology & Metabolism	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2F	Gastroenterology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2G	Geriatric Medicine	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33, 93
2H	Hematology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33

Specialty Code	Name	Description	Associated Provider Types
2I	Infectious Disease	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2J	Medical Oncology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33, 93
2K	Nephrology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2L	Pulmonary Disease	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2M	Rheumatology	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2N	Surgery - Critical Care	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2P	Surgery - General Vascular	Both Specialty and Sub-specialty. If Specialty, then 41 must be specified as the Sub-specialty.	19, 20, 33
2Q	Nuclear Medicine	Both Specialty and Sub-specialty	19, 20, 33
2R	Physician Assistant	Specialty	94, IP, PO
2S	LSU Medical Center New Orleans	Sub-specialty	19, 20, 33
2T	American Indian / Native Alaskan	Specialty	95
2U	Independent Diagnostic Testing Facility - IDTF	Sub-specialty	20
2W	Addiction Specialist	Specialty	19, 20
2X	Local Governing Entity (LGE)	Both Specialty and Sub-specialty	10, 19, 20, 27, 28, 30. 32. 34. 35, 37, 38, 39, 54, 68, 74, 76, 78, 91, AS, BC, BI, WA
2Y	OPH Genetic Disease Program	Specialty. Effective 05/2005	40
30	Radiology	Both Specialty and Sub-specialty	20, 25, 33 (removed 19, added 25)
31	Roentgenology, Radiology (DO only)	Specialty	19
32	Radiation Therapy (DO only)	Specialty	19
33	Thoracic Surgery	Both Specialty and Sub-specialty	19, 20, 33
34	Urology	Both Specialty and Sub-specialty	19, 20, 33
35	Chiropractor	Specialty	30

Specialty Code	Name	Description	Associated Provider Types
36	Pre-Vocational Habilitation	Specialty	13
37	Pediatrics	Both Specialty and Sub-specialty	19, 20, 33, 78, 93, IP, PO
38	Geriatrics	Both Specialty and Sub-specialty	19, 20, 33, 93
39	Nephrology	Both Specialty and Sub-specialty	19, 20, 33
3A	Critical Care Medicine	Both Specialty and Sub-specialty. If Specialty, then 16 must be specified as the Sub-specialty.	Only used as a subspecialty secondary to specialty 16 for PT 20, 33
3B	Gynecologic oncology	Both Specialty and Sub-specialty. If Specialty, then 16 must be specified as the Sub-specialty.	20, 33
3C	Maternal & Fetal Medicine	Both Specialty and Sub-specialty. If Specialty, then 16 must be specified as the Sub-specialty.	20, 33
3D	Community Choices Waiver - Respiratory Therapy	Sub-Specialty only	44, 65
3E	Community Choices Waiver - PT and OT	Sub-Specialty only	44, 65
3F	Community Choices Waiver - PT and S/L T	Sub-Specialty only	44, 65
3G	Community Choices Waiver - PT and RT	Sub-Specialty only	44, 65
3H	Community Choices Waiver - OT and S/L T	Sub-Specialty only	44, 65
3J	Community Choices Waiver - OT and RT	Sub-Specialty only	44, 65
3K	Community Choices Waiver - S/L T and RT	Sub-Specialty only	44, 65
3L	Community Choices Waiver - PT, OT & S/L T	Sub-Specialty only	44, 65
3M	Community Choices Waiver - PT, OT & RT	Sub-Specialty only	44, 65
3N	Community Choices Waiver - PT, S/L T & RT	Sub-Specialty only	44, 65
3P	Organized Health Care Delivery System (OHCDS)	Sub-Specialty only	SP
3Q	Community Choices Waiver - OT, S/L T & RT	Sub-Specialty only	44, 65
3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	Sub-Specialty only	44, 65

Specialty Code	Name	Description	Associated Provider Types
3S	LSU Medical Center Shreveport	Sub-Specialty only	19, 20, 33
3T	DBPP - Dental Benefit Plan Prescriber	Specialty	AY, PO
3U	Community Choices Waiver – Assistive Devices – Home Health	Specialty	17
3W	Supportive Housing Agency	Specialty	AW
3X	Extended Duty Dental Assistant	Specialty	AV
3Y	DBPM - Dental Benefit Plan Management	Specialty	AY
3Z	Transportation Subcontractor	Specialty	TS
40	Hand Surgery	Both Specialty and Sub-specialty	19, 20, 33
41	Internal Medicine	Both Specialty and Sub-specialty	19, 20, 33, 93, PO
42	Federally Qualified Health Centers	Specialty	72
43	Not in Use		
44	Public Health	Specialty	70, 93
45	NEMT - Non-profit	Specialty	42
46	NEMT - Profit	Specialty	42
47	NEMT - Friends + Family (F&F)	Specialty	42
48	Podiatry - Surgical Chiropody	Specialty	32, 33, PO
49	Miscellaneous (Admin. Medicine)	Both Specialty and Sub-specialty	20, 33
4A	Developmentally Disabled (DD)	Specialty	01, 02, 11
4B	NOW RN	Specialty only	06
4C	NOW LPN	Specialty only	06
4D	NOW Psychologist	Specialty only	06
4E	NOW Social Worker	Specialty only	06
4F	Pharmacist	Sub-specialty	33
4G	New, Provider Domain	Specialty only	11
4H	Conversion, Participant Domain	Specialty only	11
4J	Conversion, Provider Domain	Specialty only	11
4K	Home and Community-Based Services (HCBS)	Specialty only	01
4L	New, Participant Domain	Specialty only	11
4M	EHR Managed Care (Behavior Health)	Sub-specialty only	56, IP

Specialty Code	Name	Description	Associated Provider Types
4R	Registered Dietician	Specialty only	06, 41
4S	Ochsner Med School	Sub-specialty	19, 20, 33
4U	OPH Registered Dietitian	Specialty	AU
4V	CCW DME Only	Specialty	17
4W	Waiver Services	Sub-specialty only	01, 31, 35, 37, 39, 41, 42,44, 45, 47, 73, 82, 84, 85
4X	Waiver-Only Transportation	Sub-specialty only	42
4Y	EHR Managed Care (Medical)	Sub-specialty only	56, IP
4Z	CCW Home Health and DME	Specialty	17
50	Day Habilitation	Specialty	14
51	Med Supply / Certified Orthotist	Specialty	40
52	Med Supply / Certified Prosthetist	Specialty	40
53	Med Supply Co W/CRTD PROSTH OR	Specialty	40
54	Med Supply / Not Included in 51, 52, 53	Specialty	40
55	Indiv Certified Orthotist	Specialty	40
56	Indiv Certified Prosthetist	Specialty	40
57	Indiv Certified Prosthetist - Orthotist	Specialty	40
58	Indiv Not Included in 55, 56, 57	Specialty	40
59	Ambulance Service Supplier, Private	Specialty	51
5A	PCS-LTC	Specialty onl	24
5B	PCS-EPSDT	Specialty only	24
5D	PCS-LTC, PCS-EPSDT	Specialty	24
5H	Community Mental Health Center	Specialty	18
5I	Statewide Management Organization (SMO)	Specialty	AB
5J	Youth Support	Specialty	AC
5K	Family Support	Specialty	AC
5L	Both Youth and Family Support	Specialty	AC
5M	Multi-Systemic Therapy	Specialty	12
5P	PACE	Specialty only	50

Specialty Code	Name	Description	Associated Provider Types
5Q	CCN-P (Coordinated Care Network, Pre-paid)	Specialty	05
5R	CCN-S (Coordinated Care Network, Shared Savings)	Specialty	52
5S	Tulane Med School	Sub-specialty	19, 20, 33
5U	Individual	Specialty	AD
5V	Agency/Business	Specialty	AD
5W	Community Choices Waiver - Personal Assistance Service	Sub-Specialty only	44
5X	Therapeutic Group Homes	Specialty	AT
5Y	PRCS Addiction Disorder	Specialty	19, 20
60	Public Health or Welfare Agencies & Clinics	Specialty	57, 61, 62, 67
62	Psychologist Crossovers only	Specialty	29, 31
63	Portable X-Ray Supplier (Billing Independently)	Specialty	25
64	Audiologist (Billing Independently)	Specialty	29, 34, 40
65	Indiv Physical Therapist	Specialty	29, 35
66	General Dentistry (DDS/DMS)	Specialty	27, 33, IP, PO
67	Oral and Maxillofacial Surgery	Specialty	20, 27, 33
68	Pediatric Dentistry	Specialty	27, 33
69	Independent Laboratory (Billing Independently)	Specialty	23
6A	Psychologist -Clinical	Sub-specialty only (Specialty 95 or 96 only)	31
6B	Psychologist-Counseling	Sub-specialty only (Specialty 95 or 96 only)	31
6C	Psychologist - School	Sub-specialty only (Specialty 95 or 96 only)	31
6D	Psychologist - Developmental	Sub-specialty only (Specialty 95 or 96 only)	31
6E	Psychologist - Non-Declared	Sub-specialty only (Specialty 95 or 96 only)	31
6F	Psychologist - All Other	Sub-specialty only (Specialty 95 or 96 only)	31
6G	Medical Psychologist	Specialty	31, PO
6H	LaPOP	Specialty	01
6M	Transportation Management Contractor	Specialty	TM

Specialty Code	Name	Description	Associated Provider Types
6N	Endodontist	Specialty only	27
6P	Periodontist	Specialty only	27
6R	Rehab Hospital	Specialty only	60
6S	E Jefferson Fam Practice Ctr - Residency Program	Specialty only	19, 20, 33
6T	Community Choices Waiver - Physical Therapy	Specialty only	35, 44, 65
6U	Applied Behavioral Analyst	Specialty only	31, AX
6W	Licensed Mid-Wife	Specialty	MW
70	Clinic or Other Group Practice	Specialty	10, 19, 20, 27, 28, 30, 32, 34, 35, 37, 38, 39, 54, 68, 74, 76, 78, 90, 91, AS, BI, BC, WA
71	Speech Therapy	Specialty	29, 39
72	Diagnostic Laboratory	Specialty	23
73	Social Worker Enrollment	Specialty	**23, 73**
74	Occupational Therapy	Specialty	29, **37**
75	Other Medical Care	Specialty	65
76	Adult Day Care	Specialty	85
77	Habilitation	Specialty	85
78	Mental Health Rehab	Specialty	77
79	Nurse Practitioner	Specialty	78, IP, PO
7A	SBHC - NP - Part Time - less than 20 hrs week	Sub-specialty	38
7B	SBHC - NP - Full Time - 20 or more hrs week	Sub-specialty	38
7C	SBHC - MD - Part Time - less than 20 hrs week	Sub-specialty	38
7D	SBHC - MD - Full Time - 20 or more hrs week	Sub-specialty	38
7E	SBHC - NP + MD - Part Time - total = less than 20 hrs week	Sub-specialty	38
7F	SBHC - NP + MD - Full Time - total = 20 or more hrs week	Sub-specialty	38
7G	Community Choices Waiver - Speech/Language Therapy	Sub-specialty	39, 44, 65
7H	Community Choices Waiver - Occupational Therapy	Sub-specialty	37, 44, 65
7M	Retail Convenience Clinics	Sub-specialty	19, 20, 78

Specialty Code	Name	Description	Associated Provider Types
7N	Urgent Care Clinics	Sub-specialty	19. 20, 78
7P	ABA Therapy Psychologist	Specialty	31
7R	Aquatic Therapy	Specialty	35, 37,
7S	Leonard J Chabert Medical Center - Houma	Sub-specialty	19, 20, 33
7T	Art Therapy	Specialty	35, 37,
7U	Art and Music	Sub-specialty	35, 37
7V	Music Therapy	Specialty	35, 37,
7X	Sensory Integration	Specialty	35, 37
7Y	Therapeutic Horseback Riding	Specialty	35, 37, 39,
7Z	Hippotherapy	Specialty	35,37, 39,
80	Environmental Accessibility Adaptations	Specialty	15
81	Case Management	Specialty	07, 08, 43, 45, 46, 47, 48, 49, 81, DC
82	Personal Care Attendant	Specialty	22, 82
83	Respite Care	Specialty	83
84	Substitute Family Care	Specialty	84
85	Extended Care Hospital	Specialty	60
86	Hospitals and Nursing Homes	Specialty	55, 59, 60, 63, 64, 69, 80, 86, 88
87	All Other	Specialty	26, 44, 92, 93, PO
88	Optician / Optometrist	Specialty	28, 75, IP, PO, 89
89	Supervised Independent Living	Specialty	**89**
8A	Elderly, Community Choices Waiver, DD	Sub-specialty only	82
8B	Elderly, Community Choices Waiver	Sub-specialty only	82
8C	DD services	Sub-specialty only	82
8D	Community Choices Waiver - Caregiver Temporary Support	Both Specialty and Sub-specialty	82, 83, AN
8E	CSoC/Behavioral Health	Specialty. LIFT 7980	AA, AB, AC, AD, AE, AF, AG, AH, AJ, AK, 31, 53, 56, 70, 72, 74, 79, 82, 83, 87, 89, NB**, PS**

Specialty Code	Name	Description	Associated Provider Types
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	Sub-specialty only	AN
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	Sub-specialty only	AN
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	Sub-specialty only	AN
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	Sub-specialty only. Effective 10/2011, LIFT 7474	AN
8K	ADHC HCBS	Specialty only	AL
8L	Hospital-based PRTF	Specialty	96
8M	Community Choices Waiver - Home-Delivered Meals	Specialty only	AM
8N	Community Choices Waiver - Nursing	Sub-specialty only	44
8O	Doctor of Osteopathic Medicine	Both Specialty and Sub-Specialty	IP
8P	Physician - MD	Both Specialty and Sub-Specialty	IP
8Q	EAA Assesor, Inspector, Approver	Sub-specialty only	15
8R	PRTF, other Specialization	Specialty	96
8S	OLOL Med School	Sub-specialty	19, 20, 33
8U	Subst Abuse or Addiction	Specialty	96, AZ
8V	Methadone Clinic	Sub-specialty	Only use with Provider Type 68 and Provider Specialty 70
90	Personal Emergency Response Sys (Waiver)	Specialty	16
91	Assistive Devices	Specialty	17
92	Prescriber only and OPR	Specialty	21, 33, 56, PO
93	Hospice Service for Dual Elig.	Specialty	09
94	Rural Health Clinic	Specialty	79, 87
95	Psychologist (PBS Program Only)	Specialty	31
96	Psychologist (PBS Program and X-Overs)	Specialty	31
97	Family Planning Clinic	Specialty	71

Specialty Code	Name	Description	Associated Provider Types
98	Supported Employment	Specialty	98
9A	Community Choices Waiver - Nursing and Personal Assistance Services	Sub-specialty	44
9B	Psychiatric Residential Treatment Facility	Specialty	96
9D	Residential Care	Specialty	97
9E	Children's Choice Waiver	Specialty	03
9F	Therapeutic Foster Care (TFC)	Specialty	AR
9G	Non-Medical Group Home (NMGH)	Specialty	AQ
9H*	Seeing LaHIPP Medicaid Enrollees Only	Sub-specialty	Every Provider Type
9K	FQHC Look-Alike	Sub-specialty. Specialty 42	22
9L	RHC/FQHC OPH Certified SBHC	Specialty	72, 79,87
9M	Monitored In-Home Caregiving (MIHC)	Specialty	MI
9P	Greater NO Community Healthcare Center (GNOCHC)	Specialty	PT 99, but PT 99 program ended in 2016
9Q	PT 21 -Third-Party Biller/Submitter	Sub-specialty only	21
9R	Electronic Visit Verification Submitter	Sub-specialty	21
9S	IP - Optical Supplier	Specialty	IP
9T	Exempted from State EVV	Sub-specialty)	
9U	Medicare Advantage Plans	Sub-specialty	21
9V	OCDD - Point of Entry	Sub-specialty	21
9W	OAAS - Point of Entry	Sub-specialty	21
9X	OAD - Point of Entry	Sub-specialty	21
9Y	Juvenile Court/Drug Treatment Center	Sub-specialty	21
9Z	Other Contract with a State Agency	Sub-specialty	21
CV	**Expedited Enrollment under COVID-19 Emergency**	Sub-specialty. Not used in adjudication, cost center allocation, or other provider processing. The intent is to flag Providers who were subject to emergency enrollment rules.	

Specialty Code	Name	Description	Associated Provider Types
XX	Error Provider	Specialty. Associated with Provider ID 9999999. .	

Provider Registry File Layout

The MCO must submit provider information in the registry as indicated in the file layout shown below.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
1 - 20	NPI	National Provider ID number	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeros, be sure to include them.	R
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type Code	1 = Individual 2 = Organization	1	Numeric	R
23	Delimiter		1	Character, use the ^ character value	
24 - 43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeros, be sure to include them.	
44	Delimiter		1	Character, use the ^ character value	

45 - 74	Provider Name OR the legal Business Name for Organizations.		30	Character If the entity type = 1 (individual), format the name in this manner: First 13 characters = provider first name, 14th character =middle initial (or space), 15-30th characters = last name. If names do not fit in these positions, truncate the end of the item so that it fits in designated positions. **DO NOT include suffixes or titles in the last name, see columns 761-765 Provider Suffix and 767-776 Provider Title.**	R
75	Delimiter		1	Character, use the ^ character value	
76 - 105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107 -136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138 - 167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169 - 170	Provider Business Mailing Address (State)	USPS state code abbreviation	2	Character	R

171	Delimiter		1	Character, use the ^ character value	
172 - 181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^ character value	
183 - 192	Provider Business Mailing Address (Country Code if outside USA	Leave blank if business mailing address in not outside the USA	10	Character, left-justify, right fill with spaces if necessary	
193	Delimiter		1	Character, use the ^ character value	
194 - 203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes nor parentheses.	10	Numeric	R
204	Delimiter		1	Character, use the ^ character value	
205 - 214	Provider Business Mailing Address (Fax Number)	Do not enter dashes nor parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216 - 245	Provider Business Location Address (First line address)	No P.O. Box here, use physical address	30	Character	R
246	Delimiter		1	Character, use the ^ character value	
247 - 276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278 - 307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309 - 310	Provider Business Location Address (State)	USPS state code abbreviation	2	Character	R

311	Delimiter		1	Character, use the ^ character value	
312 - 321	Provider Business Location Address (9-digit Postal Code)		10	Character, left-justify, right fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323 - 332	Provider Business Location Address (Country Code if outside USA	Leave blank if business mailing address in not outside the USA	10	Character, left-justify, right fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334 - 343	Provider Business Location Address (Telephone Number)	Do not enter dashes nor parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	
345 - 354	Provider Business Location Address (Fax Number)	Do not enter dashes nor parentheses.	10	Numeric	O
355	Delimiter		1	Character, use the ^ character value	

356 - 365	Healthcare Provider Taxonomy Code 1		10	Character	R Note: if a single NPI is used for multiple entities, then at least 1 taxonomy per NPI is required. For example: if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then a taxonomy is needed for both units with each sent in a separate record.
366	Delimiter		1	Character, use the ^ character value	
367 - 376	Healthcare Provider Taxonomy Code 2	Use if necessary, otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
378 - 387	Healthcare Provider Taxonomy Code 3	Use if necessary, otherwise leave blank.	10	Character	O
388	Delimiter		1	Character, use the ^ character value	
389 - 395	Other Provider Identifier	If available, enter provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional
396	Delimiter		1	Character, use the ^ character value	

397 - 400	Other Provider Identifier, Type Code	Provider Type and Provider Specialty	4	First 2 characters are provider type; last 2 characters (3-4) are provider specialty. See Companion Guide, Appendix G, for list of applicable provider types and specialties.	R
401	Delimiter		1	Character, use the ^ character value	
402 - 409	Provider Enumeration Date	NPPES Enumeration Date	8	Numeric, format YYYYMMDD	R Not required for **PT 26**; otherwise requried
410	Delimiter		1	Character, use the ^ character value	
411 - 418	Last Update Date	NPPES last update date; enter all zeros if not available	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420 - 439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate	20	Left justify, right-fill with spaces	O
440	Delimiter		1	Character, use the ^ character value	
441 - 448	NPI Deactivation Date	NPPES deactivation date; enter all zeros if not appropriate	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450 - 457	NPI Reactivation Date	NPPES reactivation date; enter all zeros if not appropriate	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	M = Male F = Female N = Not applicable	1	Character	R

460	Delimiter		1	Character, use the ^ character value	
461 - 480	Provider License Number		20	Character, left-justify, right-fill with spaces	R Required when Provider has a License, otherwise optional
481	Delimiter		1	Character, use the ^ character value	
482 - 483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485 - 534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justify, right-fill with spaces	R
535	Delimiter		1	Character, use the ^ character value	
536 - 565	Authorized Official Contact Information (Title or Position)			Character, left-justify, right-fill with spaces	O
566	Delimiter		1	Character, use the ^ character value	
567 - 576	Authorized Official Contact Information (Telephone Number))	Do not enter dashes nor parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	**Y** = Yes, panel is open. **N** = No, panel is not open.	1	Character	R for PCPs; otherwise optional
579	Delimiter		1	Character, use the ^ character value	

580	Language Indicator 1 (primary language indicator)	1 = English-speaking patients only2 = Accepts Spanish-speaking patients3 = Accepts Vietnamese-speaking4 = Accepts French-speaking patients5 = Accepts Cambodian-speaking patients6 = American Sign Language	1	Character	R for PCPs, specialists and other professionals; otherwise optional
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (secondary language indicator)	0 = no other language supported 1 = Accepts English-speaking patients 2 = Accepts Spanish-speaking patients 3 = Accepts Vietnamese-speaking 4 = Accepts French-speaking patients 5 = Accepts Cambodian-speaking patients 6 = American Sign Language	1	Character	O
583	Delimiter		1	Character, use the ^ character value	

584	Language Indicator 3 (secondary language indicator)	0 = no other language supported1 = Accepts English-speaking patients 2 = Accepts Spanish-speaking patients3 = Accepts Vietnamese-speaking4 = Accepts French-speaking patients5 = Accepts Cambodian-speaking patients6 = American Sign Language	1	Character	O
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (secondary language indicator)	0 = no other language supported 1 = Accepts English-speaking patients 2 = Accepts Spanish-speaking patients 3 = Accepts Vietnamese-speaking 4 = Accepts French-speaking patients 5 = Accepts Cambodian-speaking patients 6 = American Sign Language	1	Character	O
587	Delimiter		1	Character, use the ^ character value	

588	Language Indicator 5 (secondary language indicator)	0 = no other language supported1 = English-speaking patients only2 = Accepts Spanish-speaking patients3 = Accepts Vietnamese-speaking4 = Accepts French-speaking patients5 = Accepts Cambodian-speaking patients6 = American Sign Language	1	Character	O
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	0 = no age restriction 1 = adult only 2 = pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional
591	Delimiter		1	Character, use the ^ character value	
592 - 596	PCP Linkage Maximum	This number represents the maximum number of patients that can be linked to the PCP within this plan.	5	Numeric, left-fill with zeros. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional
597	Delimiter		1	Character, use the ^ character value	
598 - 602	PCP Actual Linkages with Plan	This number represents the actual number of plan enrollees currently linked to the PCP.	5	Numeric, left fill with zeroes. Leave all zeroes if the provider is not a PCP.	R for PCPs; otherwise optional
603	Delimiter		1	Character, use the ^ character value	

604-608	PCP Linkages with all MCOs		5	Numeric, left fill with zeroes. Leave this field all zeroes.	R
609	Delimiter		1	Character, use the ^ character value	
610	MCO Enrollment Indicator	Use this field to identify new providers, change existing providers, disenroll providers and remove records from the registry.**N** = New enrollment**C** = Change to existing enrollment**D** = Disenrollment	1	Character	R
611	Delimiter		1	Character, use the ^ character value	
612 - 619	MCO Enrollment Indicator Effective Date	Effective date of enrollment indicator above	8	Numeric format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	0 = no restrictions 1 = family members only	1	Numeric	R for PCPs; otherwise optional
622	Delimiter		1	Character, use the ^ character value	
623 - 624	Provider Sub-Specialty 1	Value set is determined by LDH and is available in the System Companion Guide	2		R for PCPs; otherwise optional
625	Delimiter		1	Character, use the ^ character value	
626 - 627	Provider Sub-Specialty 2	Value set is determined by LDH and is available in the System Companion Guide	2		O

628	Delimiter		1	Character, use the ^ character value	
629 - 630	Provider Sub-Specialty 3	If necessary, Value set is determined by LDH and is available in the System Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632 -661	MCO Contract Name or Number	This should represent the contract name/number that is established between the MCO and Provider	30	Character, zeroes or spaces may be used to indicate a non-contracted network provider.	R
662	Delimiter		1	Character, use the ^ character value	
663 - 670	MCO Contract Begin Date	Date the contract between the MCO and provider started	8	Numeric format YYYYMMDD	R = Required for participating Providers; O = Optional for non-participating Providers (Eff. 11/1/2017)
671	Delimiter		1	Character, use the ^ character value	

672 - 679	MCO Contract Term Date	Date the contract between the MCO and provider was terminated	8	Numeric format YYYYMMDD	R = Required for participating Providers; O = Optional for non-participating Providers If Contract Begin date is not 0, then Contract End Date must be greater than or equal to Contract Begin Date. Open End Date = 20991231. (eff. 11/1/2017)
680	Delimiter		1	Character, use the ^ character value	
681 - 682	Provider Parish Served - first or primary	Parish Code Value that represents the primary parish that the provider serves	2	2-digit parish code value. See System Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684 - 685	Provider Parish Served - secondary	Parish Code Value that represents a secondary or other parish that the provider servesUse only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	

687 - 688	Provider Parish Served - third	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
689	Delimiter		1	Character, use the ^ character value	
690 - 691	Provider Parish Served - fourth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693 - 694	Provider Parish Served - fifth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696 - 697	Provider Parish Served - sixth	Parish Code Value that represents a secondary or other parish that the provider servesUse only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O

698	Delimiter		1	Character, use the ^ character value	
699 - 700	Provider Parish Served - seventh	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
701	Delimiter		1	Character, use the ^ character value	
702 - 703	Provider Parish Served - eighth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705 - 706	Provider Parish Served - ninth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	

708 - 709	Provider Parish Served - tenth	Parish Code Value that represents a secondary or other parish that the provider servesUse only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
710	Delimiter		1	Character, use the ^ character value	
711 - 712	Provider Parish Served - eleventh	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714 - 715	Provider Parish Served - twelth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717 - 718	Provider Parish Served - thirteenth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O

719	Delimiter		1	Character, use the ^ character value	
720 - 721	Provider Parish Served - fourteenth	Parish Code Value that represents a secondary or other parish that the provider servesUse only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
723 - 724	Provider Parish Served - fifteenth	Parish Code Value that represents a secondary or other parish that the provider serves Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See System Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	

726	PCP Indicator	**0** = Not a PCP**1** = Regularly serves as a PCP for a general population group (i.e. can have age or gender limits but no other specialized limitations on populations). This would include appropriate provider types and have agreed to fulfill PCP responsibilities for general populations.**2** = PCP Extenders - must be linked to a supervising PCP**3** = PCP Specialized - for designated individuals only (would not show up as a PCP in any registry nor directory).	1	Numeric value 0, 1, 2 or 3	R
727	Delimiter		1	Character, use the ^ character value	
728	Display Online Indicator	0 = don't display on EB website 1 = display on EB website	1	Numeric value 0 or 1	R
729	Delimiter		1	Character, use the ^ character value	
730 - 759	Expanded Age Restriction	To allow free-form entry for provider to expand for their practice.	30	Character	O
760	Delimiter		1	Character, use the ^ character value	
761 - 765	Provider Suffix	Example: Jr, Sr, etc.	5	Character	O

766	Delimiter		1	Character, use the ^ character value	
767 - 776	Provider Title	Example: MD, RN, etc.	10	Character	O
777	Delimiter		1	Character, use the ^ character value	
778	Prescriber Indicator	Used for Prescriber Types: Medical Psychologists, Physicians, Psychiatrists, etc.	1	NumericValid values are:**Blank** = not applicable or no prescriptive authority**0** = Full Rx authority**1** = Resident with Rx authority**2** = Limited Rx authority (PA, NP, Medical Psychologist)**3** = Sanctioned**4** = Full Rx authority plus ability to Rx Suboxone (opiod dependents)**5** = Pharmacists who can Rx immunizations.	R for Prescriber types; otherwise leave blank
779	Space	End of record filler	1	Character, enter a space value	
780	End of Record	End of record delimiter	1	Character, use the ^ character value	

Provider Registry Edit Report (sample)

20:00 Friday, February 14, 2020 1

Report: MW-W-06 *RUN DATE: 20200214*

State of Louisiana
Department of Health
Bureau of Health Services Financing
BAYOU HEALTH Plan
Report MW-W-06: Weekly Provider Registry Edit/Update Report

BAYOU_HEALTH_ID=

RECORD TYPE	PROV ID	NPI	NAME	TAXONOMY 1	ASSIGNED MEDICAID ID	ACC REJ	ERR1	ERR2	ERR3	ERR4	ERR5	ERR6	ERR7
N				3336C0003X	0000000	R	028	000	000	000	000	000	000
D				3336C0003X	0607555	A	035	000	000	000	000	000	000
D				3336C0003X	0523276	A	035	000	000	000	000	000	000
D				333600000X	0000000	R	029	035	000	000	000	000	000

ERROR CODES (A=Accepted; R=Rejected)	
000=(A)	No errors found
001=R	Missing/Invalid NPI (not 10 digits)
002=R	Missing/Invalid Entity Type (must be 1 or 2)
003= R	Provider record must include taxonomy
004=R	Missing required information (name, address, contact name, etc.)
005=R	Missing/Invalid provider type (PT) or specialty (PS)
006=R	Invalid provider sub-specialty (if one is submitted and it is not a valid value
007=R	Missing/Invalid enrollment indicator (must be N, C, D)
008=R	Missing/Invalid enrollment effective date
009=R	Invalid panel open indicator value (must by Y, N)
010=R	Invalid Language indicator value (must be 0,1,2,3,4,5,6. 1st indcator cannot be 0)
011=R	Invalid Age Restriction indicator value (must be 0,1,2)
012=R	Invalid PCP Linkage Maximum value (must be numeric or zeros)
013=R	Invalid PCP Linkage BAYOU HEALTH value (must be numeric or zeros)
014=R	Invalid PCP Linkage Other value (must be numeric or zeros)
015=R	Invalid Family-Only indicator value (must be 0,1)

016=R	Missing Contract Name or Numbr (found only spaces)
017=R	Missing/Invalid Contract begin date
018=R	Missing/Invalid Contract termination date
019=R	Missing provider parish (at least 1 must be submitted)
020=R	Invalid provider parish value (for a submitted value)
021=R	Duplicate NPI records found. Only first on in the file is accepted)
022=R	Medicaid Provider ID (Other Provider Identifier) is not found on MMIS Provider File
023=R	Missing/Invalid NPPES Enum Date
024=R	Missing/Invalid Provider License Data
025=A	NPI not found on LMMIS Provider Enrollment File
026=R	Provider not found on LMMIS Provider Enrollment File
027=R	Unable to assign a Medicaid provider …too many collusions
028=R	Enrollment Ind=N (new), but provider already exists on registry
029=R	Enrollment Ind=C or D, but provider does not exist on registry
030=R	Invalid taxonomy format (Special characters not allowed)
031=R	Missing/Invalid Replacement NPI for an atypical provider
032=R	Shared Plan providers must be actively enrolled in LA Medicaid
033=R	Shared Plan Fiscal Agent-Waiver, EDI Billing Agent and Prescribing Only providers not allowed
034=R	Shared Plan Other Provider Type does not match MMIS enrollment file
035=A	Non-Par Contractor
036=A	Shared Plan Other Provider Specialty does not match MMIS enrollment file
037=R	Invalid PCP Indicator field (must be 0,1,2,3)
038=R	Invalid Display Online field (must be 0,1)
039=R	Zip Codes must be numeric without a hyphen
040=R	A ^, CR, TAB or LF was found in a text field. Please verify the positions of the delimiter fields.
041=R	Invalid value for prescriber indicator: valid values are space, 0,1,2,3,4,5,6,7,8
042=R	SETI Providers Restricted to PT 42, PS 45,46,47 or PT 51 PS 59

End of Report

Accept/Reject Code				
error_ind	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A	2	50.00	2	50.00
R	2	50.00	4	100.00

Provider Registry Edit File Layout

Columns	Field Name	Format	Size	Comments
1-7	MCO Plan ID number	Numeric	7 digits	This is the plan ID.
8	Delimiter	Character	1	Value is ^ character.
9	Enroll Code	Character	1	Submitted by plan: N=New C=Change D=Disenroll
10	Delimiter	Character	1	Value is ^ character.
11-17	Provider ID	Numeric	7 digits	This is the provider's LA Medicaid ID number
18	Delimiter	Character	1	Value is ^ character.
19-28	Provider NPI	Character	10	
29	Delimiter	Character	1	Value is ^ character.
30-59	Provider Name	Character	30	
60	Delimiter	Character	1	Value is ^ character.
61-70	Provider Taxonomy	Character	10	
71	Delimiter	Character	1	Value is ^ character.
72-78	Provider ID	Numeric	7 digits	
79	Delimiter	Character	1	Value is ^ character.
80	DXC Accept/Reject Indicator	Character	1	A=Accepted R=Rejected
81	Delimiter	Character	1	Value is ^ character.
82-84	Edit Code 1	Character	3	
85	Delimiter	Character	1	Value is ^ character.
86-88	Edit Code 2	Character	3	
89	Delimiter	Character	1	Value is ^ character.
90-92	Edit Code 3	Character	3	
93	Delimiter	Character	1	Value is ^ character.
94-96	Edit Code 4	Character	3	
97	Delimiter	Character	1	Value is ^ character.
98-100	Edit Code 5	Character	3	

101	Delimiter	Character	1	Value is ^ character.
102-104	Edit Code 6	Character	3	
105	Delimiter	Character	1	Value is ^ character.
106-108	Edit Code 7	Character	3	
109	Delimiter	Character	1	Value is ^ character.
110-112	Edit Code 8	Character	3	
113	Delimiter	Character	1	Value is ^ character.
114-116	Edit Code 9	Character	3	
117	Delimiter	Character	1	Value is ^ character.
118-120	Edit Code 10	Character	3	
121	Delimiter	Character	1	Value is ^ character.

Provider Registry Edit Text File

```
[redacted]^N[redacted]3^[redacted]^[redacted]^3336C0003X^0000000^R^028^000^000^000^000^000^000^000^000^000^000^
[redacted]^D^[redacted]3^[redacted]^[redacted]^3336C0003X^0607555^A^035^000^000^000^000^000^000^000^000^000^
[redacted]^D^[redacted]2^[redacted]^[redacted]^3336C0003X^0523276^A^035^000^000^000^000^000^000^000^000^000^
[redacted]^D^[redacted]7^[redacted]^[redacted]^333600000X^0000000^R^029^035^000^000^000^000^000^000^000^000^
```

Provider Registry Site File

MCOs have access to the Site Provider Registry link on the HLA menu web page:

www.lamedicaid.com

The MCO must log in to this website before being allowed to get to the menu page. The process for using the site is similar to the Provider Registry where the plan will upload their site file updates to DXC using the naming schema “YYYYMMDD_NNNNNNN_Site_PR.txt”, where YYYYMMDD is the date of the submission (YMD) and NNNNNNN is their assigned Medicaid check digit provider ID.

If an MCO makes a change to a provider on the Provider Registry master file, then it is the MCO’s responsibility to make the corresponding change to their site file. DXC will not manually make this change. If the MCO makes a change to the master registry record for a provider, the MCO must also send the provider’s site record(s). The reason for this is because DXC utilizes information from the master registry record on the site record that is sent to Maximus. If the MCO makes a change to provider type, specialty, max linkages, etc., then the site record(s) must be submitted so that these changes are propagated to.

The Provider Registry Site File Format can be found on the following pages.

Site File Format

Note that the first three data items (MCO Plan ID, Provider NPI and Provider Taxonomy) make up the key fields by which this information will be matched to the Provider Registry information. If DXC is not able to find a match on the Provider Registry, the submitted record will be rejected.

Column ID	Field Position in record	Field	Type	Length	Required or Optional	Valid values	Other notes	Applicable Error Code(s) (see table below).
1	1-7	MCO Plan ID	Numeric	7	Required	Must be your assigned Plan ID	Use your Plan ID formatted 2162nnn, where nnn is your specific assigned number. Once, assigned It must remain consistent.	016
2	8	Delimiter	Character	1	Required	^		023
3	9-18	Provider NPI	Numeric	10	Required	Must be the provider's NPI		001, 004, 013, 015 017. (015 is not a rejection error for Pre-Paid plans),
4	19	Delimiter	Character	1	Required	^		023
5	20-29	Provider Taxonomy	Character	10	Required	Must be a valid Taxonomy		002, 020
6	30	Delimiter	Character	1	Required	^		023
7	31-37	LMMIS Medicaid Provider ID	Numeric	7	Optional	If not available then place all zeros in this field.	This is the assigned Louisiana Medicaid Provider ID. It is the check-digit number. Check-digit provider numbers begin with 1 or 2, not with 00 or 01.	014 . (014 is not a rejection error for Pre-Paid plans).
8	38	Delimiter	Character	1	Required	^		023
9	39-41	Site Number	Numeric	3	Required	**Must be a number between 001 and 998. May not be 000 or 999.** Be sure to left-fill with zeros, if appropriate. **Plan's MUST maintain consistency with this number by NPI and Taxonomy.**	Site Number should be a unique number for each practice site/location by Provider (NPI and Taxonomy). For a specific provider, it should start with 001 for the first site, then 002, etc.	003, 022
10	42	Delimiter	Character	1	Required	^		023
11	43-92	Practice/Site Street Address 1	Character	50	Required		Do not use a PO Box.	003, 013, 021

							Do not send multiple site records that share the exact same address, based on columns 11, 13, 15, and 17.	
12	93	Delimiter	Character	1	Required	^		023
13	94-143	Practice/Site Street Address 2	Character	50	Optional	If not used, then place spaces in this field.	Do not use a PO Box.	003, 013, 021
14	144	Delimiter	Character	1	Required	^		023
15	145-194	City	Character	50	Required	Must not be all spaces.		003
16	195	Delimiter	Character	1	Required	^		023
17	196-197	State Abbreviation	Character	2	Required	Must use the appropriate USPS State or Territory abbreviation.		003
18	198	Delimiter	Character	1	Required	^		023
19	199-207	Zip Code	Numeric	9	Required	Must use the USPS ZIP+4 format. If the last 4 digits are not available, then code them with 0000.		003
20	208	Delimiter	Character	1	Required	^		023
21	209-210	Parish Code	Numeric	2	Required	Must use a valid Louisiana Medicaid parish code value between '01' and '64' if in-state or '99' if out-of-state.		011, 012
22	211	Delimiter	Character	1	Required	^		023
23	212-261	Contact Name	Character	50	Required	Must not be all spaces.		003
24	262	Delimiter	Character	1	Required	^		023
25	263-272	Contact Phone Number	Numeric	10	Required	Must be 10 numeric digits		003
26	273	Delimiter	Character	1	Required	^		023
27	274-283	Contact Fax Number	Numeric	10	Optional	Must be 10 numeric digits. If not available, then use 0000000000.		003
28	284	Delimiter	Character	1	Required	^		023
29	285	PCP Indicator	Character	1	Required	Y or N. Blank/space value will cause an error.		008
30	286	Delimiter	Character	1	Required	^		023
31	287	Accepting New Patients Indicator	Character	1	Optional	Y or N. If not known, then use N. If you send a blank/space value, it will be interpreted as Y.		007
32	288	Delimiter	Character	1	Required	^		023
33	289-318	Age Restriction Information	Character	30	Optional	If not known, then place all spaces in this field.	This is a text field that may be used by the plan to represent age restrictions at the practice site/location. If	

							there are no age restrictions, you may enter the value NONE.	
34	319	Delimiter	Character	1	Required	^		023
35	320-369	Group Affiliation Information	Character	50	Optional	If not used, then place all spaces in this field.	This is a text field that the plan may use to identify a group or clinic for which the provider site is affiliated. Examples are: LSU Healthcare Network Ochsner Clinics We request that the plan maintain consistency in this field.	
36	370	Delimiter	Character	1	Required	^		023
37	371	Submission Type / Enrollment Indicator	Character	1	Required	**N**=New Site Record **C**=Change to Existing Site Record **D**=Disenrollment of Site Record **X**=Remove	For changes and dis-enrollments, this record (identified by **Plan ID, NPI, Taxonomy and Site Number**) must already exist on the site registry. For new records, the record must not already exist on the site registry.	005, 018, 019
38	372	Delimiter	Character	1	Required	^		023
39	373-380	Submission Date	Numeric	8	Required	Must be a numeric date value in the format YYYYMMDD.	This is the date that you are submitting the record.	006
40	381	Delimiter	Character	1	Required	^		023
41	382-389	Site Enrollment Effective Begin Date	Numeric	8	Required	Must be a numeric date value in the format YYYYMMDD.	This is the effective begin date of the practice/site enrollment. You may not use zeros, and it must represent a valid date.	009
42	390	Delimiter	Character	1	Required	^		023
43	391-398	Site Enrollment Effective End Date	Numeric	8	Required	Must be a numeric date value in the format YYYYMMDD.	This is the effective end date of the practice/site enrollment. You may not use zeros, and it must represent a valid date.	010

							Do not use zeros to indicate open-end; instead, use 20991231 to indicate open-end. The enrollment end date must be greater than or equal to the enrollment begin date.	
44	399	END OF RECORD INDICATOR	Character	1	Required	^	If not present, the record will be rejected.	023

Error Messages

'000'='No errors found'

'001'='Missing/Invalid NPI (not 10

digits)'

'002'='Provider record must include taxonomy'

'003'='Missing required information (site number, name, address, phone,

etc.)'

'004'='Only provider types 19, 20, 78, 92, 94, 72, 79, 87 allowed on site

registry'

'005'='Missing/Invalid submission type (must be N, C, D or X)'

'006'='Missing/Invalid submission date'

'007'='Invalid Accepting New Patients value (must be Y,

N)'

'008'='Invalid PCP Indicator value (must be Y, N)'

'009'='Missing/Invalid effective begin date'

'010'='Missing/Invalid effective end date'

'011'='Missing provider site parish'

'012'='Invalid provider site parish value (for a submitted value)'

'013'='Duplicate NPI/site records found. Only first one in the file is

accepted'

'014'='LMMIS Provider ID not found on MMIS Provider File'

'015'='NPI not found in LMMIS Provider Enrollment File'

'016'='HEALTHY LOUISIANA **Plan** ID not found on LMMIS Provider Enrollment File'

'017'='Provider does not exist on provider registry or was dis-enrolled'

'018'='Enrollment Ind=N (new), but provider already exists on site registry'

'019'='Enrollment Ind=C or D, but provider does not exist on site registry'

'020'='Invalid taxonomy format (Special characters not allowed)'

'021'='Same site practice address found on provider registry'

'022'='Site number cannot be **000 or** 999'

'023'='Record format is not delimited or end-of-record indicator is missing/invalid'.

Error File Format

Column	Name	Size	Type
1	MCO Plan ID	7	Numeric
8	Delimiter	1	^
9	Submission Type	1	Alphanumeric
10	Delimiter	1	^
11	Provider NPI	10	Numeric
21	Delimiter	1	^
22	Provider Name	30	Alphanumeric
52	Delimiter	1	^
53	Provider Taxonomy	10	Alphanumeric
63	Delimiter	1	^
64	Site Number	3	Numeric
67	Delimiter	1	^
68	Error Indicator	1	Alphanumeric
69	Delimiter	1	^
70	Error 1	3	Numeric
73	Delimiter	1	^
74	Error 2	3	Numeric
77	Delimiter	1	^
78	Error 3	3	Numeric
81	Delimiter	1	^
82	Error 4	3	Numeric
85	Delimiter	1	^
86	Error 5	3	Numeric
89	Delimiter	1	^
90	Error 6	3	Numeric
93	Delimiter	1	^
94	Error 7	3	Numeric
97	Delimiter	1	^
98	Error 8	3	Numeric
101	Delimiter	1	^
102	Error 9	3	Numeric
105	Delimiter	1	^
106	Error 10	3	Numeric
109	Delimiter	1	^

Primary Care Physician (PCP) Linkage Directory

MCOs are required to send to the FI, along with the Weekly Provider Registry File, a full replacement recipient Primary Care Physician Linkage Directory. The format for the PCP Linkage File Layout, along with instructions, can be found on the following pages.

MCO Batch Electronic File Layout for PCP Linkage

Subject to Change

PART 1: PLAN FILE SUBMISSIONS

File submissions should occur once per week on or before Friday COB (5:00 p.m. CT) unless it is a holiday and then the MCO may submit the file on the previous applicable work day. If the MCO chooses to do so because it is applicable to its processing environment, a file may be submitted on Friday if it is a holiday.

The MCO may submit only one file per week, and this file should contain all records that you expect to submit during that week.

The weekly file should be a full file representing all PCP-to-recipient linkages (current and historical) that the MCO has in its system. There is no incremental update process; instead, the FI will perform a full replacement from the MCOs weekly file submission.

File submissions should utilize DXC's non-EDI sFTP service.

Plan File submission naming convention: PCP-BATCH-NNNNNNN-YYYYMMDD.txt Where NNNNNNN is the MCO Plan ID and YYYYMMDD is the date of submission.

The submission file has a fixed-length record format. Each record is 100 characters in length, and uses the following record layout. As noted, all fields are required (R). The file does not use delimiters and is formatted as an ASCII text file.

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*R=Required O=Optional*	*Notes*
001	1-7	PCP_LINKAGE_PLAN_ID	number(7)	R	Use your assigned plan ID
002	8-17	PCP_LINKAGE_PCP_NPI	number(10)	R	10-digit NPI of the PCP.
003	18-27	PCP_LINKAGE_PCP_TAXONOMY	char(10)	R	10-character taxonomy of the PCP.
004	28-40	PCP_LINKAGE_RECIPIENT_MEDICAID_ID	char(13)	R	13-digit Medicaid ID number of the Recipient. Left-fill with zero(s).
005	41-49	PCP_LINKAGE_RECIPIENT_SSN	char(9)	R	9-digit Social Security Number of the Recipient. Left-fill with zero(s).
006	50-57	PCP_LINKAGE_RECIPIENT_DOB	number(8)	R	Recipient Date of Birth. Format=YYYYMMDD.
007	58-65	PCP_LINKAGE_BEGIN_DATE_YYMMDD	number(8)	R	Beginning date of Recipient's Linkage to PCP. Format=YYYYMMDD.

					Value should not precede 20120201.
Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
008	66-73	PCP_LINKAGE_END_DATE_YYMMDD	number(8)	R	Ending date of Recipient's Linkage to PCP. Format=YYYYMMDD. Value for an open-ended linkage should be 99991231.
009	74-100	FILLER	char(27)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

DXC will capture the MCOs file, archive it, edit it, and use it to update DXC's Data Warehouse. DXC's update process performs edits and produces an error text file that they will send back to the MCO via your sFTP server (showing only your submitted records, if they hit an edit). If none of the MCO's records hit an edit, DXC will send back an empty error text file.

The error text file will use the naming convention: **PCP-ERROR-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is the MCO Plan ID and YYYYMMDD is the date from your submission file.

The error text file will have this layout:

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***Notes***
1	1-100	PCP_LINKAGE_RECORD	char(100)	The record you sent.
2	101-103	ERROR CODE 1	number(3)	3-digit number representing error code (see below).
3	104-106	ERROR CODE 2	number(3)	2nd 3-digit error code, if necessary. May be 000.
4	107-109	ERROR CODE 3	number(3)	3rd 3-digit error code, if necessary. May be 000.
5	110-112	ERROR CODE 4	number(3)	4th 3-digit error code, if necessary. May be 000.
6	113-115	ERROR CODE 5	number(3)	5th 3-digit error code, if necessary. May be 000.
7	116	END-OF-RECORD INDICATOR	char(1)	Value is "#".

ERROR CODES

Error codes are associated with the Field values identified in the submission record layout shown above, and are:

001 Invalid value for Field 001 (PCP_LINKAGE_PLAN_ID).
21 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The NPI value submitted does not have 10 digits.
22 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The NPI value submitted is zero or the value is not numeric.
23 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The NPI value submitted is not found on your plan's provider registry for the given Taxonomy value.
31 Invalid value for Field 003 (PCP_LINKAGE_PCP_TAXONOMY). Taxonomy value submitted does not have 10 characters.
32 Invalid value for Field 003 (PCP_LINKAGE_PCP_TAXONOMY). Taxonomy value submitted is not found on your plan's provider registry for the given NPI value.
41 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is not 13 digits.
42 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is zero or the value is not numeric.
43 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is not found in the LMMIS Medicaid Recipient File.
043 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is not linked to the plan.
51 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is not 9 digits.
52 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is zero or the value is not numeric.
53 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is not found in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
54 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is not equal to the one in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
61 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is zero or the value is not numeric.
62 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is too far in the past or is in the future.
63 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is not a valid date value.
64 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is not found in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
65 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is not equal to the one in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
71 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is zero or the value is not numeric.
72 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is before 20120201 or is after 99991231.
73 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is after the End Date value submitted.
74 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is not a valid date value.
81 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is zero or the value is not numeric.
82 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is before 20120201 or is after 99991231.

83 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is before the Begin Date value submitted.
84 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is not a valid date value.

Anytime you receive a record in the edit text file, it indicates that the associated record in your submission file failed to update the LMMIS PCP Linkage File. If you receive no error record for a submitted record, you may assume that the record passed all edits and was applied to the LMMIS PCP Linkage File.

If you receive an edit record, you may correct the issue and resubmit the record in a future full-file submission.

END OF SECTION

Provider Supplemental Record Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 1049 bytes. If a field is listed as Optional (O), and the MCO elects not to populate the field, then it should be filled with blanks as appropriate to the Length. *Note: Numeric values will be filled with blanks, if missing.					
1-7	MCO-Plan ID	Managed Care Provider ID	7	Numeric	R
8-8	Delimiter	Use the ^ character value	1	Character	R
9-18	NPI	National Provider Identification number. If the NPI does not exist, use the Replacement NPI submitted on the Provider Registry. It will never contain the Medicaid-Assigned-ID	10	Numeric	R
19-19	Delimiter	Use the ^ character value	1	Character	R
20-26	Medicaid Assigned ID	Managed Care Medicaid Assigned ID Not the Medicaid Legacy ID, but the ID assigned to the provider for the MCO. Note that the provider will have a different ID for each MCO.	7	Numeric	R
27-27	Delimiter	Use the ^ character value	1	Character	R
28-36	SSN	Provider Social Security Number	9	Numeric	O R if Tax ID is blank
37-37	Delimiter	Use the ^ character value	1	Character	R
38-46	Tax ID	Provider Tax ID	9	Numeric	O R if SSN is blank
47-47	Delimiter	Use the ^ character value	1	Character	R
48-55	Date of Birth	Provider Date of Birth	8	Date	O
56-56	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
57-58	Ownership-Code	A code denoting the ownership interest and/or managing control information. The valid values list is a Medicare standard list. 01 Voluntary – Non-Profit – Religious Organizations 02 Voluntary – Non-Profit – Other 03 Voluntary – multiple owners 04 Proprietary – Individual 05 Proprietary – Corporation 06 Proprietary – Partnership 07 Proprietary – Other 08 Proprietary – multiple owners 09 Government – Federal 10 Government – State 11 Government – City 12 Government – County 13 Government – City-County 14 Government – Hospital District 15 Government – State and City/County 16 Government – other multiple owners 17 Voluntary /Proprietary 18 Proprietary/Government 19 Voluntary/Government 88 N/A – The individual only practices as part of a group, e.g., as an employee	2	Numeric	R
59-59	Delimiter	Use the ^ character value	1	Character	R
60-61	FIPS State	The FIPS State code is a 2-digit code developed by the US Census Bureau for state designation. To obtain the correct state designation, please click the name of the field.	2	Numeric	R
62-62	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
63-65	FIPS Parish/County	The FIPS County code is a 3-digit code developed by the US Census Bureau for county designation within a state. To obtain the correct county designation, please click the name of the field.	3	Numeric	R
66-66	Delimiter	Use the ^ character value	1	Character	R
67-126	Provider Business Mailing Email Address	The email address associated with the provider's billing address. Blank (Space filled) if no email address exists.	60	Character	O
127-127	Delimiter	Use the ^ character value	1	Character	R
128-187	Provider Business Location Email Address	The email address associated with the provider's physical address. Blank (Space filled) if no email address exists.	60	Character	O
188-188	Delimiter	Use the ^ character value	1	Character	R
189-189	License Type 1	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other	1	Numeric	R
190-190	Delimiter	Use the ^ character value	1	Character	R
191-210	License Or Accreditation-Number 1	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	R
211-211	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
212-271	License issuing ID 1	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	R
272-272	Delimiter	Use the ^ character value	1	Character	R
273-280	License effective date 1	The beginning effective date of the license	8	Date	R
281-281	Delimiter	Use the ^ character value	1	Character	R
282-289	License End date 1	The last date the license was active. (20991231 for open and unknown)	8	Date	R
290-290	Delimiter	Use the ^ character value	1	Character	R
291-291	License Type 2	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
292-292	Delimiter	Use the ^ character value	1	Character	R
293-312	License Or Accreditation-Number 2	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
313-313	Delimiter	Use the ^ character value	1	Character	R
314-373	License issuing ID 2	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
374-374	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
375-382	License effective date 2	The beginning effective date of the license	8	Date	O
383-383	Delimiter	Use the ^ character value	1	Character	R
384-391	License End date 2	The last date the license was active. (20991231 for open and unknown)	8	Date	R
392-392	Delimiter	Use the ^ character value	1	Character	R
393-393	License Type 3	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
394-394	Delimiter	Use the ^ character value	1	Character	R
395-414	License Or Accreditation-Number 3	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
415-415	Delimiter	Use the ^ character value	1	Character	R
416-475	License issuing ID 3	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
476-476	Delimiter	Use the ^ character value	1	Character	R
477-484	License effective date 3	The beginning effective date of the license	8	Date	O
485-485	Delimiter	Use the ^ character value	1	Character	R
486-493	License End date 3	The last date the license was active. (20991231 for open and unknown)	8	Date	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
494-494	Delimiter	Use the ^ character value	1	Character	R
495-495	License Type 4	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
496-496	Delimiter	Use the ^ character value	1	Character	R
497-516	License Or Accreditation-Number 4	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
517-517	Delimiter	Use the ^ character value	1	Character	R
518-577	License issuing ID 4	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
578-578	Delimiter	Use the ^ character value	1	Character	R
579-586	License effective date 4	The beginning effective date of the license	8	Date	O
587-587	Delimiter	Use the ^ character value	1	Character	R
588-595	License End date 4	The last date the license was active. (20991231 for open and unknown)	8	Date	R
596-596	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
597-597	License Type 5	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
598-598	Delimiter	Use the ^ character value	1	Character	R
599-618	License Or Accreditation-Number 5	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
619-619	Delimiter	Use the ^ character value	1	Character	R
620-679	License issuing ID 5	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
680-680	Delimiter	Use the ^ character value	1	Character	R
681-688	License effective date 5	The beginning effective date of the license	8	Date	O
689-689	Delimiter	Use the ^ character value	1	Character	R
690-697	License End date 5	The last date the license was active. (20991231 for open and unknown)	8	Date	R
698-698	Delimiter	Use the ^ character value	1	Character	R
699-706	MCO Enrollment Begin Date 1	Effective beginning date of services which can be paid by MCO	8	Date	R
707-707	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
708-715	MCO Enrollment End Date 1	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	R
716-716	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
717-718	MCO Enrollment Termination Code 1	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	R
719-719	Delimiter	Use the ^ character value	1	Character	R
720-727	MCO Enrollment Begin Date 2	Effective beginning date of services which can be paid by MCO	8	Date	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
728-728	Delimiter	Use the ^ character value	1	Character	R
729-736	MCO Enrollment End Date 2	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
737-737	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
738-739	MCO Enrollment Termination Code 2	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
740-740	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
741-748	MCO Enrollment Begin Date 3	Effective beginning date of services which can be paid by MCO	8	Date	O
749-749	Delimiter	Use the ^ character value	1	Character	R
750-757	MCO Enrollment End Date 3	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
758-758	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
759-760	MCO Enrollment Termination Code 3	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
761-761	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
762-769	MCO Enrollment Begin Date 4	Effective beginning date of services which can be paid by MCO	8	Date	O
770-770	Delimiter	Use the ^ character value	1	Character	R
771-778	MCO Enrollment End Date 4	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
779-779	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
780-781	MCO Enrollment Termination Code 4	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
782-782	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
783-790	MCO Enrollment Begin Date 5	Effective beginning date of services which can be paid by MCO	8	Date	O
791-791	Delimiter	Use the ^ character value	1	Character	R
792-799	MCO Enrollment End Date 5	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
800-800	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
801-802	MCO Enrollment Termination Code 5	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
803-803	Delimiter	Use the ^ character value	1	Character	R
804-813	Taxonomy 01	Primary (Current) Taxonomy	10	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
814-814	Delimiter	Use the ^ character value	1	Character	R
815-824	Taxonomy 02	Secondary taxonomy	10	Character	O
825-825	Delimiter	Use the ^ character value	1	Character	R
826-835	Taxonomy 03	Tertiary taxonomy	10	Character	O
836-836	Delimiter	Use the ^ character value	1	Character	R
837-846	Taxonomy 04	Additional taxonomy	10	Character	O
847-847	Delimiter	Use the ^ character value	1	Character	R
848-857	Taxonomy 05	Additional taxonomy	10	Character	O
858-858	Delimiter	Use the ^ character value	1	Character	R
859-868	Taxonomy 06	Additional taxonomy	10	Character	O
869-869	Delimiter	Use the ^ character value	1	Character	R
870-879	Taxonomy 07	Additional taxonomy	10	Character	O
880-880	Delimiter	Use the ^ character value	1	Character	R
881-890	Taxonomy 08	Additional taxonomy	10	Character	O
891-891	Delimiter	Use the ^ character value	1	Character	R
892-901	Taxonomy 09	Additional taxonomy	10	Character	O
902-902	Delimiter	Use the ^ character value	1	Character	R
903-912	Taxonomy 10	Additional taxonomy	10	Character	O
913-913	Delimiter	Use the ^ character value	1	Character	R
914-923	Taxonomy 11	Additional taxonomy	10	Character	O
924-924	Delimiter	Use the ^ character value	1	Character	R
925-934	Taxonomy 12	Additional taxonomy	10	Character	O
935-935	Delimiter	Use the ^ character value	1	Character	R
936-945	Taxonomy 13	Additional taxonomy	10	Character	O
946-946	Delimiter	Use the ^ character value	1	Character	R
947-956	Taxonomy 14	Additional taxonomy	10	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
957-957	Delimiter	Use the ^ character value	1	Character	R
958-967	Taxonomy 15	Additional taxonomy	10	Character	O
968-968	Delimiter	Use the ^ character value	1	Character	R
969-978	Taxonomy 16	Additional taxonomy	10	Character	O
979-979	Delimiter	Use the ^ character value	1	Character	R
980-989	Taxonomy 17	Additional taxonomy	10	Character	O
990-990	Delimiter	Use the ^ character value	1	Character	R
991-1000	Taxonomy 18	Additional taxonomy	10	Character	O
1001-1001	Delimiter	Use the ^ character value	1	Character	R
1002-1011	Taxonomy 19	Additional taxonomy	10	Character	O
1012-1012	Delimiter	Use the ^ character value	1	Character	R
1013-1022	Taxonomy 20	Additional taxonomy	10	Character	O
1023-1023	Delimiter	Use the ^ character value	1	Character	R
1024-1048	Filler	spaces	25	Character	O
1049-1049	Delimiter	Use the ^ character value	1	Character	R

Provider Supplemental Record Layout Error Codes

Error codes are associated with the Field values identified in the submission record layout shown above, and are:

Error Codes (A=Accepted, R=Rejected):
000= (A) No errors found
001=(R) Missing/Invalid NPI
003=(R) Provider record must include taxonomy
004=(R) Numeric field contains characters
005=(R) Invalid Ownership Code. Must be 01-19, 88.
006=(R) Invalid Business Email Address format. Must contain "@" and ".".
007=(R) Invalid Physical Location Email Address format. Must contain "@" and ".".
009=(R) Invalid Plan ID
010=(R) Invalid License Type (must be 1, 2, 3, 4, 5.)
011=(R) Missing License or Accreditation Number
012=(R) Missing License Issuing ID
013=(R) Invalid License Effective Date
014=(R) Invalid License End Date or License End Date before License Effective Date
015=(R) Invalid MCO Enrollment Begin Date
016=(R) Invalid MCO Enrollment End Date or MCO Enrollment End Date before MCO Enrollment Begin Date
017=(R) Invalid MCO Enrollment Termination Code
018=(R) Invalid FIPS State or Parish
022=(R) Medicaid Assigned ID was not found on Provider Registry File
023=(R) Invalid Date of Birth Date
029=(R) Provider does not exist on Provider Registry
030=(R) Duplicate record was submitted

END OF SECTION

Appendix H

EDI Test Plan and File Exchange Schedule

EDI Test Plan

This appendix provides a step-by-step account of the FI's plan for testing the ASC X12N 837 COB and 835 electronic transaction sets for use in submitting encounter data for storage in the MMIS claims history file. The Test Plan consists of three (3) tiers of testing, which are outlined in detail below.

Tier

I – Registration and Credentialing Phase

The first step in submitter testing is enrollment performed via DXC Electronic Data Interchange (EDI) Services, Inc. Each MCO must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. In most cases, the MCO will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the MCO to be able to both transmit and receive.

The second step performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and DXC Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the DXC Electronic Data Interchange (EDI). There are certain errors that will occur while testing with EDIFECS that shall not be considered when determining whether a MCO has passed or failed the EDIFECS portion of testing.

EDI must certify each MCO prior to the MMIS receipt of encounters via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the DXC Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 999 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 5010 format, not in the 4010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;

- validate the test submission with 999 Acceptance transactions; and
- generate IRL or paired transaction

Once EDIFECS testing is complete, the MCO is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the MCO are identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The MCO must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item MCO paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their Medicaid provider number. These fields are used in the MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the MCO paid amount and not TPL or any other COB amount. For more details, please refer to the DXC Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the LDH.

Tier II – Claims Testing Phase

Once each MCO has successfully passed more than 50% of their encounter data claims through the pre-processors, DXC will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the MCO via IDEX. Each MCO is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to ensure all claims that were submitted are accounted for in the data collection. DXC will send the new edit code reports to the MCO and LDH for evaluation, as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. DXC is available to answer any questions that any MCO may have concerning the edit codes.

Tier III – Production Phase

Once satisfactory test results are documented, DXC will move the MCO into production. DXC anticipates receiving files from each MCO in production mode at least once monthly.

The EDI Test Plan can be found on the following pages:

MCO EDI Test Plan - Tier I, II, & III

Tier I --- Registration/Credentialing Phase

ITEM NBR	ITEM DESCRIPTION	EXPECTATION	REQUIRED BY MCO	DUE DATE or ANTICIPATED COMPLETION DATE	ACTUAL COMPLETION DATE
1	Complete Registration with Molina Provider Enrollment Unit	Obtain unique Molina Provider ID Provider Type = 05, Provider Specialty=5Q Molina to establish a Submitter ID Number & Carrier Code .	ALL MCO'S TO COMPLETE ABBREVIATED PE50. UHC & AETNA NEED TO COMPLETE FULL PACKET.		
2	Register Provider ID on Molina's provider web site: www.lamedicaid.com.	Go to www.lamedicaid.com and click on the left-hand link: Provider Web Account Registration Instructions. The first account established is the administrator account, and it can be used to set-up multiple other user accounts (Max .500)	MCO		
3	Log on to Molina's provider web site to presence. Review the list of application links available on the PROVIDER APPLICATIONS AREA.	www.lamedicaid.com. Click the red PROVIDER LOGIN button at the top left of the main page.	MCO		
4a	Web application: Test e-CDI (electronic Clinical Data Inquiry)	Molina will create test cases/scenarios	MCO		
4b	Web application: Test e-MEVS (electronic Medicaid Eligibility Verification)	Molina will create test cases/scenarios	MCO		

4c	Establish sFTP credentials with Molina: TEST and PROD	MCOs will be responsible for accessing files from Molina's sFTP site during testing and in production. Molina's contact is Doug Cobb (Douglas.Cobb@MolinaHealthCare.com)	MCO		
4d	Test claims history file download	Molina sFTP from Molina_folder Objective is to ensure that MCO can access each report: CCN - W-005, W-010, W-001	MCO		
4e	MCO to send TPL Discovery data to Molina	Molina sFTP to_Molina folder	MCO		
4f	Obtain Test Provider Rates File from Molina sFTP (CCR & Inpatient per	Molina sFTP from _Molina folder	MCO		
4g	Test upload of Provider Registry data	Molina sFTP to_Molina folder	MCO		
4h	Test download of Provider Registry edit report from Molina sFTP	Molina sFTP from _Molina folder	MCO		
4i	Go live with Provider Registry	Move to Production	MCO		
4j	Test download of 820 file	Molina sFTP from _Molina folder	MCO		
5a	Test upload of PCP linkages file	Molina sFTP from _Molina folder	MCO		
5b	Test download of PCP linkages error file	Molina sFTP from_Molina folder	MCO		
5c	Test upload of PA file	Molina sFTP to_Molina folder	MCO		
5d	Test download of PA/Precert transaction file	Molina sFTP from_Molina folder	MCO		
5e	Test download of Provider list	Molina sFTP from_Molina folder	MCO		
5f	Test download of Molina TPL file	Molina sFTP from_Molina folder	MCO		

5g	Test download of Molina diagnosis	Molina sFTP from_Molina folder			
5h	Test download of carrier code	Molina sFTP from_Molina folder	MC		
5i	Test Provider Supplemental Layout	T-MSIS related expanding on the provider registry to supply information to CMS	MC O		
	Complete registration with Molina EDIFECS				

Tier II --- Claims Testing Phase (subject to change by LDH)

ITEM NBR	ITEM DESCRIPTION	EXPECTATION	REQUIRED BY MCO	DUE DATE or ANTICIPATED COMPLETION DATE	ACTUAL COMPLETION DATE
1a	**Ramp Manager Testing Begins 837**	Test a small sample of each of the Claim Types that a MCO is accepting. (20-30	AETNA & UHC ONLY		
1b	Test Receipt of Inpatient	20-30 claims	AETNA & UHC ONLY		
1c	Test Receipt of Outpatient	20-30 claims	AETNA & UHC ONLY		
1d	Test Receipt of Home Health	20-30 claims	AETNA & UHC ONLY		
1e	Test Receipt of Rehab	20-30 claims	AETNA & UHC ONLY		
1	Test Receipt of	20-30 claims	AETNA & UHC ONLY		
1g	Test Receipt of Pharmacy	Can be tested only in submitter self test and not ramp manager.	AETNA & UHC ONLY		
1h	Test Receipt of	20-30 claims	ALL BYU MCO's		
1	Test Receipt of NEMT	20-30 claims	ALL BYU MCO's		
1	Test Receipt of Professional	20-30 claims	AETNA & UHC ONLY		
1k	Test Receipt of Dental	20-30 claims	N		
2	**Ramp Manager Testing**		AETNA & UHC ONLY		
3a	**Submitter Self Testing Begins**	Test a full daily size file for 95% acceptance rate.	AETNA & UHC ONLY		

3b	Test Receipt of Inpatient	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3c	Test Receipt of Outpatient	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3d	Test Receipt of Home Health	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3e	Test Receipt of Rehab	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3f	Test Receipt of DME	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3g	Test Receipt of Pharmacy	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3h	Test Receipt of EMT	Full Daily Size File / Minimum Testing Threshold is 95 %	ALL MCO'S		
3i	Test Receipt of NEMT	Full Daily Size File / Minimum Testing Threshold is 95 %	ALL MCO'S		
3j	Test Receipt of Professional	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC		
3k	Test Receipt of Dental	Full Daily Size File / Minimum Testing Threshold is 95 %	N		
4	**Submitter Self Testing Completed**		AETNA & UHC		
5	File Exchanges - see Tab File	Discussion of all daily, weekly and monthly file exchanges	AETNA & UHC		

Tier III --- Production Phase (subject to change by LDH)

ITEM NBR	ITEM DESCRIPTION	EXPECTATION	REQUIRED BY MCO	DUE DATE/COMPLETION DATE	ACTUAL COMPLETION DATE
1	Begin Production	Within (60) days of operation the BYU MCO's systems shall be ready to submit encounter data to DHH's FI in HIPAA compliant provider - to payer to payer COB format.	ALL MCO'S		
2	Testing of Adjustments		AETNA & UHC		
3	Testing of Voids		AETNA & UHC		
4	Testing of Interest Payments on claims		AETNA & UHC ONLY		

5	LDH ability to access MCO systems (inquiry capabilities)		ALL MCO'S		

File Exchange Schedule

The MCO is required to receive and submit files to and from the Fiscal Intermediary on a daily, weekly, and monthly basis. The current File Exchange Schedule for Outbound Files from the Fiscal Intermediary to the MCO and Inbound Files from the MCO to the Fiscal Intermediary may be found on the following pages.

The MCO is required to retrieve and submit all files to/from the Fiscal Intermediary according to the schedule which can be found on the following pages.

OUTBOUND FILES FROM DXC

File Name	File Description	HISTORY OF THE FILE	Frequency	Send On	File From:	File To:
LINKAGE_RESPONSE_{DAILY8}.TXT	Response transactions indicating whether the Healthy Louisiana daily linkage update (initial enrollment and disenrollment) transactions received from Maximus were 'rejected' or 'processed' by the LMMIS system.		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	DXC	MAXIMUS
MLN-<DAILY8>-PRV-DAILY.ZIP	Daily Provider updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	DXC	MCNA
MLN-<DAILY8>-RECI-DAILY.ZIP	Daily Recipient updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	DXC	MCNA
PROVIDER_DAILY_UPDATE_{DAILY8}.ZIP	Daily Provider updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	DXC	MAXIMUS, MAGELLAN
RECIPIENT_DAILY_DELETED_{DAILY8}.ZIP	Daily file of recipient information for recipients that were deleted from the LMMIS system per MEDS activity.		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	DXC	MAXIMUS

RECIPIENT_DAILY_UPDATE_{DAILY8}.ZIP	Daily Recipient updated records extracts	Exclude periods of eligibility the month after a recipient turns 22 years of age.	Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	DXC	MAXIMUS, MAGELLAN
RECIPIENT_WEEKLY_RETRO_YYYYMMDD.ZIP	Extract of retroactive recipient eligibility changes that may impact the coverage period in Magellan 1.0 or CSOC contract.		Weekly	Every Saturday, but occasionally on early Sunday	DXC	MAGELLAN
CSOC-RETURN-YYYYMMDD.txt	CSOC Return File		Daily	Every Work Day	DXC	MAGELLAN
TPL-ERROR-PLANID-CCYYMMDD.TXT	Weekly edit report of TPL records submitted by MCOs		Weekly	Every Thursday Night	DXC	MCO
CCN_PA_Precert_Transactions_CCYYMMDD.zip	Weekly PA Extract for MCO		Weekly	Each Tuesday by COB	DXC	MCO, MAGELLAN
CCN_Provider_Attestation_List_CCYYMMDD.zip	List of providers with at least one of the 13 3-digit codes used for ACA enhanced reimbursement (108, 137, 141, 208, 237, 241, 308, 337, 341, 408, 437, 441, and 500)		Weekly	Each Tuesday by COB	DXC	MCO

CCN_Provider_List_CCYYMMDD.zip	List of Medicaid providers enrolled since 2011		Weekly	Each Tuesday by COB	DXC	MCO, MAGELLAN
CCNPlanID_TPLCCYYMMDD2135.txt	Weekly TPL file for MCOs		Weekly	Each Tuesday by COB	DXC	MCNA
CCN-W_DENIALS_CPO90_<DAILY8>.txt (MCO NAME)	Weekly Denied Encounter Error Analysis and Encounter EOB Analysis CP-0-90-D Reports		Weekly	Every Thursday Night	DXC	MCO, MAGELLAN
CCN-W-001-PLANID-CCYYMMDD.txt	Weekly summarization of the errors incurred for HLA claims/encounters processing		Weekly	Each Tuesday by COB	DXC	MCO
CCN-W-005-PLANID-CCYYMMDD.txt	Weekly summarization of the edit codes for HLA claims/encounters processing		Weekly	Each Tuesday by COB	DXC	MCO
CCN-W-010-PLANID-CCYYMMDD.zip	Weekly list of all encounters and their error codes, including denied error codes, for HLA claims/encounters processing		Weekly	Each Tuesday by COB	DXC	MCO
CLAIMS_WEEKLY_{DAILY8}.ZIP	FFS Weekly claims extracts	Exclude Age 22 and older with DOS 12/01/2015	Weekly	Every Weekend	DXC	MAGELLAN
CLAIMS_WEEKLY_UPDATE_{DAILY8}.ZIP	FFS Weekly claims extracts		Weekly	Every Weekend	DXC	MAXIMUS

ENCNTRS_WEEKLY_{DAILY8}.ZIP	Encounter Weekly claims extracts	Exclude Age 22 and older with DOS 12/01/2015	Weekly	Every Weekend	DXC	MAGELLAN
MLN-<DAILY8>-CLMDENT-WKLY.ZIP	FFS and Encounters weekly Dental claims		Weekly	Every weekend	DXC	MCNA
MLN-<DAILY8>-PRV-WKLY.ZIP	Weekly full Provider extracts		Weekly	Every Weekend	DXC	MCNA
MLN-<DAILY8>-RECI-WKLY.ZIP	Weekly full Recipent extracts		Weekly	Every Weekend	DXC	MCNA
MLN-<RUNDT8>-WKLY-ENCRPT.ZIP	Weekly Denied Encounter Error Analysis and Encounter EOB Analysis CP-0-90-D Reports		Weekly	Every Thursday night	DXC	MCNA
PCP-ERROR-planID-YYYYMMDD.txt	Weekly PCP Linkage error file		Weekly	Each Tuesday by COB	DXC	MCO
PHARMACY_WEEKLY_{DAILY8}.ZIP	Pharmacy Weekly FFS/ENC claims extracts	Exclude Age 22 and older with DOS 12/01/2015	Weekly	Every Weekend	DXC	MAGELLAN

plansubidYYYYMMDD5010.835	ANSI ASC X12N 835 Remittance Advice (835) files		Weekly	Each Tuesday by COB	DXC	MCO
PROVIDER REGISTRY	Weekly Provider Registry edit reports		Weekly	Every Friday Night	DXC	MCO, MCNA, MAGELLAN
PlanNamedata-Plan Provider ID-YYYYMMDD.txt	Weekly list of all provider registry records		Weekly	Every Friday Night	DXC	MAXIMUS
PROVIDER_WEEKLY_COMPLETE_{DAILY8}.ZIP	Weekly full Provider extracts		Weekly	Every Weekend	DXC	MAGELLAN
PROVIDER_WEEKLY_UPDATE_{DAILY8}.ZIP	Weekly full Provider extracts		Weekly	Every Weekend	DXC	MAXIMUS
Recipient Voided IDs.txt			Daily	Each working Monday through Thursday Evening and Friday after weekly processing	DXC	MAGELLAN, MCNA
RECIPIENT_WEEKLY_COMPLETE_{DAILY8}.ZIP	Weekly full Recipent extracts	Exclude periods of eligibility the month after a recipient turns 22 years of age.	Weekly	Every Weekend	DXC	MAGELLAN
RECIPIENT_WEEKLY_UPDATE_{DAILY8}.ZIP	Weekly full Recipient extracts		Weekly	Every Weekend	DXC	MAXIMUS
SMO-W-001-PlanID-CCYYMMDD.txt	Weekly summarization of the errors incurred for encounters processing		Weekly	Each Tuesday by COB	DXC	MAGELLAN, MCNA
SMO-W-005-PlanID-CCYYMMDD.txt	Weekly summarization of the edit codes for encounters processing		Weekly	Each Tuesday by COB	DXC	MAGELLAN, MCNA

SMO-W-010-PlanID-CCYYMMDD.zip	Weekly list of all encounters and their error codes, including denied error codes, for encounter processing		Weekly	Each Tuesday by COB	DXC	MAGELLAN, MCNA
TPL-ERROR-PlanID-CCYYMMDD.TXT	Weekly edit report of TPL records submitted by MCOs		Weekly	Every Thursday Night	DXC	MAGELLAN, MCNA
Weekly 837 files (Inpatient, Outpatient, Professional)	Crossover 837 encounters files		Weekly	Weekly on Thursday by 12:00 noon CT	DXC	MAGELLAN
PCPLINKAGES-CCYYMMDD.TXT	MCO plan PCP Linkages file from DXC to Magellan		Weekly	COB each Monday	DXC	MAXIMUS
MMIS_PLAN_EXTRACT_<DAILY8>.TXT	Supplement to Fee Schedule		Weekly	File is available to the MCO on Fridays, is sent to the MCO's sFTP verified site address	DXC	MCO, MAGELLAN, MCNA
DHH_LEERS_EXPD_ccyymmdd.TXT	The ccyymmdd being the Friday date (ex20150123)	DXC began receiving a LEERS file from OPH. The LEERS file contains data related to all of the birth deliveries in Louisiana. DXC forwards the LEERS file to each of the	Weekly	This file is sent every Friday evening	MOLINA	MCO

		current plans on a weekly basis.The LEERS file is plan specific-meaning, the file the plans receive only relates to recipients within each plan. The file is not a complete replacement but is a copy of the data received each week. the plans will use the LEERS file as a retrospective review to validate medical necessity for births less than 39 weeks gestation.				

179_BIRTH_HISTORY.TXT	Molina processing and forwarding of file to MCO		Quarterly	TBD	MOLINA	MCOs
WEEKLY_RECIP_RECON_RESP_{DAILY8}.TXT	Response file		Weekly	Every Tuesday	MOLINA	MAGELLAN
WEEKLY_RECIP_RECON_REPT_{DAILY8}.TXT	MM-O-310 report		Weekly	Every Tuesday COB	MOLINA	MAGELLAN
WEEKLY_RECIP_RECON_REPT_FILE_{DAILY8}.TXT	Unformatted (tab delimited) version of MM-O-310 report		Weekly	Every Tuesday COB	MOLINA	MAGELLAN
CAP-2177141-20160111-CSOC.txt	Monthly PMPM payments 820 files for CSoC		Monthly	On payment schedule	MOLINA	MAGELLAN
CAP-PLANID-CCYYMMDD.txt	Monthly PMPM payments 820 files for MCOs		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-BABY.TXT	Plan retro baby PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-DOC.TXT	Plan DOC recovery PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-DOD.TXT	Plan DOD recovery PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-Medicare-Recovery.TXT	Plan Medicare recovery PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CCN_Carrier_File_CCYYMMDD.txt	List of LMMIS TPL carrier code assignments		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN, MCNA

CCN_CLIA_CCYYMMDD.zip	List of all CLIA (clinical laboratory improvements amendment) registrations associated with laboratory providers enrolled with the Louisiana Medicaid MMIS.		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN
CCN_Diagnosis_Codes_CCYYMMDD.txt	List of all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Pre-cert) operation with Louisiana Medicaid MMIS		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN
CCNprovrate-PLANID-CCYYMMDD.txt	Provider negotiated rates file (per-diem, CCR, etc.)		Monthly	COB on first work day of each month	MOLINA	MCO
KICK-PLANID-CCYYMMDD.zip	Monthly maternity KICK payments 820 files for MCOs		Monthly	On payment schedule	MOLINA	MCO
Monthly 820 DOC recovery files	DOC recoveries 820 file		Monthly	On payment schedule	MOLINA	MCNA
Monthly 820 DOD recovery files	DOD recoveries 820 file		Monthly	On payment schedule	MOLINA	MCNA, MAGELLAN
Monthly 820 files	Monthly PMPM 820 file		Monthly	On payment schedule	MOLINA	MCNA, MAGELLAN
Monthly 820 retro files	Retro PMPM payments 820 file		Monthly	On payment schedule	MOLINA	MCNA, MAGELLAN

CAP-PLANID-YYYYMMDD-SSI-ADJ.TXT	Plan retro SSI adjustments PMPM 820 file		Quarterly	On payment schedule	MOLINA	MCO
KICK-RETRO-PLANID-YYYYMMDD.txt	Plan retro Kick payments 820 file		Quarterly	On payment schedule	MOLINA	MCO
ad-hoc PMPM adjustment 820 text file(s), filename TBD	Plan ad-hoc PMPM payments 820 file		AS NEEDED	As necessary	MOLINA	MCO
DHH_SPECIAL_RESPONSE_{DAILY8}.TXT	Response transactions indicating whether the specially requested and LDH-approved Healthy Louisiana linkage update (initial enrollment and disenrollment) transactions received from Maximus were 'rejected' or 'processed' by the LMMIS system.		SPECIAL REQUEST	When Specially Requested by LDH	MOLINA	MAXIMUS
Magellan-Provider-Registry-CCYYMMDD.txt	Magellan Provider Registry to allow the plans knowledge of providers that provide services in mental health.		Monthly	1st Month of month beginning April 2015 and ending December 2015	MOLINA	MCO
DHH_LEERS_EXPD_CCYYMMDD.TXT	LEERS data from OPH		Weekly	Every Friday COB	MOLINA	MCO
CCN-PRTF-nnnnnnn-CCYYMMDD.txt	PRTF member file		Weekly	Every Tuesday COB	MOLINA	MCO
CCNnnnnnnnn_TPLFullCCYYMM.txt	TPL Reconciliation files for the HLA plans		Monthly	5th day of each month	MOLINA	MCO

PplanID_YYYYYMM.txt (ex: P999999_Y201509.TXT)	HLA Retro Cancels/Closures for month		Monthly	1st Monday of the month	MOLINA	MCO
STOLA_MOLINA_CHISHOLM_YYYYMM.TXT	Monthly Chisholm file		Monthly	Last day of the month or the 1st day of the next month, unless these fall on a weekend or holiday. Then it will be the next business day.	MOLINA	MAGELLAN
MGLN-PA-YYYYYMMDD.txt	PA File Layout from Magellan		9/30/15, 10/25/15, 11/13/15 then daily from 11/30/15-12/14/15	Specific days then daily from 11/30-12/14	MOLINA	MCO
LEERS-YYYYMMDD.TXT	Expanded LEERS Elective deliveries file from ULM		Weekly	Every Thursday Night	MOLINA	MCO
TPL-ERROR-NNNNNNN-YYYYMMDD.txt	MW-W-21D text file		Daily		MOLINA	MCO
Preterm_Birth_History.YYYYMMDD.txt	17P Preterm Birth History		Quarterly		Molina	MCO

NOTE: subject to change by LDHLDH

INBOUND FILES TO MOLINA

Molina is changing its delivery system from a PUSH to PULL. The 3 exisiting prepaid plans will still be able to PUSH until 6/30/15. Aetna & UHC will be PULL only.

File Name	File Description	Frequency	Send On	Turn Around Time:	File From:	File To:
LINKAGE_{DAILY8}.CSV	Healthy Louisiana daily linkage update (initial enrollment and disenrollment) transactions received from Maximus, to be applied to the LMMIS system	Daily	COB		MAXIMUS	MOLINA
STOLA_MOLINA_RECON_YYYYMMDD.TAB	The file date must have the Monday's date in the naming convention (YYYYMMDD).	Weekly	Every Monday COB	Every Tuesday COB	MAGELLAN	MOLINA
CCYYMMDD_PLANID_PR.txt	Weekly provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCO	MOLINA
CCYYMMDD_planID_SMO_PR.txt	Weekly provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MAGELLAN	MOLINA
CCYYMMDD_PlanID_SMO_PR.txt	Weekly provider registry records submited by the MCOs for processing	Weekly	Every	First working day of following week COB Friday COB	MCNA	MOLINA
CCYYMMDD_PLANID_Site_PR.txt	Weekly site provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCO	MOLINA

CCYYMMDD_PLANID_Provider_Suppl_WEEKLY.txt	Weekly provider supplemental records submitted by MCOs for TMSIS	Weekly	Every Friday COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PlanSubmitterID_MCO_PA_Weekly.txt	Weekly list of Prior Authorizations submitted by MCOs	Weekly	Every Friday COB	First working day of following week COB	PREPAID PLAN	MOLINA
CCYYMMDD_submitterID_MCO_PA_Weekly.txt	Weekly list of Prior Authorizations submitted by MCOs	Weekly	Every Friday COB	First working day of following week COB	MAGELLAN	MOLINA
TPL-BATCH-PLANID-CCYYMMDD.txt	TPL records submitted by MCOs for processing	Daily	On a work-day basis by COB (4:00 pm CST)	Daily	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PlanSubmitterID_MCO_PA_History.txt	Monthly list of historical Prior Authorizations submitted by MCOs	Weekly	Every Friday COB until 2 years of history are submitted	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_submitterID_MCO_PA_History.txt	Monthly list of historical Prior Authorizations submitted by MCOs	Weekly	Every Friday COB until 2 years of history are submitted	First working day of following week COB	MAGELLAN	MOLINA
PCP-BATCH-planID-YYYYMMDD.txt	Plan PCP Linkage file	Weekly	Last working day of Week by COB	First working day of following week COB	MCO	MOLINA
Encounter files	837 and NCPDP encounter submission files	Weekly	By Wednesday, 12:00 noon CT. Note that NCPDP encounters may not be submitted on Thursday	On Check Write Schedule	MCO, MAGELLAN, MCNA	MOLINA

CCYYMMDD_PLANID_Provider_Suppl_Monthly.txt	Monthly provider supplemental records submitted by MCOs for TMSIS	Monthly	1st Friday of month COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
SPECLNK_{DAILY8}.CSV	Specially requested and LDHLDH-approved Healthy Louisiana linkage update (initial enrollment and disenrollment) transactions received from Maximus, to be applied to the LMMIS system.	SPECIAL REQUEST	When Specially Requested by LDH		MAXIMUS	MOLINA
MGLN-PA-YYYYYMMDD.txt	PA file Layout	9/30/15, 10/25/15, 11/13/15 then daily from 11/30/15-12/14/15	Specific days then daily from 11/30-12/14		MAGELLAN	MOLINAHLA
STOLA_MOLINA_CSOC_YYYYMMDD.TAB	LTC CSoC Segment File Layout	Every Workday then daily beginning 12/1/15			MAGELLAN	MOLINA
PRETERM_BIRTH_HISTORY.TXT	ULM file submission to Molina sFTP site		Quarterly	TBD	ULM	MOLINA

NOTE: subject to change by LDH

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Appendix I

Helpful Websites

The following websites are provided as references for useful information not only for MCOs, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.lamedicaid.com or http://www.lmmis.com	LDH FI Provider Web site You need a valid Louisiana Medicaid Provider ID or MCO ID in order to register on the web site. Provider Applications (such as those used to upload and download files) are available on this web site to authorized, registered providers or MCO organizations. Links available to CCN-P entities on the FI Provider Web site are: • 820 File Download • Claims File Download • Provider Enrollment File Download • Provider Registry Upload • Provider Registry Error Report Download • Third-Party Liability Data Entry

Website Address	Website Contents
	• Provider Negotiated Rates File Download • PA and Precert Requests History File • MMIS Claims Processing Information: ❖ Procedure Codes Requiring PA ❖ Diagnosis Codes Requiring Precert ❖ CLIA File
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their

Website Address	Website Contents
	meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.
http://www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.asp	This is a **monthly newsletter published by CMS's Data and System Group within the Center for Medicaid and State Operations**. It is a very good source of information for HIPAA developments. If you cannot access the website with the direct address, use http://www.cms.gov. Click on Medicaid and search using the keywords "HIPAA Plus".

Appendix J
Common Data Element Values

Types of Service (TOS)

TOS Code	Description
00	Not applicable
01	Anesthesia
02	Assistant Surgeon
03	Full-Service Physician, Labs, NEMT, Lab 60%, PACE capitation
04	Adult Dental, 62% Lab
05	Professional Component
06	Pharmacy, Crossover Immuno Drugs
07	RHC, FQHC, CommunityCARE Enhanced, 0 – 15 y/o Enhanced
08	DEFRA, Lab 62%, Ambulatory Surgery, Outpatient Hospital Rehab
09	DME, Emergency Ambulance Services (EMT), Prenatal Care Clinic Services, EPSDT Case Management, VACP, Nurse Home Visits, Infants & Toddlers, HIV, High-Risk Pregnant Women, Vision Eyeglass Program, Personal Care Services(EPSDT), Rehabilitation Centers
10	Family Planning Clinics
11	Mental Health
12	School Boards and Early Intervention Centers
13	Office of Public Health (OPH)
14	Psychological and Behavioral Services (PBS)
15	Outpatient Ambulatory Surgical Services
16	Personal Attendant Services (PAS) -- Ticket to Work Program

TOS Code	Description
17	Home Health
18	Expanded Dental Services for Pregnant Women (EDSPW)
19	Personal Care Services (LTC)
20	Enhanced Outpatient Rehab Services
21	EPSDT, EPSDT Dental
22	Childnet (Early Steps)
23	Waiver - Children's Choice
24	Waiver - ADHC
25	Waiver - EDA
26	Waiver - PCA
27	Special Purpose Facility
28	Center Based Special Purpose Facility
29	American Indian
30	Acute Care Outpatient Services
31	Family Planning Waiver
32	Supports Waiver
33	New Opportunity Waiver (NOW)
34	DME Special Rates
35	Residential Options Waiver (ROW)
36	Community Mental Health Center
37	Small Rural Hospital Outpatient
38	Adult Residential Care (ARC)
39	State Hospital Outpatient Services
40	Sole Community Hospital

TOS Code	Description
41	Psychiatric Residential Treatment Facility
42	Mental Health Rehabilitation
43	LaPOP, Louisiana Personal Options Program
44	Pediatric Day Health Care Facility (PDHC)
45	Coordinated Care Network - Pre-paid (CCN-P) - MCO
46	Coordinated Care Network - Shared Services (CCN-S)
51	CSoC, PIHP - Coordinated System of Care, Pre-paid Inpatient Health Plan (Behavioral Health) PMPM (Adults)
57	LBHP School Board – Other Licensed Practitioners
62	188 Non-Payable Specialized Behavioral Health

Category of Service (COS)

State COS	Description
00	Inpatient Service in TB Hospital
01	Inpatient Service in General Hospital
02	Inpatient Service in Mental Hospital
03	SNF Service
04	ICF-DD
05	ICF-I Service
06	ICF-II Service
07	Physician Services
08	Outpatient Hospital Services
09	Clinic - Hemodialysis
10	Clinic - Alcohol & Substance Abuse
11	Clinic - Mental Health
12	Clinic - Ambulatory Surgical
13	Rehab Services
14	Adult Day Care
15	Independent Lab
16	Chiropractic Services
17	Home Health
18	Prescribed Drugs and Immunizations by Pharmacists
19	Habilitation
20	DME (Appliances)
21	Rural Health Clinics
22	Family Planning Service

State COS	Description
23	Non-Emergency Medical Transportation
24	Medical Transportation
25	Adult Dental Services
26	EPSDT - Screening Services
27	EPSDT - Dental
28	EPSDT - Other
29	Homemaker Services
30	Other Medical Services
31	Default
32	Administrative Error State Funds Only
33	Recovery Unidentified Services
34	EPSDT Health Services Non-School Board
35	Medical TPL
36	Title XIX Health Insurance Payment
37	Case Management
38	FQHC
39	PCA
40	Personal Health Care Clinic Services
41	HMO Over 65
42	Rehab for Chronically Mentally Ill
43	Children’s' Choice Waiver
44	EPSDT - Personal Care Services
45	Dental Services for Pregnant Women
46	EPSDT Health Services
47	VD Clinic

State COS	Description
48	TB Clinic
49	Title XIX Part-A Premium
50	Psychology
51	Audiology
52	Physical Therapy
53	Multi-Specialty Clinic Services
54	Certified Registered Nurse (CRNA)
55	Private Duty Nurse
56	Occupational Therapy
57	CM - HIV
58	CM - CMI
59	CM - PW
60	Rehab - ICF/DD
61	CM - DD
62	DD Waiver
63	CM - Infants & Toddlers
64	Home Care Elderly Waiver
65	Head Injury Maintenance Waiver
66	Hospice / NF
67	Social Worker Services
68	Contractors / CM
69	Nurse Home Visits - First Time Mothers Program
70	NOW Waiver
71	LTC - Personal Care Services
72	PAS - Personal Care Services

State COS	Description
73	Early Steps
74	Behavior Management Services
75	PACE
76	American Indian/Native Alaskans
77	Family Planning Waiver
78	Support Waiver
79	Community Mental Health Center
80	Residential Options Waiver (ROW)
81	Coordinated Care Network
91	Coded for internal purposes only
99	LTC Administrative Cost

Louisiana Medicaid Claim Type Codes

Date Modified : 11/03/2010

Claim Type	Description	Trans Type
01	Inpatient Hospital	837I, UB04
02	LTC/NH	837I, UB04
03	Outpatient	837I, UB04
04	Professional	837P, CMS 1500
05	Rehab	837P, CMS 1500
06	Home Health Outpatient	837I, UB04
07	EMT (Transportation)	837P, CMS 1500
08	NEMT (Transportation)	837P, CMS 1500
09	DME	837P, CMS 1500
10	Dental EPSDT	837D, ADA
11	Dental Adult	837D, ADA
12	Pharmacy	NCPDP D.0
13	EPSDT	837P, CMS 1500
14	Medicare Cross-over Institutional	837I, UB04
15	Medicare Cross-over Professional	837P, CMS 1500
16	Adult Day Care	837I, UB04

Louisiana Medicaid Region Codes

Region	Description
01	New Orleans
02	Baton Rouge
03	Thibodaux
04	Lafayette
05	Lake Charles
06	Alexandria
07	Shreveport
08	Monroe
09	Mandeville

Louisiana Medicaid Parish Codes

Parish Code	Recipient Parish Description	Recipient Medicaid Region
01	ACADIA	4
02	ALLEN	5
03	ASCENSION	2
04	ASSUMPTION	3
05	AVOYELLES	6
06	BEAUREGARD	5
07	BIENVILLE	7
08	BOSSIER	7
09	CADDO	7
10	CALCASIEU	5
11	CALDWELL	8
12	CAMERON	5
13	CATAHOULA	6
14	CLAIBORNE	7
15	CONCORDIA	6
16	DESOTO	7
17	EAST BATON ROUGE	2
18	EAST CARROLL	8
19	EAST FELICIANA	2
20	EVANGELINE	4
21	FRANKLIN	8
22	GRANT	6

Parish Code	Recipient Parish Description	Recipient Medicaid Region
23	IBERIA	4
24	IBERVILLE	2
25	JACKSON	8
26	JEFFERSON	1
27	JEFFERSON DAVIS	5
28	LAFAYETTE	4
29	LAFOURCHE	3
30	LASALLE	6
31	LINCOLN	8
32	LIVINGSTON	9
33	MADISON	8
34	MOREHOUSE	8
35	NATCHITOCHES	7
36	ORLEANS	1
37	OUACHITA	8
38	PLAQUEMINES	1
39	POINTE COUPEE	2
40	RAPIDES	6
41	RED RIVER	7
42	RICHLAND	8
43	SABINE	7
44	ST BERNARD	1
45	ST CHARLES	3

Parish Code	Recipient Parish Description	Recipient Medicaid Region
46	ST HELENA	9
47	ST JAMES	3
48	ST JOHN	3
49	ST LANDRY	4
50	ST MARTIN	4
51	ST MARY	3
52	ST TAMMANY	9
53	TANGIPAHOA	9
54	TENSAS	8
55	TERREBONNE	3
56	UNION	8
57	VERMILION	4
58	VERNON	6
59	WASHINGTON	9
60	WEBSTER	7
61	WEST BATON ROUGE	2
62	WEST CARROLL	8
63	WEST FELICIANA	2
64	WINN	6
65	East Jefferson	1
87	Texas	10
88	Mississippi	11
89	Arkansas	12

Parish Code	Recipient Parish Description	Recipient Medicaid Region
90	Texas Border County	10
91	Mississippi Border County	11
92	Arkansas Border County	12
99	Other Out-of-State	13

Louisiana Medicaid Pricing Action Code (PAC)

PAC	Description
MEDICAL	
250	Price at Level III – Anesthesia1
260	Price as for Anesthesia
810	Price manually, individual consideration (IC)
820	Deny
830	Price at Level I (U&C File)
850	Price at Level III - Louisiana BHSF set price on Procedure/Formulary File
860	Price at Level I and Level II (U&C File and Prevailing Fee File)
880	Maximum amount - Pend if billed charge is greater than Procedure/Formulary price
8C0	CCN Encounter Code, pay at zero
8F0	Maximum amount - Pay at billed amount

Appendix K

Third Party Liability (TPL) Batch File Submission and File Layout

Two MCOs are required to submit to the FI on a daily basis, the Third Party Liability (TPL) Batch File Submission. The Batch File Submission and File Layout can be found on the following pages along with instructions and error codes.

The file name should be TPL-BATCH-NNNNNNN-YYYYMMDD.txt.

The TPL Batch File is intended to be used for records where the MCO Plan identifies 'other insurance' coverage information that is not already on the Medicaid TPL resource file, whether identified via claims data (an Explanation of Benefits from the primary carrier) or identified by the MCO's TPL contractor. The FI will process the TPL Batch File add/update records and send accepted records to HMS as TPL leads.

HEALTHY LOUISIANA MCO BATCH ELECTRONIC FILE LAYOUT for TPL INFORMATION

Document Date: 12/29/2016
Edited: 03/16/2018

This information is subject to change

Modification Log:

Date	Who	Modification
01/12/2017	Jeff R.	Field 53 is now only values 1 or 3 (no space allowed).
~~02/02/2017~~	~~Jeff R.~~	~~Field 29 may be sent as all zeros.~~
05/31/2017	Jeff R.	Changed edit requirements for fields 29, 30, 31, 32, 33, 34, 36, and 55 .
02/21/2018	Jeff R.	Changed edit requirements for field 29.
03/7/2018	Jeff R.	Fields 54 and 55 are modified: one is for record sequence number and the other for plan trace number. Edit 022 changed. Clarified edits 029, 036, 048, and 053. New edit code **134** on TPL Policy Nbr: we found a duplicate entry (by recipient, policy number, carrier code, and process type) in the daily submission process. HMS and LaHIPP take precedence. New edit code **153** on TPL Policy Nbr (type 1 records only): policy number is similar to an existing policy number already on file for the recipient. Also changed the response (error) file layout in Part 2.
03/7/2018	Jeff R.	Added information about the TPO13 file to Part 2 (see the end of the document).
03/14/2018	Jeff R.	Added edit code **253**: plans cannot change RESO records that already have initiator 02 or 25 (Title IV-D and LaHIPP, respectively).

PART 1: PLAN FILE SUBMISSIONS

File submissions may occur on a work-day basis by COB (4:00 p.m. CT) unless it is a holiday and then you may submit the file on the previous applicable work day or the next applicable work day.

If you don't have a file to submit in a given work day, then do not submit one.

Plan File submission naming convention: **TPL-BATCH-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is your Plan ID (2162934=ACLA, 2162519=Amerigroup, 2162845=LHC, 2377167=Aetna, 2376985=UHC Prepaid) and YYYYMMDD is the date of submission.

Use Molina's non-EDI sFTP server to submit your files.

The submission file has a fixed-length record format. Each record is 700 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields are optional (O). If a field is optional, then a value of all space(s) is acceptable, unless otherwise noted. If you enter a value that is not all spaces, the value will be edited appropriately. The file does not use delimiters and is formatted as an ASCII text file.

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*R=Required O=Optional*	*Notes*
1	1-8	TPL_CREATE_DATE	char(8)	R	YYYYMMDD, e.g. 20121017 Date that the TPL record was created.
2	9-14	TPL_CREATE_TIME	char(6)	R	HHMMSS in military time, e.g. 235959 Time that the TPL record was created.
3	15	TPL_RECORD_SOURCE_CD	char(1)	R	Value should always be: **1=general TPL update.**
4	16-27	TPL_PRI_INDIV_NAME_LAST	char(12)	R	Left Justify. May not be all spaces.
5	28-34	TPL_PRI_INDIV_NAME_FIRST	char(7)	R	Left Justify. May not be all spaces.
6	35	TPL_PRI_INDIV_NAME_MI	char(1)	R	Use a space if not available
7	36-48	TPL_PRI_MED_ID_NO	char(13)	R	Medicaid recipient ID Must be a valid 13-digit recipient ID.
8	49-57	TPL_PRI_INSURED_SSN	char(9)	R	Enter a valid SSN If the primary insured is a baby under one year old, and you do not know the SSN, you may enter all zeros; otherwise, you should enter a valid 9-digit social security number.
9	58-59	TPL_INITIATOR_CODE	char(2)	R	Value: 15=Amerigroup 16=ACLA 17=LHC 20=Aetna 21=UHC Prepaid.
10	60-71	TPL_CASE_NAME_LAST	char(12)	O	Left justify. Use all spaces if not known.
11	72-78	TPL_CASE_NAME_FIRST	char(7)	O	Left justify. Use all spaces if not known.
12	79	TPL_CASE_NAME_MI	char(1)	O	Use a space if not available
13	80-92	TPL_CASE_ID	char(13)	O	Leave spaces if not used

14	93-96	TPL_CASELOAD_NO	char(4)	O	Leave spaces if not used
15	97-108	TPL_POLICY_HOLDER_NAME_LAST	char(12)	O	Left justify. Use all spaces if not known.
16	109-115	TPL_POLICY_HOLDER_NAME_FIRST	char(7)	O	Left justify. Use all spaces if not known.
17	116	TPL_POLICY_HOLDER_NAME_MI	char(1)	O	Use a space if not available
18	117-141	TPL_POLICY_HOLDER_STREET	char(25)	O	Left justify. Use all spaces if not known.
19	142-161	TPL_POLICY_HOLDER_CITY	char(20)	O	Left Justify. Use all spaces if not known.
20	162-163	TPL_POLICY_HOLDER_STATE	char(2)	O	USPS abbreviation. Use all spaces if not known.
21	164-172	TPL_POLICY_HOLDER_ZIP	char(9)	O	Left Justify
22	173-181	TPL_POLICY_HOLDER_SSN	char(9)	R	Must be 9 digits. Use all zeros if not available. May not be all 9s.
23	182-234	TPL_EMPLOYER_GRP_MAINT_COVERAGE	char(53)	O	Left Justify. Use all spaces if not known.
24	235-259	TPL_EMPLOYER_CLAIM_FIL_STREET	char(25)	O	Left Justify. Use all spaces if not known.
25	260-279	TPL_EMPLOYER_CLAIM_FIL_CITY	char(20)	O	Left Justify. Use all spaces if not known.
26	280-281	TPL_EMPLOYER_CLAIM_FIL_STATE	char(2)	O	Left Justify. Use all spaces if not known.
27	282-290	TPL_EMPLOYER_CLAIM_FIL_ZIP	char(9)	O	Left Justify. Use all spaces if not known.
28	291-343	TPL_INSURANCE_NAME	char(53)	R	Left Justify. May not be all spaces.
29	344-349	TPL_INSURANCE_NUMBER	char(6)	R	Use the appropriate Louisiana MMIS Carrier Code.
30	350-374	TPL_INSURANCE_CLAIM_FIL_STREET	char(25)	R	Left Justify.
31	375-394	TPL_INSURANCE_CLAIM_FIL_CITY	char(20)	R	Left Justify.
32	395-396	TPL_INSURANCE_CLAIM_FIL_STATE	char(2)	R	USPS abbreviation
33	397-405	TPL_INSURANCE_CLAIM_FIL_ZIP	char(9)	R	Left Justify

34	406-418	TPL_POL_NBR	char(13)	R	Left Justify, may not be all spaces and may not contain embedded spaces or punctuation marks or special characters; may not be all 9s or all 0s.
35	419-433	TPL_GROUP_NBR	char(15)	O	Left Justify. Use all spaces if not known.
36	434-435	TPL_SCOPE_OF_COVERAGE_1	char(2)	R	See Scopes of Coverage in SCG. May be all spaces if not known.
37	436-437	TPL_SCOPE_OF_COVERAGE_2	char(2)	O	See Scopes of Coverage in SCG, if provided. May be all spaces if not known.
38	438	TPL_SCOPE_OF_COVERAGE_CD_1	char(1)	O	Leave space.
39	439	TPL_SCOPE_OF_COVERAGE_CD_2	char(1)	O	Leave space.
40	440-447	TPL_BEGIN_DATE_YYMMDD	char(8)	R	YYYYMMDD. Must be a valid date.
41	448-455	TPL_END_DATE_YYMMDD	char(8)	R	YYYYMMDD, use 20991231 if the entry is open-ended. Must be a valid date.
42	456-480	TPL_AGENT_NAME	char(25)	O	Left Justify
43	481-490	TPL_AGENT_PHONE	char(10)	O	Left Justify
44	491-515	TPL_AGENT_STREET	char(25)	O	Left Justify
45	516-535	TPL_AGENT_CITY	char(20)	O	Left Justify
46	536-537	TPL_AGENT_STATE	char(2)	O	Left Justify
47	538-546	TPL_AGENT_ZIP	char(9)	O	Left Justify
48	547-548	TPL_PARISH	char(2)	O	**Use a parish code value from 01-65 or 77.** See Parish Code table in SCG. May be all spaces if not known.
49	549	FILLER	char(1)	O	Leave space.
50	550-562	TPL_PRIV_INSUR_SUBMIT_ID	char(13)	O	Leave spaces.
51	563-567	TPL_PRIV_DOB	char(5)	O	Leave spaces.
52	568-569	TPL_PRIV_CAT	char(2)	O	Leave spaces.
53	570	TPL_PROCESS_TYPE	char(1)	R	Values: 1=new entry for a new policy and new carrier.

					3=update an existing entry when the policy and carrier exist.
54	571-577	TPL_SEQUENCE_NUMBER	char(7)	R	File record sequence number: The first record 0000001, the second 0000002, etc.
55	578-597	**TPL_PLAN_TRACE_NUMBER**	char(20)	O	You may use this field to enter a trace number/value that is unique to the record. It will not be edited and will be returned on the edit response file.
56	598-700	TPL_FILLER	char(103)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, perform limited edits on it and use the file to send to HMS. Molina will send record(s) to HMS if they pass all edits.
IMPORTANT NOTE: If you do NOT receive an error text file (even one with 0 bytes) on a given work day, then it is an indication that Molina did not receive a file from you on that date.

The error text file will use the naming convention: **TPL-ERROR-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is your Plan ID (2162934=ACLA, 2162519=Amerigroup, 2162845=LHC, 2377167=Aetna, 2376985=UHC Prepaid), and YYYYMMDD is the date from your submission file.

The error text file will have this layout:

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***Notes***
1	7-Jan	TPL_PLAN_TRACE_NUMBER	char(7)	The trace number/value that you put on the record.
2	20-Aug	TPL_PRI_MED_ID_NO	char(13)	Medicaid recipient ID from your submission.
3	21-29	TPL_PRI_INSURED_SSN	char(9)	SSN from your submission.
4	30-32	ERROR CODE 1	char(3)	3-digit number representing error code (see below).
5	33-35	ERROR CODE 2	char(3)	2nd 3-digit error code, if necessary.
6	36-38	ERROR CODE 3	char(3)	3rd 3-digit error code, if necessary.
7	39-41	ERROR CODE 4	char(3)	4th 3-digit error code, if necessary.
8	42-61	TPL_PLAN_TRACE_NUMBER	char(20)	Plan trace number
9	62	TPL_PROCESS_TYPE	char(1)	Process type
10	63-68	TPL_INSURANCE_NUMBER	char(6)	Carrier Code
11	69-81	TPL_POL_NBR	char(13)	Policy Number
12	82-83	TPL_SCOPE_OF_COVERAGE_1	char(2)	SOC 1
13	84-91	TPL_BEGIN_DATE_YYMMDD	num(8)	Policy Begin Date YYYYMMDD
14	92-99	TPL_END_DATE_YYMMDD	num(8)	Policy End Date YYYYMMDD
15	100	END-OF-RECORD INDICATOR	char(1)	Value is “#”.

END OF RECORD LAYOUT

ERROR CODES

Error codes are associated with the Field values shown in the submission record layout shown above.

001	Invalid value for Field 1 (TPL_CREATE_DATE). Field does not contain a valid date or date<20120101.
002	Invalid value for Field 2 (TPL_CREATE_TIME). Field does not contain a valid time format.
003	Invalid value for Field 3 (TPL_RECORD_SOURCE_CD). A value other than 1 was found on the record.
004	Invalid value for Field 4 (TPL_PRI_INDIV_NAME_LAST). The value of the field was all spaces.
005	Invalid value for Field 5 (TPL_PRI_INDIV_NAME_FIRST). The value of the field was all spaces.
006	Invalid value for Field 6 (TPL_PRI_INDIV_NAME_MI). The field does not contain an alpha character or a space.
007	Invalid value for Field 7 (TPL_PRI_MED_ID_NO). The field contains all spaces, or the field is not numeric, or the field is not 13 digits, or the recipient ID is not found on MMIS.
008	Invalid value for Field 8 (TPL_PRI_INSURED_SSN). The field contains all spaces, or the field is not numeric, or the field is not 9 digits, or the field contains all 9s.
009	Invalid value for Field 9 (TPL_INITIATOR_CODE). Your assigned initiator code must correspond to your Plan ID.
010	Invalid value for Field 10 (TPL_CASE_NAME_LAST). This field is not edited, so you should not see edit error 010 in the edit response file.
011	Invalid value for Field 11 (TPL_CASE_NAME_FIRST). This field is not edited, so you should not see edit error 011 in the edit response file.
012	Invalid value for Field 12 (TPL_CASE_NAME_MI). This field is not edited, so you should not see edit error 012 in the edit response file.
013	Invalid value for Field 13 (TPL_CASE_ID). This field is not edited, so you should not see edit error 013 in the edit response file. However, if you send a not numeric or blank value in this field, it is changed to all zeroes.
014	Invalid value for Field 14 (TPL_CASELOAD_NO). This field is not edited, so you should not see edit error 013 in the edit response file. However, if you send a not numeric or blank value in this field, it is changed to all zeroes.
015	Invalid value for Field 15 (TPL_POLICY_HOLDER_NAME_LAST). This field is not edited, so you should not see edit error 015 in the edit response file.
016	Invalid value for Field 16 (TPL_POLICY_HOLDER_NAME_FIRST). This field is not edited, so you should not see edit error 016 in the edit response file.
017	Invalid value for Field 17 (TPL_POLICY_HOLDER_NAME_MI). This field is not edited, so you should not see edit error 017 in the edit response file.
018	Invalid value for Field 18 (TPL_POLICY_HOLDER_STREET). This field is not edited, so you should not see edit error 018 in the edit response file.
019	Invalid value for Field 19 (TPL_POLICY_HOLDER_CITY). This field is not edited, so you should not see edit error 019 in the edit response file.
020	Invalid value for Field 20 (TPL_POLICY_HOLDER_STATE). This field is not edited, so you should not see edit error 020 in the edit response file.
021	Invalid value for Field 21 (TPL_POLICY_HOLDER_ZIP). This field is not edited, so you should not see edit error 021 in the edit response file.
022	Invalid value for Field 22 (TPL_POLICY_HOLDER_SSN). You must enter a 9-digit numeric value even if it is all zeros. You may not enter all 9s.

023	Invalid value for Field 23 (TPL_EMPLOYER_GRP_MAINT_COVER). This field is not edited, so you should not see edit error 023 in the edit response file.
024	Invalid value for Field 24 (TPL_EMPLOYER_CLAIM_FIL_STREET). This field is not edited, so you should not see edit error 024 in the edit response file.
025	Invalid value for Field 25 (TPL_EMPLOYER_CLAIM_FIL_CITY). This field is not edited, so you should not see edit error 025 in the edit response file.
026	Invalid value for Field 26 (TPL_EMPLOYER_CLAIM_FIL_STATE). This field is not edited, so you should not see edit error 026 in the edit response file.
027	Invalid value for Field 27 (TPL_EMPLOYER_CLAIM_FIL_ZIP). This field is not edited, so you should not see edit error 027 in the edit response file.
028	Invalid value for Field 28 (TPL_INSURANCE_NAME). Value submitted is all spaces.
029	Invalid value for Field 29 (TPL_INSURANCE_NUMBER), aka Carrier Code. Value submitted is all spaces or value is not found on LMMIS Carrier Code file, or value is recognized as a duplicate Carrier Code (that is no longer used). Value begins with H, but scope of coverage is not 30. Scope of coverage = 30, but carrier code does not begin with H.
030	Invalid value for Field 30 (TPL_INSURANCE_CLAIM_FIL_STREET). This field may not be all blanks.
031	Invalid value for Field 31 (TPL_INSURANCE_CLAIM_FIL_CITY). This field may not be all blanks.
032	Invalid value for Field 32 (TPL_INSURANCE_CLAIM_FIL_STATE). This field is not edited, so you should not see edit error 032 in the edit response file.
033	Invalid value for Field 33 (TPL_INSURANCE_CLAIM_FIL_ZIP). This field is not edited, so you should not see edit error 033 in the edit response file.
034	Invalid value for Field 34 (TPL_POL_NBR). Value is all spaces or has an embedded space or has a punctuation or special character. Or value is all zeroes or all 9s on a process type 1 record.
035	Invalid value for Field 35 (TPL_GROUP_NBR). This field is not edited, so you should not see edit error 035 in the edit response file.
036	Invalid value for Field 36 (TPL_SCOPE_OF_COVERAGE_1). Not a valid scope of coverage, or you are attempting to change an existing record with SCOPE=27.
037	Invalid value for Field 37 (TPL_SCOPE_OF_COVERAGE_2). Not a valid scope of coverage or not=spaces.
038	Invalid value for Field 38 (TPL_SCOPE_OF_COVERAGE_CD_1). This field is not edited, so you should not see edit error 038 in the edit response file.
039	Invalid value for Field 39 (TPL_SCOPE_OF_COVERAGE_CD_2). This field is not edited, so you should not see edit error 039 in the edit response file.
040	Invalid value for Field 40 (TPL_BEGIN_DATE_YYMMDD). Must be a valid date value. Must be greater than 19650101 and must be less than 20201231.

041	Invalid value for Field 41 (TPL_END_DATE_YYMMDD). Must be a valid date value and must be >= Field 40. If the value is 20991231 or 29991231 or 99999999 or is greater than 20201231 then it is automatically changed to 20201231.
042	Invalid value for Field 42 (TPL_AGENT_NAME). This field is not edited, so you should not see edit error 042 in the edit response file.
043	Invalid value for Field 43 (TPL_AGENT_PHONE). This field is not edited, so you should not see edit error 043 in the edit response file.
044	Invalid value for Field 44 (TPL_AGENT_STREET). This field is not edited, so you should not see edit error 044 in the edit response file.
045	Invalid value for Field 45 (TPL_AGENT_CITY). This field is not edited, so you should not see edit error 045 in the edit response file.
046	Invalid value for Field 46 (TPL_AGENT_STATE). This field is not edited, so you should not see edit error 046 in the edit response file.
047	Invalid value for Field 47 (TPL_AGENT_ZIP). This field is not edited, so you should not see edit error 047 in the edit response file.
048	Invalid value for Field 48 (TPL_PARISH). May be spaces or 00, but if not spaces or 00, then it must be a valid Louisiana parish code value.
049	Invalid value for Field 49 (FILLER). This field is not edited, so you should not see edit error 049 in the edit response file.
050	Invalid value for Field 50 (TPL_PRIV_INSUR_SUBMIT_ID). This field is not edited, so you should not see edit error 050 in the edit response file.
051	Invalid value for Field 51 (TPL_PRIV_DOB). This field is not edited, so you should not see edit error 051 in the edit response file.
052	Invalid value for Field 52 (TPL_PRIV_CAT). This field is not edited, so you should not see edit error 052 in the edit response file.
053	Invalid value for Field 53 (TPL_PROCESS_TYPE). Must be a 1 or 3. Edits for 053: Process Type 1 and record already exists on TPL Resource File (same recipient, same policy). Process Type 3 and record does not exist on TPL Resource File (by recipient, policy and carrier).
054	Invalid value for Field 54 (TPL_ SEQUENCE_NUMBER). Field must be numeric.
055	Invalid value for Field 55 (TPL_ PLAN_TRACE_NUMBER). This field is not edited, so you should not see edit error 055 in the edit response file.
134	Invalid value for Field 34 (TPL_POLICY_NBR). This record is duplicate to another record (same recipient, policy nbr, carrier code, and process type) in the same daily update process either because it was entered as a duplicate by the plan, or it is also being submitted by HMS or LaHIPP in the same daily run.
153	Invalid value for Field 53 (TPL_POLICY_NBR). A similar policy number already exists on the MMIS TPL Resource file for the recipient and carrier. This edit is only applicable to Type 1 records.
253	Type 3 record is attempting to update an existing policy that has initiator 02 (Title IV-D) or initiator 25 (LaHIPP).

Anytime you receive a record in the edit text file, it indicates that the associated record in your submission file failed one or more edits. If you receive no error record for a submitted record (based on the TPL_SEQUENCE_NUMBER **and/or TPL_PLAN_TRACE_NUMBER)**, you may assume that the record passed all front-end edits and was **sent to the MMIS TPL Resource File.**

Edits are applicable to required fields and may apply to Optional fields if you submit a value. If you receive an edit record, you should correct the issue and resubmit the record in a future submission.

SPECIAL NOTE: The records that are clean (do not have edit errors on the front-end process) are sent to Molina's back-end mainframe process to update the MMIS TPL Resource File. The back-end mainframe process also engages edits, and some of the records that pass through the front-end may experience edit errors in the mainframe process. When this occurs, you may also receive a TP13 file on the Molina non-EDI sFTP server in your From_Molina folder. The filename is:

TP13-ERROR-nnnnnnn-yyyymmdd.TXT
Where **nnnnnnn** is the plan ID and **yyyymmdd** is the date.
[TP13 is the name of the mainframe edit error report].

END OF DOCUMENT

ERROR CODES
Error codes are associated with the Field values shown in the submission record layout shown above.

001 Invalid value for Field 1 (TPL_CREATE_DATE). Field does not contain a valid date or date<20120101.
002 Invalid value for Field 2 (TPL_CREATE_TIME). Field does not contain a valid time format.
003 Invalid value for Field 3 (TPL_RECORD_SOURCE_CD). A value other than 1 was found on the record.
004 Invalid value for Field 4 (TPL_PRI_INDIV_NAME_LAST). The value of the field was all spaces.
005 Invalid value for Field 5 (TPL_PRI_INDIV_NAME_FIRST). The value of the field was all spaces.
006 Invalid value for Field 6 (TPL_PRI_INDIV_NAME_MI). The field does not contain an alpha character or a space.
007 Invalid value for Field 7 (TPL_PRI_MED_ID_NO). The field contains all spaces, or the field is not numeric, or the field is not 13 digits, or the recipient ID is not found on MMIS.
008 Invalid value for Field 8 (TPL_PRI_INSURED_SSN). The field contains all spaces, or the field is not numeric, or the field is not 9 digits, or the field contains all 9s.
009 Invalid value for Field 9 (TPL_INITIATOR_CODE). Your assigned initiator code must correspond to your Plan ID.
010 Invalid value for Field 10 (TPL_CASE_NAME_LAST). This field is not edited, so you should not see edit error 010 in the edit response file.
011 Invalid value for Field 11 (TPL_CASE_NAME_FIRST). This field is not edited, so you should not see edit error 011 in the edit response file.
012 Invalid value for Field 12 (TPL_CASE_NAME_MI). This field is not edited, so you should not see edit error 012 in the edit response file.

013 Invalid value for Field 13 (TPL_CASE_ID). This field is not edited, so you should not see edit error 013 in the edit response file. However, if you send a not numeric or blank value in this field, it is changed to all zeroes.

014 Invalid value for Field 14 (TPL_CASELOAD_NO). This field is not edited, so you should not see edit error 013 in the edit response file. However, if you send a not numeric or blank value in this field, it is changed to all zeroes.

015 Invalid value for Field 15 (TPL_POLICY_HOLDER_NAME_LAST). This field is not edited, so you should not see edit error 015 in the edit response file.

016 Invalid value for Field 16 (TPL_POLICY_HOLDER_NAME_FIRST). This field is not edited, so you should not see edit error 016 in the edit response file.

017 Invalid value for Field 17 (TPL_POLICY_HOLDER_NAME_MI). This field is not edited, so you should not see edit error 017 in the edit response file.

018 Invalid value for Field 18 (TPL_POLICY_HOLDER_STREET). This field is not edited, so you should not see edit error 018 in the edit response file.

019 Invalid value for Field 19 (TPL_POLICY_HOLDER_CITY). This field is not edited, so you should not see edit error 019 in the edit response file.

020 Invalid value for Field 20 (TPL_POLICY_HOLDER_STATE). This field is not edited, so you should not see edit error 020 in the edit response file.

021 Invalid value for Field 21 (TPL_POLICY_HOLDER_ZIP). This field is not edited, so you should not see edit error 021 in the edit response file.

022 Invalid value for Field 22 (TPL_POLICY_HOLDER_SSN). You must enter a 9-digit numeric value even if it is all zeros. You may not enter all 9s.

Invalid value for Field 22 (TPL_POLICY_HOLDER_SSN). This field is not edited, so you should not see edit error 022 in the edit response file.

023 Invalid value for Field 23 (TPL_EMPLOYER_GRP_MAINT_COVER). This field is not edited, so you should not see edit error 023 in the edit response file.

024 Invalid value for Field 24 (TPL_EMPLOYER_CLAIM_FIL_STREET). This field is not edited, so you should not see edit error 024 in the edit response file.

025 Invalid value for Field 25 (TPL_EMPLOYER_CLAIM_FIL_CITY). This field is not edited, so you should not see edit error 025 in the edit response file.

026 Invalid value for Field 26 (TPL_EMPLOYER_CLAIM_FIL_STATE). This field is not edited, so you should not see edit error 026 in the edit response file.

027 Invalid value for Field 27 (TPL_EMPLOYER_CLAIM_FIL_ZIP). This field is not edited, so you should not see edit error 027 in the edit response file.

028 Invalid value for Field 28 (TPL_INSURANCE_NAME). Value submitted is all spaces.

029 Invalid value for Field 29 (TPL_INSURANCE_NUMBER), aka Carrier Code. Value submitted is all spaces or value is not found on LMMIS Carrier Code file.

030 Invalid value for Field 30 (TPL_INSURANCE_CLAIM_FIL_STREET). This field is not edited, so you should not see edit error 030 in the edit response file.

031 Invalid value for Field 31 (TPL_INSURANCE_CLAIM_FIL_CITY). This field is not edited, so you should not see edit error 031 in the edit response file.

032 Invalid value for Field 32 (TPL_INSURANCE_CLAIM_FIL_STATE). This field is not edited, so you should not see edit error 032 in the edit response file.

033 Invalid value for Field 33 (TPL_INSURANCE_CLAIM_FIL_ZIP). This field is not edited, so you should not see edit error 033 in the edit response file.

034 Invalid value for Field 34 (TPL_POL_NBR). Value is all spaces or has a + sign embedded.

035 Invalid value for Field 35 (TPL_GROUP_NBR). This field is not edited, so you should not see edit error 035 in the edit response file.

036 Invalid value for Field 36 (TPL_SCOPE_OF_COVERAGE_1). Not a valid scope of coverage or not=spaces.

037 Invalid value for Field 37 (TPL_SCOPE_OF_COVERAGE_2). Not a valid scope of coverage or not=spaces.

038 Invalid value for Field 38 (TPL_SCOPE_OF_COVERAGE_CD_1). This field is not edited, so you should not see edit error 038 in the edit response file.

039 Invalid value for Field 39 (TPL_SCOPE_OF_COVERAGE_CD_2). This field is not edited, so you should not see edit error 039 in the edit response file.

040 Invalid value for Field 40 (TPL_BEGIN_DATE_YYMMDD). Must be a valid date value. Must be greater than 19650101 and must be less than 20201231.

041 Invalid value for Field 41 (TPL_END_DATE_YYMMDD). Must be a valid date value and must be >= Field 40. If the value is 20991231 or 29991231 or 99999999 or is greater than 20201231 then it is automatically changed to 20201231.

042 Invalid value for Field 42 (TPL_AGENT_NAME). This field is not edited, so you should not see edit error 042 in the edit response file.

043 Invalid value for Field 43 (TPL_AGENT_PHONE). This field is not edited, so you should not see edit error 043 in the edit response file.

044 Invalid value for Field 44 (TPL_AGENT_STREET). This field is not edited, so you should not see edit error 044 in the edit response file.
045 Invalid value for Field 45 (TPL_AGENT_CITY). This field is not edited, so you should not see edit error 045 in the edit response file.
046 Invalid value for Field 46 (TPL_AGENT_STATE). This field is not edited, so you should not see edit error 046 in the edit response file.
047 Invalid value for Field 47 (TPL_AGENT_ZIP). This field is not edited, so you should not see edit error 047 in the edit response file.
048 Invalid value for Field 48 (TPL_PARISH). This field is not edited, so you should not see edit error 048 in the edit response file.
049 Invalid value for Field 49 (FILLER). This field is not edited, so you should not see edit error 049 in the edit response file.
050 Invalid value for Field 50 (TPL_PRIV_INSUR_SUBMIT_ID). This field is not edited, so you should not see edit error 050 in the edit response file.
051 Invalid value for Field 51 (TPL_PRIV_DOB). This field is not edited, so you should not see edit error 051 in the edit response file.
052 Invalid value for Field 52 (TPL_PRIV_CAT). This field is not edited, so you should not see edit error 052 in the edit response file.
053 Invalid value for Field 53 (TPL_PROCESS_TYPE). Must be a 1 or 3.
054 Invalid value for Field 54 (TPL_ PLAN_TRACE_NUMBER). This field is not edited, so you should not see edit error 054 in the edit response file.

Anytime you receive a record in the edit text file, it indicates that the associated record in your submission file failed one or more edits. If you receive no error record for a submitted record (based on the TPL_SEQUENCE_NUMBER), you may assume that the record passed all front-end edits and was sent to HMS.

Edits are applicable to required fields and may apply to Optional fields if you submit a value. If you receive an edit record, you should correct the issue and resubmit the record in a future submission.

SPECIAL NOTE: The records that are clean (do not have edit errors on the front-end process) are sent to HMS.

END OF DOCUMENT

TPL Resource File—Medicare Coverage Additions/Updates

Document Date: 1/13/2015

LDH will maintain the Medicare files for all of its enrollees since CMS is the only valid source of verification of Medicare benefits. The MCO will receive Medicare information on its members' TPL Resource File from Molina; however, the MCO does not have the capability to make additions or updates to its member's Medicare coverage on the TPL Resource File. The MCO should forward any requests to add or update Medicare information for one of its member's TPL Resource File to LDH to process:

- The MCO should complete the **Medicaid Recipient Insurance Information Update Form-Traditional Medicare Only** form (located at http://www.lamedicaid.com/provweb1/Forms/forms.htm , under the "Online Forms" section).

- The completed form and any attachments should be sent, via secure email, to the Program Specialist within the LDH/MMIS/TPL Unit who is assigned maintenance of the TPL Resource and Carrier Files (and cc the Program Manager 1B in the LDH/MMIS/TPL Unit).
- LDH will verify the Medicare coverage with CMS and make the appropriate changes, if necessary. The LDH/MMIS/TPL Unit will respond to the MCO's email to advise of its findings and the action taken, if any.
- If changes are made by LDH, the updated data will be sent to the MCO on the following files:
  - Weekly incremental file: **CCN*nnnnnnn*_TPL*ccyymmddhhmm*.txt**
  - Monthly full ("recon") file: **CCN*nnnnnnn*_TPLFULL*ccyymmdd*.txt**

Medicaid providers may submit requests to update the Medicare data directly to LDH using the form referenced above.

IMPORTANT NOTE: **This process does not apply to the addition or update of Medicare Advantage plans, which are treated in the same manner as private insurance for the purposes of maintenance of the TPL Resource File. (Requests for additions or updates involving the Medicare Advantage plans are to be processed by the MCO for its members.)**

END OF SECTION

TPL File Layout to Plan

TPL File Layout to Plan (incremental and full reconciliation files)				
Field Nbr	Columns	Field Identification	Format/Length	Notes
1	1-13	Member Medicaid ID (current)	char 13	
2	14-26	Member Medicaid ID (original)	char 13	
3	27-28	Insurance Type Indicator	char 2	PR=Private TPL MA=Medicare Part A MB=Medicare Part B LH=LaHIPP
4	29-34	Insurance Company Number	char 6	Louisiana Medicaid Carrier Code
5	35-36	Scope of Coverage	char 2	See DED for Scopes of Coverage Note that value 30=Medicare Part C (Medicare HMO, Medicare Advantage Plan)
6	37-48	Medicare HIC Number	char 12	
7	49-56	Insurance Begin Date	num 8	format=yyyymmdd
8	57-64	Insurance End Date	num 8	format=yyyymmdd
9	65-79	Insurance Group Number	char 15	
10	80-92	Insurance Policy Number	char 13	
11	93-112	Insurance Policy Holder Name	char 20	
12	113-121	Insurance Policy Holder SSN	char 9	
13	122-146	Agent Name	char 25	
14	147-156	Agent Phone Number	char 10	
15	157-181	Agent Street	char 25	
16	182-201	Agent City	char 20	
17	202-203	Agent State	char 2	
18	204-212	Agent Zip	char 9	

19	213-214	Initiator Code	char 2	
20	215-225	MBI	char 11	(Medicare Beneficiary ID) Will be spaces on PR and LH records.
END OF RECORD LAYOUT				

Scopes of Coverage

Scope of Coverage	Description
00	Not Available
01	Major Medical
02	Medicare Supplement
03	Hospital, Physician, Dental and Drugs
04	Hospital, Physician, Dental
05	Hospital, Physician, Drugs
06	Hospital, Physician
07	Hospital, Dental and Drugs
08	Hospital, Dental
09	Hospital, Drugs
10	Hospital Only
11	Inpatient Hospital Only
12	Outpatient Hospital Only
13	Physician, Dental and Drugs
14	Physician and Dental
15	Physician and Drugs
16	Physician Only
17	Dental and Drugs Only
18	Dental Only
19	Drug Only coverage meaning no major medical coverage identified
20	Nursing Home Only
21	Cancer Only
22	CHAMPUS/CHAMPVA
23	Veterans Administration

Scope of Coverage	Description
24	Transportation
25	HMO
26	Carrier declared Bankruptcy
27	Major Medical without maternity benefits
28	HMO/Insurance Premium Paid by Medicaid GHIPP Program
29	Skilled Nursing Care
30	Medicare HMO (Part C)
31	Physician Only HMO
32	PBM Rx Coverage with known major medical coverage
33	HMO No Maternity

TPL Carrier Code File Layout

On a monthly basis, the MCO receives the MMIS Carrier File from the Fiscal Intermediary. The file provides to the MCO a list of TPL carrier code assignments.

The file naming convention is ccn_carrier_file_ccyymm.txt file. Layout of the file is as follows:

Cols 1-6: Carrier Code (Payer ID)

Col 7: delimiter, value is ^

Cols 8-60: Insurance company name

Col 61: delimiter, value is ^

Cols 62-86: Street Address 1

Col 87: delimiter, value is ^

Cols 88-112: Street Address 2

Col 113: delimiter, value is ^

Cols 114-133: City

Col 134: delimiter, value is ^

Cols 135-136: State (abbrev)

Col 137: delimiter, value is ^

Cols 138-146: zip+4

Col 147: delimiter, value is ^.

Appendix L

Capitation Fee Payments

On a monthly basis, LDH provides to the MCO, the following risk-adjusted capitated payments.

- PMPM Payment
- Maternity Kick Payments

The chart below provides the information utilized by LDH to make these payments to the MCO.

MCO Capitation Codes

	Combined Rate Cell		Cap Code
Description	**Code**	**Description**	
SSI	N01	0-2 Months	01N01
SSI	N02	3-11 Months	01N02
SSI	CHD	Child 1-20 Years	01CHD
SSI	ADT	Adult 21+ Years	01ADT
Family and Children	N01	0-2 Months	02N01
Family and Children	N02	3-11 Months	02N02
Family and Children	CHD	Child 1-20 Years	02CHD
Family and Children	ADT	Adult 21+ Years	02ADT
Breast and Cervical Cancer	BCC	BCC, All Ages Female	03BLL
LaCHIP Affordable Plan	LAP	All Ages	04LLL
HCBS Waiver	HCBS	Child 0-20 Years	05CHD
HCBS Waiver	HCBS	Adult 21+	05ADT
Chisholm Class Members	CCM	CCM, All Ages	06CCM
Foster Care Children	FLL	Foster Care, All Ages Male & Female	07FLL

	Combined Rate Cell		Cap Code
Description	**Code**	**Description**	
Maternity Kick Payment	KLL	Maternity Kick Payment, All Ages	01KLL
Early Elective Delivery Kick Payment	EED	Early Elective Delivery Kick Payment	01KEE
NEMT	MTH	HCBS, All Ages	NEMTH
NEMT	MTC	CCM, All Ages	NEMTC
NEMT	MTO	Other, All Ages	NEMTO
SBH - Chisholm Class Members	CCM	SBH – Chisholm, All Ages Male & Female	1CCM
SBH – Dual Eligible	DE1	SBH – Dual Eligible, All Ages	2DE1
SBH – HCBS Waiver	CHD	SBH – 20 & Under, Male and Female	3CHD
SBH – HCBS Waiver	ADT	SBH – 21+ Years, Male and Female	3ADT
SBH – Other	OT1	SBH – Other, All Ages	4OT1

LDH determines the capitated payments based on member's category of assistance, and region code. Members are assigned to 1 of 9 parishes; however for rate payment purposes, LDH has mapped the current 9 region codes to 4 new region codes.

The Member Category of Assistance (COA); Member Region Code (RC); 4 New Region Codes; the 4-Region Code to 9-Region Code Crosswalk; and the Member Parish to Region Code Crosswalk can be found on the following pages.

Medicaid Expansion Capitation Codes

Cap Code	Gender	Age Low	Age High
91XF1	Female	19	24
91XM1	Male	19	24
92XF2	Female	25	39
92XM2	Male	25	39
93XF3	Female	40	49
93XM3	Male	40	49
94XF4	Female	50	64
94XM4	Male	50	64
95XU5	BOTH	ALL	AGES

Member Category of Aid (COA)

COA Identification

- 01=SSI
- 02=Family and Children
- 03=Breast and Cervical Cancer
- 04=LaChip Affordable
- 05=HCBS Waiver
- 06=Chisholm Class Members
- 07=Foster Care Children
- KI=Maternity Kick Payment
- ED=Early Elective Delivery Kick Payment, All Ages

Member Region Code (RC)

New 4-Region Codes

Region Code	Region Description	Includes Geographic Region
01	Gulf	New Orleans Thibodaux
02	Capital	Baton Rouge North Shore
03	South Central	Lafayette Lake Charles Alexandria
04	North	Shreveport Monroe

9-Region to 4- Region Code Crosswalk

Previous Region Code	Geographic Region Description	Grouped Regions Code	Grouped Regions Description
01	New Orleans	01	Gulf
02	Baton Rouge	02	Capital
03	Thibodaux	01	Gulf
04	Lafayette	03	South Central
05	Lake Charles	03	South Central
06	Alexandria	03	South Central
07	Shreveport	04	North
08	Monroe	04	North
09	North Shore	02	Capital

Member Parish to Region Code Crosswalk

2015 HLA Region		
GULF	1	
CAPITAL	2	
SOUTH CENTRAL	3	
NORTH	4	

Parish Code	Recipient Parish Description	Provider Parish Description	Provider Region	Recipient Medicaid Region	Recipient CCARE Region	DUR Region	2015 HLA Region
01	Acadia	Acadia	4	4	4	3	3
02	Allen	Allen	5	5	5	3	3
03	Ascension	Ascension	2	2	2	2	2
04	Assumption	Assumption	3	3	3	2	1
05	Avoyelles	Avoyelles	6	6	6	3	3
06	Beauregard	Beauregard	5	5	5	3	3
07	Bienville	Bienville	7	7	7	4	4
08	Bossier	Bossier	7	7	7	4	4
09	Caddo	Caddo	7	7	7	4	4
10	Calcasieu	Calcasieu	5	5	5	3	3
11	Caldwell	Caldwell	8	8	8	4	4
12	Cameron	Cameron	5	5	5	3	3
13	Catahoula	Catahoula	6	6	6	4	3
14	Claiborne	Claiborne	7	7	7	4	4
15	Concordia	Concordia	6	6	6	4	3
16	Desoto	Desoto	7	7	7	4	4
17	East Baton Rouge	East Baton Rouge	2	2	2	2	2
18	East Carroll	East Carroll	8	8	8	4	4
19	East Feliciana	East Feliciana	2	2	2	2	2
20	Evangeline	Evangeline	4	4	4	3	3
21	Franklin	Franklin	8	8	8	4	4
22	Grant	Grant	6	6	6	4	3
23	Iberia	Iberia	4	4	4	2	3
24	Iberville	Iberville	2	2	2	2	2
25	Jackson	Jackson	8	8	8	4	4
26	Jefferson	Jefferson	1	1	1	1	1
27	Jefferson Davis	Jefferson Davis	5	5	5	3	3
28	Lafayette	Lafayette	4	4	4	3	3
29	Lafourche	Lafourche	3	3	3	2	1
30	LaSalle	LaSalle	6	6	6	4	3
31	Lincoln	Lincoln	8	8	8	4	4
32	Livingston	Livingston	9	9	9	2	2
33	Madison	Madison	8	8	8	4	4
34	Morehouse	Morehouse	8	8	8	4	4
35	Natchitoches	Natchitoches	7	7	7	4	4
36	Orleans	Orleans	1	1	1	1	1
37	Ouachita	Ouachita	8	8	8	4	4
38	Plaquemines	Plaquemines	1	1	1	1	1

Parish Code	Recipient Parish Description	Provider Parish Description	Provider Region	Recipient Medicaid Region	Recipient CCARE Region	DUR Region	2015 HLA Region
39	Pointe Coupee	Pointe Coupee	2	2	2	2	2
40	Rapides	Rapides	6	6	6	4	3
41	Red River	Red River	7	7	7	4	4
42	Richland	Richland	8	8	8	4	4
43	Sabine	Sabine	7	7	7	4	4
44	St Bernard	St Bernard	1	1	1	1	1
45	St Charles	St Charles	3	3	3	1	1
46	St Helena	St Helena	9	9	9	2	2
47	St James	St James	3	3	3	2	1
48	St John	St John	3	3	3	2	1
49	St Landry	St Landry	4	4	4	3	3
50	St Martin	St Martin	4	4	4	3	3
51	St Mary	St Mary	3	3	3	3	1
52	St Tammany	St Tammany	9	9	9	1	2
53	Tangipahoa	Tangipahoa	9	9	9	1	2
54	Tensas	Tensas	8	8	8	4	4
55	Terrebonne	Terrebonne	3	3	3	2	1
56	Union	Union	8	8	8	4	4
57	Vermilion	Vermilion	4	4	4	3	3
58	Vernon	Vernon	6	6	6	4	3
59	Washington	Washington	9	9	9	1	2
60	Webster	Webster	7	7	7	4	4
61	West Baton Rouge	West Baton Rouge	2	2	2	2	2
62	West Carroll	West Carroll	8	8	8	4	4
63	West Feliciana	West Feliciana	2	2	2	2	2
64	Winn	Winn	6	6	6	3	3
65	East Jefferson			1	1	1	1
66	N. O. /Algiers			0		1	
67	N. O. /Uptown			0		1	
68	N. O. /Downtown			0		1	
69	N. O. /Gentilly			0		1	
70	Baton Rouge			0			
71	Orleans Region			0			
72	Alexandria			0			
73	Monroe Regional			0			
74	Region IX			0			
75	Shreveport			0			
76	Lafayette			0			
77	Out Of State	N/A	N/A	N/A	N/A		2
78	Lake Charles			0			
79	Thibodaux			0			
80	Hammond			0			
81	New Orleans			0			
82	Baton Rouge			0			

Parish Code	Recipient Parish Description	Provider Parish Description	Provider Region	Recipient Medicaid Region	Recipient CCARE Region	DUR Region	2015 HLA Region
83	Thibodaux			0			
84	Lafayette			0			
85	Lake Charles			0			
86	Alexandria			0			
87	Shreveport	Texas	10	0	Prov: OOS, not a border county		
88	Monroe	Mississippi	11	0	Prov: OOS, not a border county		
89	Natchitoches	Arkansas	12	0	Prov: OOS, not a border county		
90	OCS Field Servi.	Texas Counties	10	0	Prov: Border county		
91	Region I	Mississippi Counties	11	0	Prov: Border county		
92	B.R. Region Med.	Arkansas Counties	12	0	Prov: Border county		
93	Region III			0			
94	Region IV			0			
95	Region V			0			
96	Region VI			0			
97	Region VII			0			
98	Region VIII			0			
99	O. Juvenile Serv	Other o-o-s	13	0	Prov: OOS, not a border county		

Member Border Cities by Zip Code to Parish/Region Code Crosswalk

City	Zip code	MEDS Parish Code	Managed Care Region Code	Managed Care Region Code and Description
Natchez, MS	39120	15- Concordia	03	South Central
Natchez, MS	39121	15- Concordia	03	South Central
Burkeville, TX	75932	58- Vernon	03	South Central
Jasper, TX	75951	58- Vernon	03	South Central
Kirbyville, TX	75956	6- Beauregard	03	South Central
Newton, TX	75966	58- Vernon	03	South Central
Buna, TX	77612	6- Beauregard	03	South Central
Lumberton, TX	77657	10- Calcasieu	03	South Central
Junction City, AR	71749	56- Union	04	North
Junction City, AR	71749	56- Union	04	North
Osyka, MS	39657	53- Tangipahoa	02	Capital
Chatawa, MS	39632	53- Tangipahoa	02	Capital
Picayune, MS	39466	52- St. Tammany	02	Capital
Nicholson, MS	39463	52- St. Tammany	02	Capital
Pearlington, MS	39572	52- St. Tammany	02	Capital

Louisiana Medicaid Recipient Aid Category Codes

Aid Category	Short Description	Long Description
01	Aged	Persons who are age 65 or older.
02	Blind	Persons who meet the SSA definition of blindness.
03	Families and Children	Families with minor or unborn children.
04	Disabled	Persons who receive disability-based SSI or who meet SSA defined disability requirements.
05	Refugee Asst	Refugee medical assistance administered by LDH 11/24/2008 retroactive to 10/01/2008. Funded through Title !V of the Immigration and Nationality Act (not the Social Security Act - not Medicaid funds)
06	OCS Foster Care	Foster children and state adoption subsidy children who are directly served by and determined Medicaid eligible by OCS.
08	IV-E OCS/OYD	Children eligible under Title IV-E (OCS and OYD whose eligibility is determined by OCS using Title IV-E eligibility policy).
11	Hurricane Evacuees	Hurricane Katrina Evacuees
13	LIFC	Individuals who meet all eligibility requirements for LIFC under the AFDC State Plan in effect 7/16/1996.
14	Med Asst/Appeal	Individuals eligible for state-funded medical benefits as a result of loss of SSI benefits and Medicaid due to a cost-of-living increase in State or local retirement.
15	OCS/OYD Child	OCS and OYD children whose medical assistance benefits are state-funded. OCS has responsibility for determining eligibility for these cases. These children are not Title XIX Medicaid eligible.
16	Presumptive Eligible	Women medically verified to be pregnant and presumed eligible for Medicaid CHAMP Pregnant Woman benefits by a Qualified Provider.
17	QMB	Persons who meet the categorical requirement of enrollment in Medicare Part A including conditional enrollment.
20	TB	Individuals who have been diagnosed as or are suspected of being infected with Tuberculosis.
22	OCS/OYD (XIX)	Includes the following children in the custody of OCS: those whose income and resources are at or below the LIFC standard but are not IV-E eligible because deprivation is not met; those whose income and resources are at or below the standards for Regular MNP; those who meet the standards of CHAMP Child or CHAMP PW; and children aged 18-21 who enter the Young Adult Program.
30	1115 HIFA Waiver	LaChoice and LHP and GNOCHC
40	Family Planning or LBHP/CSoC LON Individual	Family Planning Waiver or LBHP/Coordinated System of Care – Severely Mentally Disturbed Waiver

Aid Category	Short Description	Long Description
50	ME Adults (Medicaid Expansion)	Adults Age 19-64 (Medicaid Expansion, effective 7/1/2016)
51	MEI Medicaid Expansion Incarcerated Adults	High Need Incarcerated Adults Age 19-64

Louisiana Medicaid Recipient Type Case Codes

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	0
002	Deemed Eligible	0
003	SSI Conversion	0
005	SSI/LTC	1
007	LACHIP Phase 1	0
008	PAP - Prohibited AFDC Provisions	0
009	LIFC - Unemployed Parent / CHAMP	0
013	CHAMP Pregnant Woman (to 133% of FPIG)	0
014	CHAMP Child	0
015	LACHIP Phase 2	0
018	ADHC (Adult Day Health Services Waiver)	0
019	SSI/ADHC	1
020	Regular MNP (Medically Needy Program)	0
021	Spend-Down MNP	0
022	LTC Spend-Down MNP (Income > Facility Fee)	0
023	SSI Transfer of Resource(s)/LTC	1
024	Transfer of Resource(s)/LTC	0
025	LTC Spend-Down MNP	0
026	SSI/EDA Waiver	1
027	EDA Waiver	0
028	Tuberculosis (TB)	0
029	Foster Care IV-E - Suspended SSI	0
030	Regular Foster Care Child	0

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
031	IV-E Foster Care	0
032	YAP (Young Adult Program)	0
033	OYD - V Category Child	0
034	MNP - Regular Foster Care	0
035	YAP/OYD	0
036	YAP (Young Adult Program)	0
037	OYD (Office of Youth Development)	0
038	OCS Child Under Age 18 (State Funded)	0
039	State Retirees	0
040	SLMB (Specified Low-Income Medicare Beneficiary)	0
043	New Opportunities Waiver - SSI	1
047	Illegal/Ineligible Aliens Emergency Services	0
048	QI-1 (Qualified Individual - 1)	0
050	PICKLE	0
051	LTC MNP/Transfer of Resources	0
052	Breast and/or Cervical Cancer	0
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	0
055	LACHIP Phase 3	0
056	Disabled Widow/Widower (DW/W)	0
057	BPL (Walker vs. Bayer)	0
058	Section 4913 Children	0
059	Disabled Adult Child	0
060	Early Widow/Widowers	0
061	SGA Disabled W/W/DS	0
062	SSI/Public ICF/DD	1

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
063	LTC Co-Insurance	0
064	SSI/Private ICF/DD	1
065	Private ICF/DD	0
070	New Opportunities Waiver, non-SSI	0
071	Transitional Medicaid	0
076	SSI Children's Waiver - Louisiana Children's Choice	1
077	Children's Waiver - Louisiana Children's Choice	0
078	SSI (Supplemental Security Income)	1
079	Denied SSI Prior Period	0
080	Terminated SSI Prior Period	1
081	Former SSI	1
083	Acute Care Hospitals (LOS > 30 days)	0
084	LaCHIP Pregnant Woman Expansion (185-200%)	0
085	Grant Review	0
086	Forced Benefits	0
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	0
090	LTC (Long Term Care)	0
094	QDWI (Qualified Disabled/Working Individual)	0
095	QMB (Qualified Medicare Beneficiary)	0
097	Qualified Child Psychiatric	0
099	Public ICF/DD	0
100	PACE SSI	1
101	PACE SSI-related	0
102	GNOCHC Adult Parent	0
103	GNOCHC Childless Adult	0

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	0
109	LaChoice, Childless Adults	0
110	LaChoice, Parents with Children	0
111	LHP, Childless Adults	0
112	LHP, Parents with Children	0
113	LHP, Children	0
115	Family Planning, Previous LAMOMS eligibility	0
116	Family Planning, New eligibility / Non LaMOM	0
117	Supports Waiver SSI	1
118	Supports Waiver	0
119	Residential Options Waiver - SSI	1
120	Residential Options Waiver - NON-SSI	0
121	SSI/LTC Excess Equity	1
122	LTC Excess Equity	0
123	LTC Spend Down MNP Excess Equity	0
124	LTC Spend Down MNP Excess Equity(Income over facility fee)	0
125	Disability Medicaid	0
127	LaChip Phase IV: Non-Citizen Pregnant Women Expansion	0
130	LTC Payment Denial/Late Admission Packet	0
131	SSI Payment Denial/Late Admission	1
132	Spendown Denial of Payment/Late Packet	0
133	Family Opportunity Program	0
134	LaCHIP Affordable Plan	0
136	Private ICF/DD Spendown Medically Needy Program	0
137	Public ICF/DD Spendown Medically Needy Program	0

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
138	Private ICF/DD Spendown MNP/Income Over Facility Fee	0
139	Public ICF/DD Spendown MNP/Income Over Facility Fee	0
140	SSI Private ICF/DD Transfer of Resources	1
141	Private ICF/DD Transfer of Resources	0
142	SSI Public ICF/DD Transfer of Resources	1
143	Public ICF/DD Transfer of Resources	0
144	Public ICF/DD MNP Transfer of Resources	0
145	Private ICF/DD MNP Transfer of Resources	0
146	Adult Residential Care/SSI	1
147	Adult Residential Care	0
148	Youth Aging Out of Foster Care (Chaffee Option)	0
149	New Opportunities Waiver Fund	0
150	SSI New Opportunities Waiver Fund	1
151	ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	0
152	ELE School Lunch (Express Lane Eligibility -School Lunch)	0
153	SSI - Community Choices Waiver	1
154	Community Choices Waiver	0
200	CsoC-SED MEDICAID CHILD -MEDS TC and sgmt TC CSoC Waiver Children - 1915(c) waiver. Children under age 22, meeting a hospital and nursing facility LOC of CSoC will be eligibile up to 300% of FBR, using institutional eligibility criteria. LOC 60=hospital, 61=NF.	0
201	LBHP1915(i) NON MEDICAID ADULT 19 &OLDER CSoC Waiver Adults - 1915(i) only; non-Medicaid. Adults over the age of 18, not otherwise eligible for Medicaid, meeting the 1915(i) LON criteria up to 150% of FPL.	0

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
202	CSoC 1915(i)-LIKE MEDICAID CHILD sgmt 1915(i)-like Children (aka 1915(b)(3) children): temp type case on LTC segment if recipient is in LTC/NH/ICF. Otherwise Medicaid eligible children under age 22, meeting a LON of CSoC and eligible for additional services under 1915(b)(3) savings.	0
203	LBHP1915(i) MEDICAID ADULT 19 &OLDER sgmt CSoC Waiver Adults - 1915(i): temp type case on LTC segment if recipient is in LTC/NH/ICF. Adults over the age of 21, otherwise eligible for Medicaid, meeting the 1915(i) LON criteria.	0
204	LBHP1115-NON-MEDICAID ADULTS 19 & OLDER 1115 waiver for 1915(i) persons whose income is below 150% of sFTPL and meeting the LON criteria. These individuals do not have to meet a category of assistance. The new aid cat/type case combination will be 40/204 and the segment temp type case will be 204.	0
205	LBHP Spenddown (Adult)	0
210	HPE – Former Foster Care Children	0
211	Provisional Medicaid	0
212	Family Planning Eligibility Option	0
213	ROW Waiver Spenddown	0
214	CSOC – Presumptive Eligibility	0
550	Adults – Medicaid Expansion	0

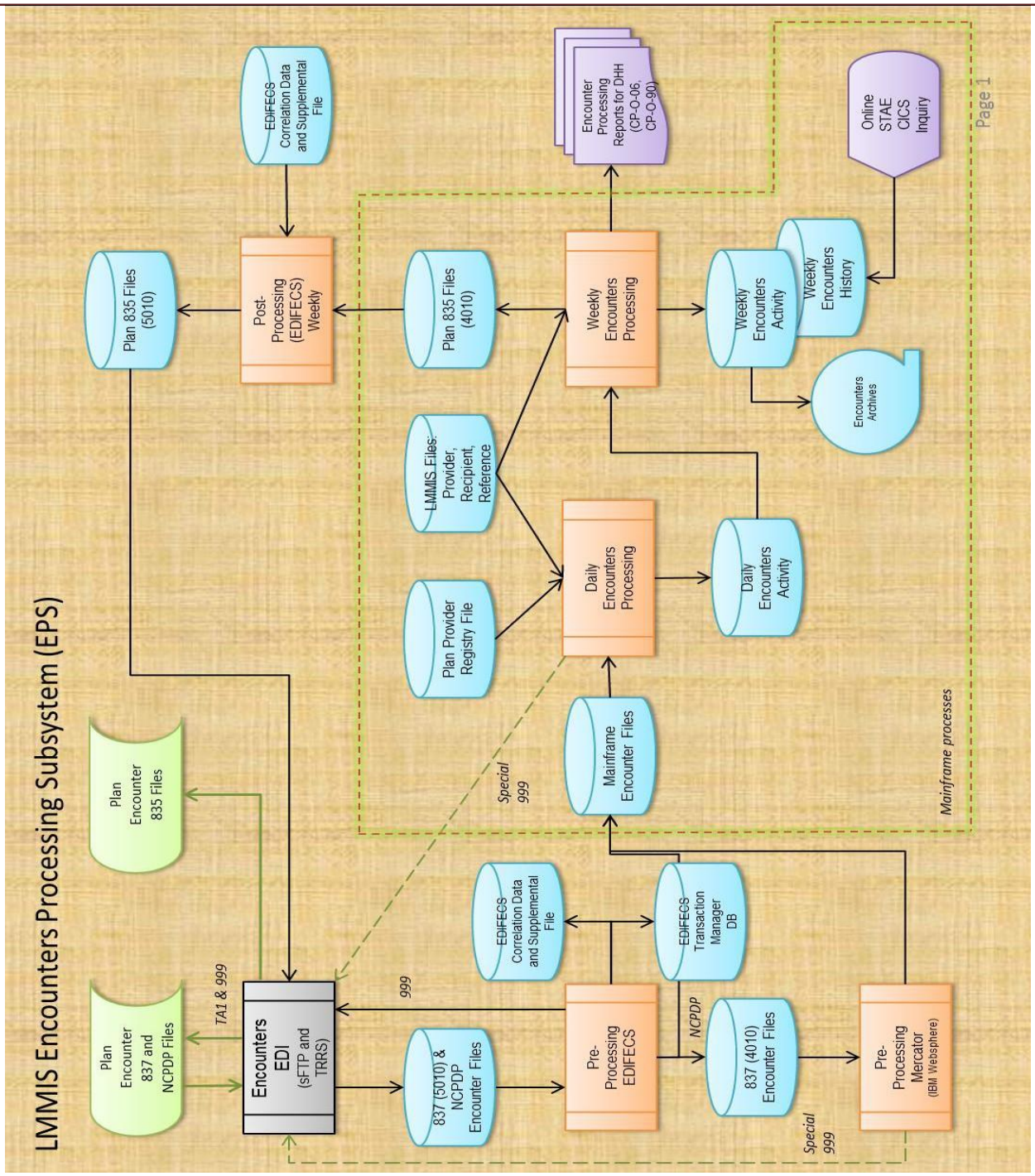
Appendix M

Claims Summary Report

On a monthly basis, MCOs are required to submit to LDH a Claims Summary Report. The report along with instructions can be found on the makingmedicaidbetter.com website.

Appendix N

Encounter Processing Flow


LMMIS Encounters Processing Subsystem (EPS)
Plan Encounter 837 and NCPDP Files
Plan Encounter 835 Files
TA1 & 999
Encounters EDI (sFTP and TRRS)
999
837 (5010) & NCPDP Encounter Files
Pre-Processing EDIFECS
EDIFECS Correlation Data and Supplemental File
EDIFECS Transaction Manager DB
NCPDP
837 (4010) Encounter Files
Special 999
Pre-Processing Mercator (IBM Websphere)
Plan 835 Files (5010)
Post-Processing (EDIFECS) Weekly
EDIFECS Correlation Data and Supplemental File
Plan 835 Files (4010)
LMMIS Files: Provider, Recipient, Reference
Plan Provider Registry File
Weekly Encounters Processing
Daily Encounters Processing
Mainframe Encounter Files
Special 999
Encounter Processing Reports for DHH (CP-O-06, CP-O-90)
Weekly Encounters Activity
Daily Encounters Activity
Weekly Encounters History
Encounters Archives
Online STAE CICS Inquiry
Mainframe processes
Page 1

Appendix O

Encounter Data Certification Form

The Encounter Data Certification Form is located on the following pages.

LOUISIANA DEPARTMENT OF HEALTH

LOUISIANA DEPARTMENT OF HEALTH
ENCOUNTER DATA CERTIFICATION FORM

Please Type or Print Clearly	
Managed Care Organization	**Name of Preparer/Title**
For The Period Ending **_____, 20____**	**Contact Phone Number/Email Address**

Healthy Louisiana DATA Certification Statement

On behalf of the above-named managed care organization (MCO), I attest, based on best knowledge, information and belief, that all data submitted to the Louisiana Department of Health (LDH) is accurate, complete, and true. This statement applies to all documents and files submitted to LDH.
I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable federal and state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the MCO contract.

File Type	ISA FILE #	Date File Sent (MMDDYR)	Total Number of Records	Sum Charged Amount	Sum of Paid Amount

Date Form Submitted:_____

Please circle as appropriate. Original Submission? Y N Void? Y N
Resubmission of Corrected or Voided Encounters ? Y N

Signature
This certification must be signed by the Chief Executive Officer or Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Officer or Chief Financial Officer. Please check here if a delegated authority is certifying this submission _____

_____	_____	_____
Date	MCO Chief Executive Officer/Delegate Name & Title	Signature

_____	_____	_____
Date	MCO Financial Officer/Delegate Name & Title	Signature

Appendix P

Batch Pharmacy Encounters Companion Guide

The Batch Pharmacy Encounters Companion Guide is a Supplement to this Managed Care Organization System Companion Guide. Therefore, revisions will only be made to the Pharmacy Guide itself.

Appendix Q

Pharmacy Encounters Supplemental File Layout

Subject to change

PART 1: PLAN FILE SUBMISSIONS

MCOs are required to submit a Pharmacy Supplemental File including the specified fields within two weeks of an accepted encounter.

The plan Submission File is a non-delimited ASCII text file. Records are variable length, up to a maximum of 1,447 bytes. File should be submitted weekly by Friday COB (5:00 p.m. CT).

File should be submitted to Molina's Non-EDI sFTP server in the Plan's To_Molina Folder.

Plan File submission naming convention:
BYU-nnnnnnn-RX-ENC-SUPPLEMENTAL- YYYYMMDD.txt
Where NNNNNNN is the MCO Plan ID and YYYYMMDD is the date of submission.

Pharmacy Supplemental File (Submission File Record) Layout

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
1	1	7	Numeric	7	N/A		Plan Submitter ID. See comments.	Submitter identification number assigned to the plan. See comments.	AMG=4508063 ACLA=4508073 LHCC=4508067 Aetna=4508985 UHC=4508989
2	8	17	Numeric	10	N/A		NNNNNNNNNN, left fill with zeros.	This is a sequential record number in the submission file. The first record should have value 0000000001, the 2nd should have value 0000000002, etc.	File Submission Record Number
3	18	47	Char	30	N/A		Plan ICN submitted on encounter	Please send the same plan ICN you send on the NCPDP encounter record.	
4	48	57	Numeric	10	201-B1	Service Provider ID	10 digit NPI. Left fill with zeros if applicable.	NPI assigned to pharmacy	Must be on the Plan's Provider Registry
5	58	67	Char	10	N/A	Service Provider Taxonomy	10 character taxonomy, if known.	Taxonomy for the pharmacy if known	If not known, send 10 spaces.
6	68	75	Numeric	8	401-D1	Date of Service	YYYYMMDD	Date of service of the claim	Date of service of the claim
7	76	83	Numeric	8	N/A	Date Received	YYYYMMDD	N/A	Date that the plan or its PBM contractor received the claim.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
8	84	84	Numeric	1	N/A	Encounter Status	1=original claim paid by plan 2=void of previous paid claim.	N/A	You should send claims that are paid and voided.
9	85	85	Numeric	1	N/A	Encounter Modifier	1=original claim 4=void of previous paid claim.	N/A	
10	86	86	Numeric	1	***111-AM***	***Segment Identification***	***Value=1***	***Patient***	
11	87	88	Char	2	307-C7	Place of Service	Use value 01.		Required if value=01 (Pharmacy) and 384-4X=12 (PRTF)
12	89	90	Char	2	384-4X	Patient Residence	If PRTF then use value 12; otherwise use value 00.		Required if value=12 (PRTF) and 307-C7=01 (Pharmacy)
13	91	91	Numeric	1	***111-AM***	***Segment Identification***	***Value=4***	***Insurance***	
14	92	104	Numeric	13	302-C2	Cardholder ID	Medicaid ID Number of the recipient, left fill with zeros if necessary.	Insurance ID assigned to the cardholder	13 digit LA Medicaid ID
15	105	105	Numeric	1	***111-AM***	***Segment Identification***	***Value=7***	***Claim***	
16	106	117	Char	12	402-D2	Prescription/Service Reference Number	12 digit Rx number	Reference number assigned by the provider for the dispensed drug provided	The pharmacy's file number for this prescription.
17	118	128	Char	11	407-D7	Product/Service ID	11 digit NDC. Left fill with zeros if necessary.	National Drug Code	For Compounds populate with zeros.
18	129	139	Numeric	11	442-E7	Quantity Dispensed	NNNNNNN.NNN, include the decimal. Left fill with zeros.	Quantity dispensed expressed in metric decimal units	
19	140	141	Numeric	2	406-D6	Compound Code	01=Not a compound 02=Compound.	Code indicating whether or not the prescription is a compound	If value is 02 then at least one Compound Segment 10 is required (see fields 85-89 below).

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
20	142	143	Numeric	2	420-DK	Submission Clarification Code	00=Not 340B 20=340B.	Code indicating that the pharmacist is clarifying the submission.	Required if value=20 (340B Program Indicator) if the product dispensed or administered was purchase under the Federal 340B program. Otherwise use 00.
21	144	145	Numeric	2	308-C8	Other Coverage Code	00=Not specified by patient 01=No other coverage 02=Other coverage exists - payment collected 03=Other coverage billed - claim not covered 04=Other coverage exists - payment not collected.	Indicates whether the Medicaid recipient has other health insurance coverage.	If you specify a value other than 00 or 01 then we require at least one COB Segment.
22	146	146	Numeric	1	***111-AM***	***Segment Identification***	***Value=3***	***Prescriber***	
23	147	156	Numeric	10	411-DB	Prescriber ID	NPI	National Provider ID assigned to the prescriber.	Must be on the Plan's Provider Registry
24	157	166	Char	10	N/A	Prescriber Taxonomy, if known	Taxonomy.	Prescriber taxonomy, if known.	If not known, send 10 spaces.
25	167	168	Numeric	2	***111-AM***	***Segment Identification***	***Value=11***	***Pricing***	
26	169	178	Numeric	10	409-D9	Ingredient Cost Submitted	NNNNNNN.NN, include the decimal, left fill with zeros.	For a compound, this is the sum of all individual ingredient costs	
27	179	188	Numeric	10	412-DC	Dispensing Fee Submitted	NNNNNNN.NN, include the decimal, left fill with zeros.		

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
28	189	193	Numeric	5	481-HA	Flat Sales Tax Submitted	NN.NN, include the decimal, left fill with zeros.	This is submitted provider fee field from the pharmacy to the MCO	Must be numeric and not less than zero.
29	194	203	Numeric	10	426-DQ	Usual and Customary Charge	NNNNNNN.NN, include the decimal, left fill with zeros.	The usual and customary charge for the prescription	
30	204	213	Numeric	10	430-DU	Gross Amount Due	NNNNNNN.NN, include the decimal, left fill with zeros.	Gross Amount Due	
31	214	223	Numeric	10	N/A	Amount HLA Plan paid the PBM	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount that the HLA plan paid their PBM contractor	
32	224	225	Numeric	2	423-DN	Basis of Cost Determination	01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 08 = 340B Disproportionate Share Pricing 09 = Other 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	Code indicating the method by which Ingredient Cost Submitted was calculated	
33	226	227	Numeric	2	***111-AM***	***Segment Identification***	***Value=23***	***Response Pricing***	
34	228	237	Numeric	10	505-F5	Patient Pay Amount	NNNNNNN.NN, include the decimal, left fill with zeros.		

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
35	238	247	Numeric	10	506-F6	Ingredient Cost Paid	NNNNNNN.NN, include the decimal, left fill with zeros.	Drug ingredient cost paid included in "Total Amount Paid"(509-F9)	Paid to pharmacy provider
36	248	257	Numeric	10	507-F7	Dispensing Fee Paid	NNNNNNN.NN, include the decimal, left fill with zeros.	Dispensing fee paid included in "Total Amount Paid"(509-F9)	Required if this is used in the calculation of final reimbursement to Pharmacy provider
37	258	262	Numeric	5	558-AW	Flat Sales Tax Amount Paid	NN.NN, include the decimal, left fill with zeros.	Flat sales tax paid which is included in the "Total Amount Paid"(509-F9)	This is a state mandated provider fee paid by the MCO to the Pharmacy provider. Must reflect $0.10. May be zero if there is secondary TPL (field 42 Other Payer information).
38	263	272	Numeric	10	509-F9	Total Amount Paid	NNNNNNN.NN, include the decimal, left fill with zeros.	Total amount paid by the claims processor to the pharmacy provider.	This paid amount should not include fees that would be considered a payment for access to a network.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
39	273	274	Numeric	2	522-FM	Basis of Reimbursement Determination	00=Not specified 01=Ingredient cost paid as submitted 02=Ingredient cost reduced to AWP pricing 03=Ingredient cost reduced to AWP less X% pricing 04=Usual & Customary Paid as submitted 05=Paid lower of Ingredient Cost Plus Fees versus Usual & Customary 06=MAC Pricing Ingredient Cost paid 07=MAC Pricing Ingredient Cost Reduced to MAC 08=Contract Pricing 09=Acquisition Pricing 10=ASP (Average Sales Price) – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11=AMP (Average Manufacturer Price) – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer.	Code indicating the method by which the drug cost was calculated.	Required if Ingredient Cost Paid (506-F6) is greater than zero (0). Required if Basis of Cost Determination (423-DN) is submitted on billing.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
							12=34ØB/Disproportionate Share/Public Health Service Pricing – The 34ØB Drug Pricing Program from the Public Health Service Act, sometimes referred to as "PHS Pricing" or "6Ø2 Pricing" is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price. 13=WAC (Wholesale Acquisition Cost) – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 14=Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount.		
40	275	284	Numeric	10	523-FN	Amount Attributed to Sales Tax	NNNNNNN.NN, include the decimal, left fill with zeros.		Required when TPL or COB is involved
41	285	285	Numeric	1	***111-AM***	***Segment Identification***	***Value=5***	***COB/Other Payments***	**1st COB set**

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
42	286	295	Char	10	340-7C	Other Payer ID 1	Left justify	MCOs to send Louisiana assigned Carrier Codes	If no other payer, then use 10 spaces. DO NOT REPORT YOUR PLAN PAYMENT AMOUNT IN A COB LOOP. If you need to submit a segment and you do not know the payer ID (carrier code), then use 000000.
43	296	297	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-1	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If no other payer, then use value 00.
44	298	307	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-1	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If no other payer, then use value zeros.
45	308	309	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-2	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
46	310	319	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-2	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
47	320	321	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-3	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
48	322	331	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-3	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
49	332	333	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-4	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
50	334	343	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-4	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
51	344	345	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-5	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
52	346	355	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-5	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
53	356	357	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-6	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
54	358	367	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-6	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
55	368	368	Numeric	1	***111-AM***	***Segment Identification***	***Value=5***	***COB/Other Payments***	**2nd COB set**
56	369	378	Char	10	340-7C	Other Payer ID 2	Left justify	MCOs to send Louisiana assigned Carrier Codes	If no other payer, then use 10 spaces. DO NOT REPORT YOUR PLAN PAYMENT AMOUNT IN A COB LOOP. If you need to submit a segment and you do not know the payer ID (carrier code), then use 000000.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
57	379	380	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-1	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
58	381	390	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-1	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
59	391	392	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-2	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
60	393	402	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-2	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
61	403	404	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-3	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
62	405	414	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-3	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
63	415	416	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-4	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
64	417	426	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-4	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
65	427	428	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-5	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
66	429	438	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-5	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
67	439	440	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-6	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
68	441	450	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-6	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
69	451	451	Numeric	1	***111-AM***	***Segment Identification***	***Value=5***	***COB/Other Payments***	**3rd COB set**
70	452	461	Char	10	340-7C	Other Payer ID 3	Left justify	MCOs to send Louisiana assigned Carrier Codes	If no other payer, then use 10 spaces. DO NOT REPORT YOUR PLAN PAYMENT AMOUNT IN A COB LOOP. If you need to submit a segment and you do not know the payer ID (carrier code), then use 000000.
71	462	463	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-1	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
72	464	473	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-1	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
73	474	475	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-2	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
74	476	485	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-2	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
75	486	487	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-3	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
76	488	497	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-3	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
77	498	499	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-4	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
78	500	509	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-4	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
79	510	511	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-5	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
80	512	521	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-5	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
81	522	523	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-6	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
82	524	533	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-6	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
Other Information in the common portion of the file									
83	534	534	Numeric	1	461-EU	Prior Authorization Type	0 = Not specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from Copay and/or Coinsurance 5 = Exemption from RX 6 = Family Plan Indic. 7 = AFDC (Aid to Families with Dependent Children) 8 = Payer Defined Exemption 9 = Emergency Preparedness		
84	535	583	Char	49	N/A	FILLER	USE SPACES		For future expansion if needed.
Compound Drug Information									
85	584	585	Numeric	2	***111-AM***	***Segment Identification***	***Value=10***	***Compound***	***May have repeating compound products up to a maximum of 24, including the 1st compound product. See Note 1 below. If***

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
									the record is not a compound drug, then do not include fields 85-89.
86	586	596	Numeric	11	489-TE	Compound Product ID-1	11 digit NDC. Left fill with zeros if necessary.	NDC of an ingredient used in a compound	
87	597	607	Numeric	11	448-ED	Compound Ingredient Quantity-1	NNNNNNN.NNN, include the decimal, left fill with zeros.	Amount Expressed in metric decimal units of the product included in the compound mixture	
88	608	617	Numeric	10	449-EE	Compound Ingredient Drug Cost-1	NNNNNNN.NN, include the decimal, left fill with zeros.	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in (Field 448-ED)	
89	618	619	Numeric	2	490-UE	Compound Ingredient Basis of Cost Determination-1	01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 08 = 340B Disproportionate Share Pricing 09 = Other 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	

Note 1: For compounds, you should repeat fields 85 through 89 for each additional compound product, up to a maximum of 24 products including the 1st compound product. Each additional production should add an additional 36 bytes and should be included using the same layout as fields 85-89 (which represent the 1st product).
Note 2: If the claim is not a compound, then do not include fields 85-89.

Part 2: Edit Response File

Molina will edit your submission file for correctness, and return an edit response file to the From_Molina folder on the non-EDI sFTP server.
The Edit Response File is a delimited ASCII text file.
Records are fixed length, 58 bytes
The edit response file will have the filename: BYU-nnnnnnn-RX-ENC-EDIT-yyyymmdd.TXT
Where nnnnnnn is the plan's submitter ID (assigned by Molina) and yyyymmdd is the date of submission.
If you do not receive an edit file, then that is an indication that Molina did not receive your submission file.
If you receive an empty response file, then that is an indication that all records on the submitted file are accepted with no errors.
Each field will be edited for a correct value. If a field is found to have an error in the value, then you will see an error code on the edit response file with the field ID.
So, for example, if a record has incorrect values in fields 4 and 9, you will see edit errors 004 and 009 on the edit response file.
Records that have errors will not be accepted into Molina's system. You may correct records that are in error and resubmit them on a later submission file.
The layout for the edit response file is shown below:

Edit Response File Record Layout

Field ID	Columns				Value set or Format	Comments
1	1-7				Plan Submitter ID. See comments.	AMG=4508063 ACLA=4508073 LHCC=4508067 Aetna=4508985 UHC=4508989
2	8-17				File Submission Record Number	This is the file submission record number that you sent in the submission file. It identifies the record in error. See field 2 in the submission record layout above.
3	18				Value = ^	
4	19-21				1st error code	
5	22				Value = ^	
6	23-25				2nd error code	

7	26				Value = ^	
8	27-29				3rd error code	
9	30				Value = ^	
10	31-33				4th error code	
11	34				Value = ^	
12	35-37				5th error code	
13	38				Value = ^	
14	39-41				6th error code	
15	42				Value = ^	
16	43-45				7th error code	
17	46				Value = ^	
18	47-49				8th error code	
19	50				Value = ^	
20	51-53				9th error code	
21	54				Value = ^	
22	55-57				10th error code	
23	58				Value = ^	
24	59-88				Plan ICN	This is the plan ICD submitted on the record. It may be up to 30 characters in length
25	89				Value = ^	End of Record

ERROR CODES

Code	Description
001	Invalid value for Plan Submitter ID
002	Field has a zero value or a non-numeric value or is not unique in the submission file
003	Field value is missing (has value=spaces)
004	NPI is not numeric or is not 10 digits or is not on Plan Registry
005	Taxonomy may be spaces, but if a non-blank value is submitted, it must be 10 characters
006	Date is not valid or does not make sense (is prior to plan contract or is a future date based on the date of the submission)
007	Date is not valid or does not make sense (is prior to plan contract or is a future date based on the date of the submission)

	Also, date value must be on or after the DOS.
008	Must be value 1 or 2
009	Must be value 1 or 4. If value is 1 then field 008 value must be 1. If value is 4, then field 008 value must be 2.
010	Must be value 1
011	Must be value 01
012	Must be value 00 or 12
013	Must be value 4
014	Value must be a valid recipient ID, must be 13 digits, and must be linked to the plan on the DOS
015	Must be value 7
016	Must be a number and must be 12 digits
017	Must be a number and must be 11 digits
018	Must be a valid numeric value with the decimal
019	Must be value 01 or 02. If value is 02, then at least one compound segment must be present in the record.
020	Must be value 00 or 20
021	Must be a value in the range 00 to 04.
022	Must be value 3
023	NPI is not numeric or is not 10 digits or is not on Plan Registry
024	Taxonomy may be spaces, but if a non-blank value is submitted, it must be 10 characters
025	Must be value 11
026	Must be a valid numeric value with the decimal
027	Must be a valid numeric value with the decimal
028	Must be a valid numeric value with the decimal and must not be less than zero.
029	Must be a valid numeric value with the decimal
030	Must be a valid numeric value with the decimal
031	Must be a valid numeric value with the decimal
032	Must be a value in the range 01 to 12
033	Must be value 23
034	Must be a valid numeric value with the decimal
035	Must be a valid numeric value with the decimal
036	Must be a valid numeric value with the decimal
037	If value is not 00.10, then you will get this error. May be zero if there is secondary TPL submitted on the record.

038	Must be a valid numeric value with the decimal
039	Must be a value in the range 00 to 14.
040	Must be a valid numeric value with the decimal
041	Must be value 5
042	Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016 LDH decided edit 042 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.
043	Must be a value in the range 01 to 10.
044	Must be a valid numeric value with the decimal
045	Must be a value in the range 01 to 10. May be zero.
046	Must be a valid numeric value with the decimal
047	Must be a value in the range 01 to 10. May be zero.
048	Must be a valid numeric value with the decimal
049	Must be a value in the range 01 to 10. May be zero.
050	Must be a valid numeric value with the decimal
051	Must be a value in the range 01 to 10. May be zero.
052	Must be a valid numeric value with the decimal
053	Must be a value in the range 01 to 10. May be zero.
054	Must be a valid numeric value with the decimal
055	Must be value 5
056	Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, LDH decided edit 042 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.
057	Must be a value in the range 01 to 10. May be zero.
058	Must be a valid numeric value with the decimal
059	Must be a value in the range 01 to 10. May be zero.
060	Must be a valid numeric value with the decimal
061	Must be a value in the range 01 to 10. May be zero.
062	Must be a valid numeric value with the decimal
063	Must be a value in the range 01 to 10. May be zero.

064	Must be a valid numeric value with the decimal
065	Must be a value in the range 01 to 10. May be zero.
066	Must be a valid numeric value with the decimal
067	Must be a value in the range 01 to 10. May be zero.
068	Must be a valid numeric value with the decimal
069	Must be value 5
070	Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, DHH decided edit 042 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.
071	Must be a value in the range 01 to 10. May be zero.
072	Must be a valid numeric value with the decimal
073	Must be a value in the range 01 to 10. May be zero.
074	Must be a valid numeric value with the decimal
075	Must be a value in the range 01 to 10. May be zero.
076	Must be a valid numeric value with the decimal
077	Must be a value in the range 01 to 10. May be zero.
078	Must be a valid numeric value with the decimal
079	Must be a value in the range 01 to 10. May be zero.
080	Must be a valid numeric value with the decimal
081	Must be a value in the range 01 to 10. May be zero.
082	Must be a valid numeric value with the decimal
083	Must be a numeric value between 0 and 9.
084	Must be spaces.
085	Must be value 10. If a compound segment is included and field 019 is not value 02, then you will get this error.
086	Must be numeric and 11 digits, and must be a valid NDC
087	Must be a valid numeric value with the decimal
088	Must be a valid numeric value with the decimal
089	Must be a value in the range 01 to 12

Note: Field edits 085 through 089 will repeat for additional compound segments when submitted on the record, accordingly.

So, the 2nd compound segment may experience edits 090 through 094; the 3rd compound segment may experience edits 095 through 099, etc.

Appendix R

Louisiana Health Information Exchange (LaHIE)

LaHIE Interface

As part of the American Recovery and Reinvestment Act (ARRA) of 2009, the Office of the National Coordinator for Health Information Technology (ONC) granted 56 awards totaling $548 million to help states and territories advance health information exchange among providers and hospitals in their designated areas. The Louisiana Health Care Quality Forum received $10.6 million in 2010 and serves as the designated, neutral entity to build and support a health information exchange (HIE) in our state.

Known as LaHIE, the exchange allows authorized providers and organizations to electronically access and share health-related information through a secure and confidential network for the purpose of improving patient safety, quality of care and health outcomes.

The State Health Information Exchange Program aims to ensure that every eligible health care provider has at least one option for health information exchange that meets the requirements of the Medicare and Medicaid EHR Incentive Programs, as defined by CMS in 2010. To this end, LaHIE will create and implement up-to-date privacy and security requirements for HIE; coordinate with Medicaid and state public health programs to establish an integrated approach; monitor and track meaningful use HIE capabilities; set strategy to meet gaps in HIE capabilities; and ensure consistency with national standards.

The visit registry will begin with patient matching, service location, service date/time and chief complaints. This feature will enhance care coordination, increase patient safety, reduce redundant tests and avoid unnecessary admissions.

The ADT message includes basic information about a patient's visit to a hospital or emergency room. Information identifies the treating facility, patient demographics including contact information, next-of-kin with contact information, patient's primary care provider and insurance information, as well as information related to allergies, diagnoses, and procedures performed during the visit. The ADT message is generated when a patient is admitted to a hospital or emergency department, discharged from a hospital or emergency department, transferred to another facility, or any demographic information is updated.

For more information: http://www.lhcqf.org/lahie-specs

Appendix S

Prior Authorization Requests Data Elements
(MCO to FI)

On a weekly basis, Managed Care Organization is required to submit ALL Prior Authorization Requests, in a file format, to the FI.

PRIOR AUTHORIZATION REQUESTS DATA ELEMENTS
1. We will only keep the latest record in case more than one record is sent for the same PlanID/PA# /Line# primary key combination.
2. Corrections to, or additions of lines >1, can be sent without a line 1, as long as, the line 1 was remitted in a previous file, or prior to the correction.
3. The naming convention will be "ccyymmdd_xxxxxxx_MCO_PA.txt", where ccyymmdd is the date of transmission and "xxxxxxx" is the MCO's provider ID as indicated in the Plan Submitter ID field of the layout.
4. The naming convention for the one-time historical file will be "ccyymmdd_xxxxxxx_MCO_PA_History.txt".
5. MCOs will use Molina's non-edi sFTP server to transmit their files.
6. All files are to be transmitted to Molina by 5:00 pm Saturday.

The file layout for MCO Prior Authorization Requests to the FI can be found on the following pages.

Field Name	Usage Notes	Data Type	Purpose
Submitter ID	4508073, 4508063, 4508067, 4508090, 4508062, 4508178, 4508846,4508985,4809999	int (Primary Key)	Health Plans Submitter ID (4809999 is for Xerox only)
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Number		varchar(30)	The PA Authorization Number **(Required) not blank**
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Line Number		int	The PA line Number **(Required) not blank**
Delimiter	'^'	char(1)	Column Separator

	Authorization Type	~~01 Inpatient Pre-Admission Certification~~ 05 Rehabilitation Services 06 Home Health Care 09 DME 12 Pharmacy 16 Personal Care Service 17 Medical -(Procedures and Diagnostics test) 18 Transportation ~~19 Dental~~ 20 Radiation Therapy 21 Surgery 22 Transplant 23 Hemodialysis 24 Injectable/Physician Administered Drugs 25 Observation 29 Other: Medical Physical Outpatient/Professional 31 Psychosocial Rehabilitation (PSR) 32 Community Psychiatric Support & Treatment (CPST) 33 Crisis Intervention 34 Crisis Stabilization 35 Psychotherapy 36 Medication Management 37 Assertive Community Treatment (ACT) 38 Multi-systemic Therapy (MST) 40 Imaging 41 Functional Family Therapy (FFT) 42 Homebuilders 43 ASAM 1: Outpatient 45 ASAM 2.1: Intensive Outpatient Treatment 46 ASAM 2: Ambulatory Withdrawal Management 49 Other - Behavioral Health (Outpatient/Professional) 50 Long-Term Personal Care Services (LTPCS)	Char(2)	Prior Authorization Type **(Required-2 character)** **Restrict to approve PA types.** *** 01 INPATIENT - NO LONGER VALID AFTER 8/1/18** **NEMT not included at this time.** ***19 DENTAL - NO LONGER VALID AFTER 8/1/18**	

		51 Inpatient: Acute 52 Inpatient: Rehabilitation 53 Inpatient: Skilled Nursing Facility (SNF) 54 Inpatient: Long Term Acute Care Hospital (LTAC) 55 Inpatient: Hospice 59 Other: Medical/Physical Inpatient 60 PRTF 61 TGH 62 ASAM 3.1 63 ASAM 3.2 WM 64 ASAM 3.3 65 ASAM 3.5 66 ASAM 3.7 67 ASAM 3.7 WM 68 ASAM 4 WM 69 Other - Behavioral Health Inpatient/Residential 70 Long-Term Care (LTC) 71 Pediatric Day Health Care 75 IP - Psych - Child 0 - 12 76 IP - Adol 13 - 17 77 IP - Adult 18+ 88 Hospice (Outpatient) ~~90 Specialized Behavioral Health (Wells Reporting)~~ 91 CSoC ~~99 Other (Wells Reporting)~~ A1 Dental - EPSDT A2 Dental - Adult Denture B1 ABA C1 Vision - EPSDT V1 VAS - Adult Dental V2 VAS - Adult Vision V3 VAS - Other		***90 SPECIALIZED BEHAVIORAL HEALTH - NO LONGER VALID AFTER 8/1/18.** ****USED only by CSoC Entity for CSoC SERVICES** ****MCOs not to use Auth Type 91** ***99 OTHER - NO LONGER VALID AFTER 8/1/18**	
Delimiter	'^'	char(1)	Column Separator	
Medicaid Recipient ID		char(13)	Current Medicaid Recipient ID **(Required) Valid**	
Delimiter	'^'	char(1)	Column Separator	
Provider NPI		Char(10)	Requesting provider NPI **(Required EXCEPT for T1019EP with Authorization Status = 'E') 10 digits - not all 0s nor all 9s.** **T1019 PAs - must have PT = 24 as requesting**	

			provider.
Delimiter	'^'	char(1)	Column Separator
Provider Taxonomy		char(10)	Requesting provider taxonomy **required** for EPSDT PCS Provider Type (PT 24) PA records**; Optional** for all other Provider Types, but if reported, it will be edited. Blanks or 10 characters accepted - cannot be all 0s nor all 9s
Delimiter	'^'	char(1)	Column Separator
Service Codes	If it's pharmacy PA then NDC or HICL or THERAPEUTIC CLASS or GPI (Generic Product Number)	char(20)	Requested service code (CPT or NDC, HICL OR THERAPEUTIC CLASS or GPI) (Required)
			01 is no longer a valid code it is being replaced by 51-55 and 59. Blanks will be allowed for Auth Types 51-55 59;70; and 75-77.
			For Rx: NDC, HICL or Therapeutic class or GPI are needed.
			T1019 PAs - must have PT 24 as requesting provider
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 1		char(2)	CPT modifier up to 4 **- blanks or 2 characters** **T1019 PAs - must have an EP modifier**
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 2		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 3		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 4		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
Referring Provider NPI		char(10)	Referring Provider NPI - **Blank or 10 digits - not all 0s nor all 9s**
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Status	**A** = Approved (with NPI) **D** = Denied **(with NPI)** **R** = Reduced Authorized (with NPI) **N** = No Decision, Pending (with NPI) **V** = Void **B** = approved (no NPI on file or registry)	char(1)	**The Prior Authorization Line status (Required) – Valid values** **For partial authorizations, use value 'R'.** **Except for Authorization Status E, edit requesting provider NPI for all T1019EP PA records against the MCO's provider registry record.**

	E= denied (no NPI on file or registry) **S** = reduced authorized (no NPI on file or registry) **O** = no decision, pending (no NPI on file or registry)		**Plan Authorization Status' 'B' (approved, no NPI on file or registry), 'S' (reduced authorization, 'O' (no decision-pending, no NPI on file or registry) aren't applicable to T1019 PA records and will not bypass PA NPI requirement.**
Delimiter	'^'	char(1)	Column Separator
Auth begin date	Format=CCYYMMDD	int	The beginning date of service associated with the PA Request **(Required) in valid date format; not all 0s nor all 9s.** **Pharmacy Auth Type 12 PAs, (Conditional): Approved PAs must provide the valid dates. Denied PAs will enter a zero.**
Delimiter	'^'	char(1)	Column Separator
Auth end date	Format=CCYYMMDD	int	The ending date of service associated with the PA Request **(Required) in valid date format; not all 0s nor all 9s.** **Pharmacy Auth Type 12 PAs, (Conditional): Approved PAs must provide the valid dates. Denied PAs will enter a zero.**
Delimiter	'^'	char(1)	Column Separator
Requested Units		int	Maximum Units Requested by Provider **(Required) Valid integer including 0. Use Auth Units.**
Delimiter	'^'	char(1)	Column Separator
Auth Units		int	Maximum Units authorized by plan **(Required) Valid integer including 0. Use Auth Units.**
Delimiter	'^'	char(1)	Column Separator
Auth amount ($)		Money	Maximum dollar amount authorized by plan **(Required) Valid money including $0**
Delimiter	'^'	char(1)	Column Separator
Auth received date	Format=CCYYMMDD	int	The date health Plan received PA request **(Required) Valid date format and >= 20120201**
Delimiter	'^'	char(1)	Column Separator
Auth notice date	Format=CCYYMMDD	int	The date health Plan notice the decision **(Required) Valid date format and >= 20120201**
Delimiter	'^'	char(1)	Column Separator
Auth Denied Reason	01 Not Medically Appropriate 02 Not a Covered Benefit	char(2)	Denials, including reduced authorizations, require a denial reason code (i.e. cannot be left blank unless approved0. **Valid if populated (blank, 01, 02, 03, 04, 05, 99)**

	03 Administrative - Lack of Information 04 Reduced Authorized 05 Other 99 Timeline Expired Without Decision		**If you absolutely cannot map to these values, then use value 05 - Other. If you can map, please do so.**
Delimiter	'^'	char(1)	Column Separator
Documentation Received Date	Format=CCYYMMDD	int	The last date that health plan received additional documentation **(Required for all with the initial value being date of request. It must be updated only if additional documentation is received after the initial request, with the date being overwritten with the last date that the health plan received additional documentation.)** **Valid date format and >= 20120201.**
Delimiter	'^'	char(1)	Column Separator
Tax Identification Number (TIN)	Format = 2 digits-7 digits	char(10)	This information is optional. If you do not submit a TIN, then send blanks. If you do submit a TIN, then the format is XX-XXXXXXX.
Delimiter	'^'	char(1)	Column Separator
Auth Days and Hours Code		Numeric(3)	Authorized days and hours code. **(Required) T1019 PAs only.**

T1019 Criteria	**T1019 Error Message**
T1019 PAs - must have an EP modifier	'PA T1019 Must Have an EP Modifier'
T1019 PAs – must have PT 24 as requesting provider and resides on the Provider Registry	'Requesting NPI Provider Type Must Be 24 For PA T1019'
T1019 PAs – must have requesting NPI populated at all times (even when status is B)	'Requesting NPI Missing or Invalid Format'
T1019 PAs - Auth Days and Hours	'Invalid Authorized Days Code For Approved T1019 PA'
T1019 PAs – Denied PA	'Invalid Authorized Days Code For Denied T1019 PA'

Note: Even though the new Auth Days/Hours field is not required for a denied T1019 PA, if it is there, it is edited.

Layout for MCO Prior Authorization Reconciliation File

Fixed-length record
220 Characters in length
Naming schema “MCO-PA-Recon-450xxxx-ccyymmdd.txt”

Starting Column	Field Name	Size	Type
1	Plan_Submitter_ID	7	numeric
8	delimiter	1	'^'
9	Plan_Auth_Number	30	alphanumeric
39	delimiter	1	'^'
40	Plan_Auth_Line_Number	2	numeric
42	delimiter	1	'^'
43	Authorization_Type	2	alphanumeric
45	delimiter	1	'^'
46	Medicaid_Recip_ID	13	numeric
59	delimiter	1	'^'
60	Provider_NPI	10	numeric
70	delimiter	1	'^'
71	Provider_Taxonomy	10	alphanumeric
81	delimiter	1	'^'
82	Service_Code	20	alphanumeric
102	delimiter	1	'^'
103	CPT_Mod_1	2	alphanumeric
105	delimiter	1	'^'
106	CPT_Mod_2	2	alphanumeric
108	delimiter	1	'^'
109	CPT_Mod_3	2	alphanumeric
111	delimiter	1	'^'
112	CPT_Mod_4	2	alphanumeric
114	delimiter	1	'^'
115	Referring_Prov_NPI	10	numeric
125	delimiter	1	'^'
126	Plan_Auth_Status	1	character
127	delimiter	1	'^'
128	Auth_Begin_Date	8	numeric ccyymmdd
136	delimiter	1	'^'
137	Auth_End_Date	8	numeric ccyymmdd
145	delimiter	1	'^'
146	Requested_Units	4	numeric
150	delimiter	1	'^'
151	Authorized_Units	4	numeric
155	delimiter	1	'^'

156	Authorized_Amount	10.2	numeric
166	delimiter	1	'^'
167	Auth_Received_Date	8	numeric ccyymmdd
175	delimiter	1	'^'
176	Auth_Notice_Date	8	numeric ccyymmdd
184	delimiter	1	'^'
185	Auth_Denied_Reason	2	numeric
187	delimiter	1	'^'
188	Documentation_Received_Date	8	numeric ccyymmdd
196	delimiter	1	'^'
197	Tax_Id_Number	10	character
207	delimiter	1	'^'
208	Auth_Days_Hours	3	character
211	delimiter	1	'^'
212	Date_Updated	8	numeric ccyymmdd
220	delimiter	1	'^'

Note: The field Date_Updated is the date this record was updated/added to DXC's database, with the remaining fields a reflection of what was loaded. This file will be placed in the "From_Molina" folder for your retrieval.

Layout for MCO Prior Authorization Reconciliation Error File (FI > MCO)

Fixed-length record
321 Characters in length
Naming schema "MCO-PA-Recon-Errors-450xxxx-ccyymmdd.txt"

Starting Column	Field Name	Size	Type
1	Plan_Submitter_ID	7	numeric
8	delimiter	1	'^'
9	Plan_Auth_Number	30	alphanumeric
39	delimiter	1	'^'
40	Plan_Auth_Line_Number	2	numeric
42	delimiter	1	'^'
43	Authorization_Type	2	alphanumeric
45	delimiter	1	'^'
46	Medicaid_Recip_ID	13	numeric

59	delimiter	1	'^'
60	Provider_NPI	10	numeric
70	delimiter	1	'^'
71	Provider_Taxonomy	10	alphanumeric
81	delimiter	1	'^'
82	Service_Code	20	alphanumeric
102	delimiter	1	'^'
103	CPT_Mod_1	2	alphanumeric
105	delimiter	1	'^'
106	CPT_Mod_2	2	alphanumeric
108	delimiter	1	'^'
109	CPT_Mod_3	2	alphanumeric
111	delimiter	1	'^'
112	CPT_Mod_4	2	alphanumeric
114	delimiter	1	'^'
115	Referring_Prov_NPI	10	numeric
125	delimiter	1	'^'
126	Plan_Auth_Status	1	character
127	delimiter	1	'^'
128	Auth_Begin_Date	8	numeric ccyymmdd
136	delimiter	1	'^'
137	Auth_End_Date	8	numeric ccyymmdd
145	delimiter	1	'^'
146	Requested_Units	4	numeric
150	delimiter	1	'^'
151	Authorized_Units	4	numeric
155	delimiter	1	'^'
156	Authorized_Amount	10.2	numeric
166	delimiter	1	'^'
167	Auth_Received_Date	8	numeric ccyymmdd
175	delimiter	1	'^'
176	Auth_Notice_Date	8	numeric ccyymmdd
184	delimiter	1	'^'
185	Auth_Denied_Reason	2	numeric
187	delimiter	1	'^'
188	Documentation_Received_Date	8	numeric ccyymmdd
196	delimiter	1	'^'
197	Tax_Id_Number	10	character
207	delimiter	1	'^'
208	Auth_Days_Hours	3	character

211	delimiter	1	'^'
212	Date_Rejected	8	numeric ccyymmdd
220	delimiter	1	'^'
221	Error_Message	100	alphanumeric
321	delimiter	1	'^'

Note: The field Date_Rejected is the date this record was processed, but due to errors, rejected. This file will be placed in the "From_Molina" folder for your retrieval.

Appendix T

Supplement to Fee Schedule

On a weekly basis, LDH, thru the Fiscal Intermediary, provides a Supplement to Fee Schedule File to each of the MCOs. This delimited text file provides information contained in LDH's Procedure Formulary files but is not shown on the fee schedules. The fields in the text file are in the same position as the Fee Schedule Extract, therefore, the MCO is required to utilize the delimited file to create an excel document.

The file name is MMIS_PLAN_EXTRACT_<DAILY8>.TXT (with <DAILY8>being in the format of YYYYMMDD). The file is available to the MCO on Fridays is sent to the MCO's sFTP verified site address.

The Extract Record Layout, Sample of the Fee Schedule Extract, and Data Elements Dictionary can be found on the following pages.

Extract Record Layout

```
                                                                |
|                TABLE OF CONTENTS FOR LAYOUT REPORT      PAGE    1    |
| 05/28/2014                                                          |
+---------------------------------------------------------------------+
|                                                                     |
|                      PROC-RECORD................................1   |
|                                                                     |
+---------------------------------------------------------------------+
```

LAYOUT REPORT PAGE 1

LEVEL	DATA-NAME	LENGTH	TYPE	FROM	TO
01	PROC-RECORD	450	GROUP	1	450
05	PROC-MEDICAL-CODE	13	GROUP	1	13
10	PROC-CPT-CODE	5	X	1	5
10	PROC-CPT-TOS-CODE	2	X	6	7
10	PROC-CPT-MOD1	2	X	8	9
10	PROC-CPT-MOD2	2	X	10	11
10	PROC-CPT-MOD3	2	X	12	13
05	PROC-PROC-NAME	36	X	14	49
05	PROC-ACTIVE-DATES	9	GROUP	50	58
10	PROC-ACT-DT	8	N	50	57
10	PROC-ACT-DATE REDEFINES PROC-ACT-DT	8	GROUP	50	57
15	PROC-ACT-CC	2	X	50	51
15	PROC-ACT-YR	2	X	52	53
15	PROC-ACT-MO	2	X	54	55
15	PROC-ACT-DA	2	X	56	57
10	PROC-ACT-CODE	1	X	58	58
05	PROC-AGE	4	GROUP	59	62
10	PROC-MIN-AGE	2	X	59	60
10	PROC-MAX-AGE	2	X	61	62
05	PROC-SEX	1	X	63	63
05	PROC-PA-IND	1	X	64	64
05	PROC-PROV-RANGE	28	GROUP	65	92

10	PROC-PROVID	4	GROUP	65	68
	OCCURS 7 TIMES TO 92				
25	PROC-FROM	2	X	65	66

LAYOUT REPORT PAGE 2

LEVEL	DATA-NAME	LENGTH	TYPE	FROM	TO
25	PROC-TO	2	X	67	68
05	PROC-MAX-UVSP	3	X	93	95
05	PROC-SURGERY-IND	1	X	96	96
05	PROC-CLAIM-TYPE-RESTRICT	6	GROUP	97	102
10	PROC-CT-RESTRICT	2	X	97	98
	OCCURS 3 TIMES TO 102				
05	PROC-PRICING-ACTION	11	GROUP	103	113
	OCCURS 6 TIMES TO 168				
10	PROC-PRICING-ACTION-CODE	3	X	103	105
10	PROC-PRICING-EFF-DATE	8	N	106	113
05	PROC-AUTO-ERROR	3	GROUP	169	171
	OCCURS 6 TIMES TO 186				
10	PROC-AUTO-ERROR-CODE	3	N	169	171
05	PROC-DATE-MAX-CHARGE	15	GROUP	187	201
	OCCURS 8 TIMES TO 306				
10	PROC-MAX-CHARGE	7	SNE	187	193
	PIC S9(5)V99				
10	PROC-CHARGE-EFFECT-DATE	8	GROUP	194	201
15	PROC-CHARGE-BEGIN-CC	2	X	194	195
15	PROC-CHARGE-BEGIN-YY	2	X	196	197
15	PROC-CHARGE-BEGIN-MM	2	X	198	199
15	PROC-CHARGE-BEGIN-DD	2	X	200	201
05	PROC-SVC	22	GROUP	307	328
10	PROC-SVC-EFF-YEAR	4	N	307	310
10	PROC-SVC-SAME-ANY-PROV	1	X	311	311
10	PROC-SVC-DAILY-LIMIT	2	N	312	313
10	PROC-SVC-MAX-NUM	4	N	314	317
10	PROC-SVC-DOLLAR-AMT	4	N	318	321

LAYOUT REPORT PAGE 3

LEVEL	DATA-NAME	LENGTH	TYPE	FROM	TO
10	PROC-SVC-TIME-LIMIT	4	GROUP	322	325
15	PROC-SVC-YR-IND	1	X	322	322
15	PROC-SVC-DAYS	3	N	323	325
10	PROC-SVC-ERR-CODE	3	X	326	328
05	PROC-BASE-UNITS-PRICE	17	GROUP	329	345
	OCCURS 5 TIMES TO 413				
10	PROC-BASE-UNITS	2	X	329	330
10	PROC-UNIT-PRICE	7	SNE	331	337
	PIC S9(5)V99				
10	PROC-UNIT-EFF-DATE	8	N	338	345
05	FILLER	37	X	414	450

Sample Fee Schedule Extract

A001003 NONEMER AMB DUAL ENT MEDICARE DENIED19950201C00990 5959000000000000000000000000001
8201995040185019890821000000000000000000000000000000000000000000000000029900000000000000
0000818419911101000775019890821000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A001009 AMBULANCE,BLS,BASE RATE,EMERG.,1WAY 19950215C00990 5959000000000000000000000000001
8201995040185019890821860197804010000000000000000000000000000000000029900000000000000
0001653319940101001605119930101001556819920101001486919910201001420219910101001136 2
1990040100095001989082100085001987081700000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A002003 AMBULANCE SERVICE BLS PER MILE 19950201C00990 5959000000000000000000000000999
8201995040185019870101000000000000000000000000000000000000000000000000029900000000000000
0000021119911101000020019890821000018019870101000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A002009 AMBULANCE SERVICE,BLS PER MILE, 19950201C00990 5959000000000000000000000000001
8201995040185019840102000000000000000000000000000000000000000000000000029900000000000000
0000038119940101000037019930101000035919920101000034319910201000032819910101000025 0
1990070100002001984010200000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A002109 AMBULANCE SERVICE, OUTSIDE STATE PE 19901214C00990 0099000000000000000000000000999

8201984010100000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A003009 AMB.,CONVENTIONAL AIR SERVICE,1 WAY 20010607C00990 5959000000000000000000000000001
8202001070182020010401850199507078101982010100000000000000000000000000000000000000000000000000
0010000019950707000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A004009 AMB.,AIR HELICOPTER SERVICE,TRANSPRT20010607C00990 5959000000000000000000000000001
8202001070182020010401850199507078101982010100000000000000000000000000000000000000000000000000
0012000019950707000000000000000000000000000000000000000000000000000000000000000000000000000000
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A005009 AMBULANCE SERVICE, EMERGENCY, WATER,20010607C00990 0099000000000000000000000000999
8202001070182019840101000000000000000000000000000000000000000000000000000000000000000000000000
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A006009 AMBULANCE SERVICE, WAITING TIME, ONE19860926C00990 0099000000000000000000000000999
8201984010100000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A007009 AMBULANCE SERVICE, OXYGEN, ADMINIST 19860926C00990 009900000000000000000000000999
8201984010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A008003 PER MILE,VOLUNTEER,NO VESTED INTREST19930219C00990 4545000000000000000000000000999
8201993021585019911118830197810010000000000000000000000000000000000000299000000000000000
0000002419911118000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A009003 PER MILE,VOLUNTEER,INTRT.IND.,NEIGHB19930219C00990 4545000000000000000000000000999
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0000002419911118000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A010003 TAXI INTRACITY PRIMARY AREA 19980403C00990 4646000000000000000000000000001
8201998010185019911101830198108110000000000000000000000000000000000000232000000000000000
0000170019911101000200019810811000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A011003 NONPROFIT NEMT PICK-UP FEE 1ST TRIP 19930519C00990 4545000000000000000000000000001
8501993021582019780101000000000000000000000000000000000000000000000000000000000000000000
0000050019930215000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A011009 NON-EMERGENCY TRANSPORTATION AND BU 19901120C00990 5959000000000000000000000000999
8201984010100000000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A011503 NONPROFIT NEMT PICK-UP FEE 2ND TRIP 19980403C00990 4545000000000000000000000000001
8201998010185019930215820197801010000000000000000000000000000000000000232000233000000000
0000050019930215000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A012003 NONPROFIT NEMT MILEAGE FEE 1ST TRIP 19940708C00990 4545000000000000000000000000999
8201994070185019911118830197810010000000000000000000000000000000000000299000000000000000
0000003619930215000002419911118000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A012503 NONPROFIT NEMT MILEAGE FEE 2ND TRIP 19980403C00990 4545000000000000000000000000999
8201998010185019930215820197801010000000000000000000000000000000000000232000233000000000
0000003619930215000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

A013009 NON-EMERGENCY TRANSPORTATION: WHEEL-19860926C00990 0099000000000000000000000000999
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

0000000000000000000000000000000000000000000000000000000000000000

9951203 HOME VISIT, HEMODIALYSIS 20020815C00990 0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000029900000000000000
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

9953903 HOME VISIT, NOS 20041214C00990 0099000000000000000000000000001
8202005010182020020101000000000000000000000000000000000000000000000024800000000000000
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0000000000000000000000000000000000000000000000000000000000000000

9955103 HOME INFUS, PAIN MGMT, IV/SC 20020815C00990
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

9955203 HM INFUS PAIN MGMT, EPID/ITH 20020815C00990
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8202002010100000000000000000000000000000000000000000000000000000000029900000000000000
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9955403 HOME INFUS, HORMONE/PLATELET 20020815C00990
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8202002010100000000000000000000000000000000000000000000000000000000000000000000299000000000000000
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9955503 HOME INFUSE, CHEMOTHERAPHY 20020815C00990
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9955603 HOME INFUS, ANTIBIO/FUNG/VIR 20020815C00990
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8202002010100000000000000000000000000000000000000000000000000000000000000000000299000000000000000
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0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
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0099000000000000000000000000001 15
8202002010100000000000000000000000000000000000000000000000000000000000000000000299000000000000000
00000000 0000000 0000000 0000000 0000000 0000000 0000000 0000000

0000000000000000000000 000000000000000 000000000000000 000000000000000
000000000000000 000000000000000

9955803 HOME INFUSE, IMMUNOTHERAPY 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9955903 HOME INFUS, PERITON DIALYSIS 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956003 HOME INFUS, ENTERO NUTRITION 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956103 HOME INFUSE, HYDRATION TX 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956203 HOME INFUS, PARENT NUTRITION 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956303 HOME ADMIN, PENTAMIDINE 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956403 HME INFUS, ANTIHEMOPHIL AGNT 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956503 HOME INFUS, PROTEINASE INHIB 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000

9956603 HOME INFUSE, IV THERAPY 20020815C00990 0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9956703 HOME INFUSE, SYMPATH AGENT 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9956803 HOME INFUS, MISC DRUG, DAILY 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9956903 HOME INFUSE, EACH ADDL TX 20020815C00990
0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9960003 HOME VISIT NOS 20040304S00990 0099000000000000000000000000001
8202003010100000000000000000000000000000000000000000000000000000000000000299000000000000000

0000000020030101000000000 0000000 0000000 0000000 0000000 0000000

0000000 00000000000000000000000 000000000000000 000000000000000 000000000000000
000000000000000 000000000000000

Data Element Dictionary

Data Elements	Description
Procedure Code	5 digits or alpha preceded HCPCS procedure code
Type of Service	2 digit Type of Service code See Type of Service for possible values
Modifier 1	2 character Procedure code modifier. For possible values see Proc Code Modifiers
Modifier 2	2 character Procedure code modifier. For possible values see Proc Code Modifiers
Modifier 3	2 character Procedure code modifier. For possible values see Proc Code Modifiers
Procedure Name	up to 36 characters of the procedure name.
Activity Date	Date of last update activity on this record. Format CCYYMMDD
Activity Code	A, C, R show manual updates; S show system update
Age Minimum/Maximum Restriction	Restriction based on recipient age (minimum and maximum age) 00-99=None.
Sex Restriction	Sex restriction for this procedure. Value '1' = Male, Value '2' = Female; 0 = none
PA Indicator	Indicates if a procedure requires prior authorization. Value = 'R' means that a PA is required
Provider Specialty Range	Range of provider specialty or specialties, which are approved for payment of the procedure code. (For example 00-99 = all specialties; for specialties 24-24 limits services to plastic surgeons only) See Provider Specialties for possible values. Note: Space allocated for 7 ranges in record
UVS	Maximum number of units, visits, or services billable on a single line
Surgery Indicator	A code indicating that a procedure is a Ambulatory surgical procedure
Claim Type Restriction	Claim type restriction for procedure code. Used to restrict procedure code to specific claim types. For possible values see Claim Types. Note: Space allocated for 3 types in one record
Pricing Action Code	Dictates method of pricing to the system. For possible values see Pricing Action Codes. Note: Space allocated for 6 code/date combinations in record
Pricing Action Code Effective Date	Effective date of Pricing Action Code. Format CCYYMMDD Note: Space allocated for 6 pricing code/date combinations in record
Auto Error Code	A code used to automatically Pend/Deny a claim for a procedure. See Auto Errors for values that are typically applied. For complete list see list on the LaMedicaid site. Note: Space allocated for 6 error codes in record
Max Charge	The maximum allowable fee which will be paid for a procedure or service. Complete with dollars, decimal point, and cents. Note: Space allocated for 8 charge/date combinations in record
Max Charge Effective Date	Date max charge change becomes effective. Format CCYYMMDD Note: Space allocated for 8 charge/date combinations in record

Service Limits

Effective Year	The year in which this service limit became effective. Format CCYY
Prov Same or Any	A code used to indicate whether a service limitation for a procedure applies to the same or different providers. Values: Y for same provider, N for any provider,
Daily Limit	Number of times a service may be provided per day.
Maximum Number	Maximum number of provided services allowed for the service limit time period.
Maximum Dollars	Maximum dollars payable for the service limit time period.
Year Indicator	The time period, in years, for a service limitation on a procedure
Days Indicator	The time period, in days, for a service limitation on a procedure.
Service Error Code	Error to be applied If the service limit is exceeded. See Service Errors for possible values. For complete list see list on the LaMedicaid site.

Anesthesia

Anesthesia Units	A unit of value which indicates the base units for an anesthesia service. Note: Space allocated for 5 unit/price/date combinations in record
Anesthesia Price	Anesthesia price used in anesthesia payment calculations. Note: Space allocated for 5 unit/price/date combinations in record
Anesthesia Effective Date	Date anesthesia units become effective (Anesthesia codes only). Format CCYYMMDD Note: Space allocated for 5 unit/price/date combinations in record

Appendix U

Hospice Enrollment File Layout
(FI to MCO)

LDH thru its FI provides to the MCO a copy of the Hospice data that is maintained on the FI's file. The file contains data for Hospice recipients that are enrolled with the MCO.

The text file is available to the MCO weekly on Mondays by 12:00 PM CST and can be retrieved from the FI's non-EDI sFTP server in the "From" Molina folder. The naming convention is Hospice_File_YYYYMMDD.text.

The Hospice Enrollment File Layout can be found on the following page.

Record Columns	Description	Data Type and length
Cols 1-13:	Recipient Current Medicaid ID number	Character 13 bytes
Cols 14-26:	Recipient Original Medicaid ID number	Character 13 bytes
Cols 27-34:	Hospice Entitlement Date	Numeric 8 bytes, format=YYYYMMDD
Cols 35-42:	Hospice begin date	Numeric 8 bytes, format=YYYYMMDD
Cols 43-50:	Hospice end date	Numeric 8 bytes, format=YYYYMMDD
Cols 51-55:	Recipient primary diagnosis (ICD-9)	Character 5 bytes
Cols 56-60:	Recipient secondary diagnosis (ICD-9)	Character 5 bytes
Cols 61-63:	Hospice closure Code	Character 3 bytes
Cols 64-70:	Hospice provider ID	Character 7 bytes
Cols 71-72:	Hospice type	Character 2 bytes
Cols 73-73:	Hospice period Ind	Character 1 byte
Cols 74-80:	Recipient primary diagnosis (ICD-10)	Character 7 bytes
Cols 81-87:	Recipient secondary diagnosis (ICD-10)	Character 7 bytes
Cols 88-90:	Recipient Plan ID	Character 3 bytes

Appendix V

Hospice Linkage Information File Layout

MCO TO FI

The MCO is not required to submit a weekly Hospice File to the FI at this time.

Appendix W

Receive Date for Historical Encounter Data File Layout

FI to MCO

Cols	Item	Format
1-13	Molina ICN	character 13
14	^	caret delimiter
15-44	Plan ICN	character 30 padded with spaces on right
45	^	caret delimiter
46-53	Received Date	character 8 YYYYMMDD

End of record

Appendix X

Retro Cancellation/Closure File Layout

FI to MCO

On a monthly basis LDH provides to the MCO a a file of linkages that have been cancelled or closed.

The MCO is required to utilize the file accordingly as well as in conjunction with the 834 file (received daily, weekly, and monthly) to assist in identifying these linkages. This file may be retrieved from the FI's non-EDI server.

The file name is PPLANID_YYYYMM.txt (where "P" is the MCO Plan ID).

The Retro Cancellation/Closure File Layout can be found below.

RECIP	PIC X(13).	Recipient ID
FILLER	PIC X(01) VALUE ':'.	
RECIP-LAST	PIC X(06).	1st 6 characters of Last name
FILLER	PIC X(01) VALUE ':'.	
HLA-PLAN	PIC 9(07).	Plan Provider ID
FILLER	PIC X(01) VALUE ':'.	
HLA-BEG	PIC 9(08).	HLA Begin Date
FILLER	PIC X(01) VALUE ':'.	
HLA-END	PIC 9(08).	HLA End Date
FILLER	PIC X(01) VALUE ':'.	
HLA-ADD	PIC 9(08).	HLA Add Date
FILLER	PIC X(01) VALUE ':'.	
HLA-CHG	PIC 9(08).	HLA Change Date
FILLER	PIC X(01) VALUE ':'.	
DIS-ENROLL	PIC X(03).	Dis-enroll reason
FILLER	PIC X(01) VALUE ':'.	
DOB	PIC 9(08).	If Date of Birth > 20120201 this field is populated.
FILLER	PIC X(01) VALUE ':'.	

Appendix Y

Magellan Provider Registry

FI to MCO

LDH's FI makes available to the MCO the Magellan Provider Registry. This file is uploaded to and may be retrieved from the MCO's non-EDI folder on the FI's sFTP site on the first Monday of each month.

The file name is Magellan-Provider-Registry-YYYYMMDD.txt. The Magellan Provider Registry file layout can be found on the following pages.

Data Item	Size	Type	Start	End	Format/notes
PLAN_ID	7	number	1	7	MCO Medicaid Provider ID
ASSIGNED_MEDICAID_PROV_ID	7	number	8	14	Assigned Internal Provider ID
ASSIGNED_CHK_DIGIT_PROV_ID	7	number	15	21	
NPI	10	varchar	22	31	
ENTITY_TYPE	1	varchar	32	32	1=individual; 2=organization
REPLACEMENT_NPI	20	varchar	33	52	
PROVIDER_NAME	40	varchar	53	92	
PROVIDER_MAIL_ADDR_1	30	varchar	93	122	
PROVIDER_MAIL_ADDR_2	30	varchar	123	152	
PROVIDER_MAIL_CITY	30	varchar	153	182	
PROVIDER_MAIL_STATE	2	varchar	183	184	
PROVIDER_MAIL_ZIP	10	varchar	185	194	
PROVIDER_MAIL_COUNTRY	10	varchar	195	204	
PROVIDER_MAIL_PHONE	10	varchar	205	214	
PROVIDER_MAIL_FAX	10	varchar	215	224	
PROVIDER_BUS_ADDR_1	30	varchar	225	254	
PROVIDER_BUS_ADDR_2	30	varchar	255	284	
PROVIDER_BUS_CITY	30	varchar	285	314	
PROVIDER_BUS_STATE	2	varchar	315	316	
PROVIDER_BUS_ZIP	10	varchar	317	326	
PROVIDER_BUS_COUNTRY	10	varchar	327	336	
PROVIDER_BUS_PHONE	10	varchar	337	346	
PROVIDER_BUS_FAX	10	varchar	347	356	
TAXONOMY_1	10	varchar	357	366	
TAXONOMY_2	10	varchar	367	376	
TAXONOMY_3	10	varchar	377	386	
OTHER_PROVIDER_ID	7	number	387	393	LA Medicaid Provider ID

PROVIDER_TYPE	2	varchar	394	395	
PROVIDER_SPECIALTY	2	varchar	396	397	
NPPES_ENUM_DATE	8	number	398	405	
NPPES_LAST_UPDATE_DATE	8	number	406	413	
NPPES_DEACT_REASON_CODE	20	varchar	414	433	
NPPES_DEACT_DATE	8	number	434	441	
NPPES_REACT_DATE	8	number	442	449	
PROVIDER_GENDER_CODE	1	varchar	450	450	M=Male; F=Female; N=N/A
PROVIDER_LICENSE_NO	20	varchar	451	470	
PROVIDER_LICENSE_STATE	2	varchar	471	472	
OFFICIAL_CONTACT_NAME	50	varchar	473	522	
OFFICIAL_CONTACT_TITLE	30	varchar	523	552	
OFFICIAL_CONTACT_PHONE	10	varchar	553	562	
PANEL_OPEN_IND	1	varchar	563	563	Y; N
LANGUAGE_IND_1	1	varchar	564	564	
LANGUAGE_IND_2	1	varchar	565	565	
LANGUAGE_IND_3	1	varchar	566	566	
LANGUAGE_IND_4	1	varchar	567	567	
LANGUAGE_IND_5	1	varchar	568	568	
AGE_RESTRICTION_IND	1	varchar	569	569	0=no restriction; 1=adult only; 2=pediatric only
PCP_LINKAGE_MAX	5	number	570	574	Max linkage for PCP
PCP_LINKAGE_SMO	5	number	575	579	Linkage for PCP-SMO combo
PCP_LINKAGE_OTHER	5	number	580	584	Linkage for PCP outside of SMO
SMO_ENROLLMENT_IND	1	varchar	585	585	N=New; C=Change; D=Disenroll
SMO_ENROLLMENT_IND_EFF_DATE	8	number	586	593	YYYYMMDD
FAMILY_ONLY_IND	1	varchar	594	594	0=no restriction; 1=family members only
PROVIDER_SUB_SPECIALTY_1	2	varchar	595	596	
PROVIDER_SUB_SPECIALTY_2	2	varchar	597	598	
PROVIDER_SUB_SPECIALTY_3	2	varchar	599	600	

SMO_CONTRACT_NAME_NO	30	varchar	601	630	
SMO_CONTRACT_BEGIN_DATE	8	number	631	638	YYYYMMDD
SMO_CONTRACT_TERM_DATE	8	number	639	646	YYYYMMDD
PROVIDER_PARISH_1	2	varchar	647	648	
PROVIDER_PARISH_2	2	varchar	649	650	
PROVIDER_PARISH_3	2	varchar	651	652	
PROVIDER_PARISH_4	2	varchar	653	654	
PROVIDER_PARISH_5	2	varchar	655	656	
PROVIDER_PARISH_6	2	varchar	657	658	
PROVIDER_PARISH_7	2	varchar	659	660	
PROVIDER_PARISH_8	2	varchar	661	662	
PROVIDER_PARISH_9	2	varchar	663	664	
PROVIDER_PARISH_10	2	varchar	665	666	
PROVIDER_PARISH_11	2	varchar	667	668	
PROVIDER_PARISH_12	2	varchar	669	670	
PROVIDER_PARISH_13	2	varchar	671	672	
PROVIDER_PARISH_14	2	varchar	673	674	
PROVIDER_PARISH_15	2	varchar	675	676	
Prescriber_Indicator	1	varchar	677	677	
FILLER	3	varchar	678	680	

Appendix Z

Chisholm Electronic File Layout for CSOC Information

Document Date: 11/17/2015 Subject to Change

PART 1: FILE SUBMISSIONS

File is received by Molina from Statistical Research (SRI) on a monthly basis at the beginning of each month to reflect the data for the prior month. The file will be sent to each plan and will contain only the data fields shown below.

Molina File submission naming convention: STOLA_MOLINA_CHISHOLM_YYYYMM.TXT

YYYYMM is the month of the data on the file.
The submission file has a fixed-length record format. Each record is 114 characters in length, and uses the following record layout. The file does not use delimiters and is formatted as an ASCII text file. File will be moved to the "from Molina" folder for your retrieval.

Field NBR	Columns	Field	Format/Length	Notes
1	1-25	Recipient Last Name	Char(25)	Last Name of the Recipient
2	26-50	Recipient First Name	Char(25)	First Name of the Recipient
3	51-60	Primary Diagnosis	Char(10)	Diagnosis for the child reported in ICD-9 format. Left justified. This field will be ICD-10 format effective with the November file.
4	61-69	SSN	Char(9)	SSN of the Recipient
5	70-70	Filler	Char(1)	Space
6	71-80	Date of Birth	Char(10)	Date of Birth of the Recipient. In the format of MM/DD/CCYY.
7	81-85	Filler	Char(5)	Spaces
8	86-98	Recipient Medical ID	Char(13)	Medical Recipient ID as reported from SRI
9	99-99	Filler	Char(1)	Space
10	100-101	Parish	Char(2)	Parish of recipient
11	102-114	Original Recipient Medical ID	Char(13)	Original recipient ID obtained from Molina file

Appendix AA

LEERS File Layout

FI to MCO

On a weekly basis the FI makes available to the MCO the LDH LEERS File. This file contains specific data related to all of the deliveries for enrollees linked to the MCO. The data is used to validate that each delivery was not prior to 39 weeks, or if prior to 39 weeks, that it was medically necessary.

The MCO is required to retrieve the file from the FI's server in the individual MCO files. The file naming convention is LDH_LEERS_EXPD_CCYYMMDD.TXT. The file layout can be found on the following pages.

MEDICAID CCN INTERFACE

Field Name	Field Size	Field Position	Description	Value
ML_FULL_NAME	30	1-30	Mother's Last Name	Character
FILLER	1	31	FILLER	^
MSSN	9	32-40	Mother's SSN	Numeric; All 8 is None; All 9 is Unknown
FILLER	1	41	FILLER	^
PAY_SPECIFY	16	42-57	Mother's 13-digit Medicaid Recipient ID or 16-digit Medicaid Card Control Number	Numeric; All 9 is unknown
FILLER	1	58	FILLER	^
MDOB	4	59-66	Mother's DOB	YYYYMMDD
FILLER	1	67	FILLER	^
MRCITY	30	68-97	Mother's Resident City	Character
FILLER	1	98	FILLER	^
MRSTATE	2	99-100	Mother's Resident State	Character; State Postal Abbreviation
FILLER	1	101		^
MRZIP	5	102-106	Mother's Resident Zip	Numeric
FILLER	1	107	FILLER	^
IDOB	8	108-115	Child's DOB	YYYYMMDD
FILLER	1	116	FILLER	^
FNPI	10	117-126	Facility NPI Number	Numeric
FILLER	1	127	FILLER	^
HOSPNAME	40	128-167	Facility Name	Character
FILLER	1	168	FILLER	^
Under39	1	169	Under 39 weeks Gestation?	(Y/N)
FILLER	1	170	FILLER	^
NBO_MEDICAL	1	171	Was Delivery Medically indicated?	(Y/N/R); R=Needs Medical Review

Field Name	Field Size	Field Position	Description	Value
FILLER	1	172	FILLER	^
BWGT	4	173-176	Birth Weight of Infant	Numeric; All 9 is unknown
FILLER	1	177	FILLER	^
OWGEST	2	178-179	Gestational age of infant	Numeric; All 9 is unknown
FILLER	1	180	FILLER	^
CIG_BP_DP	1	181	Smoking during preganancy history	(Y/N)
FILLER	1	182	FILLER	^
PRV_PRETERM	1	183	History of preterm birth?	(Y/N)
FILLER	1	184	FILLER	^
PRV_OPPPO	1	185	History of other poor pregnancy outcome?	(Y/N)
FILLER	1	186	FILLER	^
DIAB	1	187	Gestational or other diabetes?	(Y/N)
FILLER	1	188	FILLER	^
HTENSION	1	189	Hypertension (pre-pregnancy or gestational)?	(Y/N)
FILLER	1	190	FILLER	^
39 Week	1	191	39-Week: Spontaneous Active Labor	(Y/N)
FILLER	1	192	FILLER	^
39 Week	1	193	39-Week: Abnormal Fetal Heart Rate or Fetal Distress	(Y/N)
FILLER	1	194	FILLER	^
39 Week	1	195	39-Week: Abruption	(Y/N)
FILLER	1	196	FILLER	^
39 Week	1	197	39-Week: Cardiovascular Disease other than Hypertensive Disorder	(Y/N)
FILLER	1	198	FILLER	^
39 Week	1	199	39-Week: Chronic Pulmonary Disease	(Y/N)
FILLER	1	200	FILLER	^

Field Name	Field Size	Field Position	Description	Value
39 Week	1	201	39-Week: Chorioamnionitis	(Y/N)
FILLER	1	202	FILLER	^
39 Week	1	203	39-Week: Coagulation Defects in Pregnancy	(Y/N)
FILLER	1	204	FILLER	^
39 Week	1	205	39-Week: Fetal malformation or congenital anomaly or disorder	(Y/N)
FILLER	1	206	FILLER	^
39 Week	1	207	39-Week: HIV	(Y/N)
FILLER	1	208	FILLER	^
39 Week	1	209	39-Week: Intrauterine growth restriction	(Y/N)
FILLER	1	210	FILLER	^
39 Week	1	211	39-Week: Isoimmunization	(Y/N)
FILLER	1	212	FILLER	^
39 Week	1	213	39-Week: Maternal renal or liver disease	(Y/N)
FILLER	1	214	FILLER	^
39 Week	1	215	39-Week: Placenta or vasa previa	(Y/N)
FILLER	1	216	FILLER	^
39 Week	1	217	39-Week: Polyhydraminios or Oligohydramnios	(Y/N)
FILLER	1	218	FILLER	^
39 Week	1	219	39-Week: Previously scarred uterus other than low transverse	(Y/N)
FILLER	1	220	FILLER	^
39 Week	1	221	39-Week: Premature rupture of the membranes (PROM)	(Y/N)
FILLER	1	222	FILLER	^
39 Week	1	223	39-Week: Preterm Premature rupture of the membranes (Preterm PROM or PPROM)	(Y/N)

Field Name	Field Size	Field Position	Description	Value
FILLER	1	224	FILLER	^
39 Week	1	225	39-Week: Diabetes - Prepregnancy	(Y/N)
FILLER	1	226	FILLER	^
39 Week	1	227	39-Week: Diabetes - Gestational	(Y/N)
FILLER	1	228	FILLER	^
39 Week	1	229	39-Week: Hypertension - Prepregnancy	(Y/N)
FILLER	1	230	FILLER	^
39 Week	1	231	39-Week: Hypertension - Gestational	(Y/N)
FILLER	1	232	FILLER	^
39 Week	1	233	39-Week: Hypertension - Eclampsia	(Y/N)
FILLER	1	234	FILLER	^
39 Week	1	235	39-Week: Fetal Presentation at Birth - Breech	(Y/N)
FILLER	1	236	FILLER	^
39 Week	1	237	39-Week: Fetal Presentation at Birth - Other (Non-cephalic, does NOT include vertex or cephalic)	(Y/N)
FILLER	1	238	FILLER	^
39 Week	1	239	39-Week: No Reason Listed, Need Medical Review	(Y/N)
FILLER	1	240	FILLER	^
39 Week	1	241	39-Week: No medical reason	(Y/N)
FILLER	1	242	FILLER	^
SF_NO	18	243-260	State File Number (only for registered records)	119YYYYVVV00CCC Y=Year; V=Volume; C=Certificate
FILLER	1	261	FILLER	^
SEX	1	262	Infant's Sex	(M,F,N)
FILLER	1	263	FILLER	^

Field Name	Field Size	Field Position	Description	Value
NICU	1	264	NICU Admission?	(Y,N)
FILLER	1	265	FILLER	^

Appendix AB

Psychiatric Residential Treatment Facility File Layout

FI to MCO

On a weekly basis, LDH's FI to the MCO the Psychiatric Residential Treatment Facility file layout. This file identifies Medicaid members in a PRTF.

The file is placed on the FI's non-EDI sFTP server in each MCO's "From FI" folder. The file name
is

CC-PRTF-NNNNNNN- MMMMMMDD.txt where nnnnnnn is the MCO's Plan ID.

The file layout can be found on the following page.

Item	Columns	Description	Type	Length
1	1-13	Recipient's Medicaid ID	char	13
2	14	delimiter, value is ^	char	1
3	15-22	PRTF begin date	num	8, format=yyyymmdd
4	23	delimiter, value is ^	char	1
5	24-31	PRTF end date	num	8, format=yyyymmdd
6	32	delimiter, value is ^	char	1
7	33-42	PRTF NPI	char	10
8	43	delimiter, value is ^	char	1
9	44-52	Recipient's SSN	char	9
10	53	delimiter, value is ^	char	1
11	54-61	Recipient's DOB	num	8, format=yyyymmdd
12	62	delimiter, value is ^	char	1
13	63-70	PRTF auth date	num	8, format=yyyymmdd
14	71	delimiter, value is ^	char	1
15	72-78	Plan ID	num	7
16	79	delimiter, value is ^	char	1

End of Record

Appendix AC

Third Party Liability (TPL) Batch Full Reconciliation File Layout

FI TO MCO

The Third Party Liability (TPL) Batch Full Reconciliation File is made available by LDH's FI to the MCOs on a monthly basis. MCOs are required to utilize the file to review their TPL information for completeness with what LDH MMIS has on record, and then make necessary corrections.

The file is placed in the MCOs' From_FI folder on the FI's non-EDI sFTP server with the following file naming convention: CCNnnnnnnn_TPLFULLYYYYMMYY.txt (where nnnnnnn is your MCO ID and YYYYMMDD is the date of the file).

The TPL Batch Full Reconciliation File layout can be found on the following page.

Field Nbr	***Column(s)***	***Field Identification***	***Format/Length***	***Notes***
1	1-13	Member Medicaid ID (current)	char 13	
2	14-26	Member Medicaid ID (original)	char 13	
3	27-28	Insurance Type Indicator	char 2	PR=Private TPL, MA=Medicare Part A, MB=Medicare Part B, LH=LaHIPP.
4	29-34	Insurance Company Number	char 6	Louisiana Medicaid Carrier Code.
5	35-36	Scope of Coverage	char 2	See DED for Scopes of Coverage; Note that value 30=Medicare Part C (Medicare HMO).
6	37-48	Medicare HIC Number	char 12	
7	49-56	Insurance Begin Date	num 6	format=yyyymmdd.
8	57-64	Insurance End Date	num 6	format=yyyymmdd.
9	65-79	Insurance Group Number	char 15	
10	80-92	Insurance Policy Number	char 13	
11	93-112	Insurance Policy Holder Name	char 20	
12	113-121	Insurance Policy Holder SSN	char 9	
13	122-146	Agent Name	char 25	
14	147-156	Agent Phone Number	char 10	
15	157-181	Agent Street	char 25	
16	182-201	Agent City	char 20	
17	202-203	Agent State	char 2	
18	204-212	Agent Zip	char 9.	

END OF RECORD LAYOUT

Appendix AD

Behavioral Health Provider Types and Specialties

Revised: 1/23/2019

The following pages contain a complete list of Behavioral Health Provider Types and Specialties. The MCO may utilize this list when assigning and/or confirming these data elements.

Louisiana Specialized Behavioral Health Provider Types (PT), Provider Specialties (PS), and Provider Subspecialties (PSS) Grid (Revised 01.15.2019)				
Service	**Provider Description**	**PT**	**PS**	**PSS**
Crisis Stabilization	Center Based Respite	83	8E	
	Crisis Receiving Center	AF	8E	
	Therapeutic Foster Care	AR	9F	
Behavioral Health Rehabilitation Services	Mental Health Rehabilitation Agency **(Legacy MHR)**	77	78	
	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	8E
	Behavioral Health Rehab Provider Agency **(Non-Legacy MHR)**	AG	8E	
	Assertive Community Treatment Team (ACT Services)	AA	8E	
	Multi-Systemic Therapy Agency (MST Services)	12	5M	
	Non-Licensed Behavioral Health Staff *	NB	8E	
Therapeutic Group Home	Therapeutic Group Home	AT	5X	
Addiction Services Outpatient	Substance Abuse and Alcohol Abuse Center (Outpatient)	68	70	
	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	
	Licensed Addiction Counselor	AJ	8E	
	Psychiatric Residential Treatment Facility	96	9B	

Psychiatric Residential Treatment Facility	Psychiatric Residential Treatment Facility Addiction	96	8U	
	Psychiatric Residential Treatment Facility Other Specialization	96	8R	
Psychiatric Inpatient	Free Standing Psychiatric Hospital	64	86	
	Distinct Part Psychiatric Unit	69	86	
Outpatient Therapy	Mental Health Rehabilitation Agency **(Legacy MHR)**	77	78	
	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	
	Psychologist - Clinical **	31	6A	
	Psychologist - Counseling **	31	6B	
	Psychologist - School **	31	6C	
	Psychologist - Developmental **	31	6D	
	Psychologist - Non-Declared (General) **	31	6E	
	Psychologist - Other **	31	6F	
	Medical Psychologist **	31	6G	
	Behavioral Health Rehab Agency **(Non-Legacy MHR)**	AG	8E	
	Substance Abuse and Alcohol Abuse Center (Outpatient)	68	70	
	School Based Health Center	38	70	
	Federally Qualified Health Center	72	42	8E
	Rural Health Clinic (Provider Based)	79	94	8E
	Rural Health Clinic (Independent)	87	94	8E
	Licensed Clinical Social Worker **	73	73	
	Licensed Professional Counselor **	AK	8E	
	Licensed Marriage and Family Therapist **	AH	8E	
	Doctor of Osteopathic Medicine - Psychiatry **	19	26	
	Doctor of Osteopathic Medicine - Psychiatry, Neurology **	19	27	
	Doctor of Osteopathic Medicine - Psychiatry, Neurology, Addiction Medicine **	19	2W	

	Psychiatrist - Psychiatry **	20	26	
	Psychiatrist - Psychiatry, Addiction Psychiatry **	20	2W	
	Advanced Practice Registered Nurse - Nurse Practitioner **	78	26	
	Advanced Practice Registered Nurse - Clinical Nurse Specialist **	93	26	
	Physician Assistant **	94	26	
Substance Use Residential	Substance Use Residential Treatment Facility	AZ	8U	
Coordinated System of Care (CSoC)	Family Support Organization (Parent/Youth Support and Training)	AC	5L	8E
	Independent Living/Skills Building - Individual	AD	5U	8E
	Independent Living/Skills Building - Agency/Business	AD	5V	8E
	Short-Term Respite - Respite Care Services Agency	AE	8E	
	Short-Term Respite - Personal Care Attendant (PCA) Agency	82	8E	
	Short-Term Respite - Crisis Receiving Center	AF	8E	
	Short-Term Respite - Child-Placing Agency (Therapeutic Foster Care)	AR	9F	8E
	Short-Term Respite - Supervised Independent Living (SIL) Agency	89	8E	

* Staff providing mental health rehabilitation (MHR) services must operate under an agency license issued by LDH. MHR services may not be performed by an individual, who is not under the authority of an agency license.

** Group practices of licensed practitioners are enrolled with the assigned provider type (PT) and provider specialty (PS) as established above, with a **provider sub-specialty (PSS) of 70.** EX: Psychiatry Group Practice - PT=20, PS=26, PSS=70. Agency types may not be designated as group practices. This includes MHR Agencies, Mental Health Clinics, BH Rehab Agencies, SU/AU Outpt Centers, SBHCs, FQHCs, and RHCs.

Appendix AE

Magellan Prior Authorization (PA) File Layout

(FI to MCO)

LDH provides to the MCO, thru its FI a Prior Authorization File of all open prior authorizations as received from the Statewide Management Organization (SMO) for Behavioral Health. The FI identifies the enrollees linked to the MCO, creates and loads the file to the MCO's non-EDI folder on the FI's sFTP server from which the MCO is required to retrieve it.

NOTE: The schedule for the file TBD.

The file name is MGLN-PA-nnnnnnn-20151001.txt (where nnnnnnn is the Plan ID and 20151001 is the date the file was created). The Magellan Prior Authorization File Layout can be found on the following pages.

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
Authorization MAT Number	AUTH_MAT_NUM	Magellan authorization number	Closed cases only on post-transition CRs	CHAR	9	1-9
Member Magellan ID	MEMB_MAG_ID	Magellan member identifier	Bypass cases are "999999999"	CHAR	13	10-22
Member Medicaid ID	MEMB_MED_NUM	Medicaid Recipient ID		INT	13	23-35
Member SSN	MEMB_SSN			INT	9	36-44
Member First Name	MEMB_FNAM			CHAR	15	45-59
Member Last Name	MEMB_LNAM			CHAR	25	60-84
Member Middle Initial	MEMB_MNAM			CHAR	1	85-85
Member Date of Birth	MEMB_DOB			DATE	8	86-93
Member Gender	MEMB_GENDER	M/F		CHAR	1	94-94
Facility NPI	FACIL_NPI	10-digit Provider NPI number		INT	10	95-104
Facility Tax ID	FACIL_TAXID	9-digit Tax ID		INT	9	105-113

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
Facility Name	FACIL_NAME			CHAR	50	114-163
Facility Address 1	FACIL_ADD1			CHAR	50	164-213
Facility Address 2	FACIL_ADD2			CHAR	50	214-263
Facility City	FACIL_CITY			CHAR	25	264-288
Facility State	FACIL_STATE			CHAR	4	289-292
Facility Zip 1	FACIL_ZIP1			INT	5	293-297
Facility Zip 2	FACIL_ZIP2			INT	4	298-301
Facility In/Out Network Status	FACIL_NET	INN/OON		CHAR	3	302-304
Provider NPI	PROVID_NPI	10-digit Provider NPI number		INT	10	305-314
Provider Tax ID	PROVID_TAXID	9-digit Tax ID		INT	9	315-323
Provider Name	PROVID_NAME			CHAR	50	324-373
Provider Address 1	PROVID_ADD1			CHAR	50	374-423
Provider Address 2	PROVID_ADD2			CHAR	50	424-473
Provider City	PROVID_CITY			CHAR	25	474-498

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
Provider State	PROVID_STATE			CHAR	4	499-502
Provider Zip 1	PROVID_ZIP1			INT	5	503-507
Provider Zip 2	PROVID_ZIP2			INT	4	508-511
Provider In/Out Network Statue	PROVID_NET	INN/OON		CHAR	3	512-514
Primary Diagnosis	PRIMARY_DX	ICD9/10 Code		CHAR	10	515-524
Secondary Diagnosis	SECONDARY_DX	ICD9/10 Code		CHAR	10	525-534
Tertiary Diagnosis	TERTIARY_DX	ICD9/10 Code		CHAR	10	535-544
Diagnosis Type	DIAG_TYPE	Indicates ICD9 or 10		INT	2	545-546
Level of Care	LVL_OF_CARE	Full text of Final Outcome		CHAR	50	547-596
Place of Service	PLS_OF_SVC	Full text of Place of Service		CHAR	50	597-646
Problem Type	PROB_TYPE	Full text of Problem Type		CHAR	50	647-696
Admission Date	ADMIT_DT	Initial Admission Date		DATE	8	697-704
Admission Type	ADMIT_TYPE	Urgent/Emergent/Routine		CHAR	1	705-705

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
Authorization Start Date	START_DT	Initial Authorization Start Date	Start date of the authorization, not necessarily this particular CR	DATE	8	706-713
Authorization End Date	END_DT	Authorization End Date	Final End date of the authorization, not necessarily this particular CR	DATE	8	714-721
Closing Resolution	CLOSE_RESOL	Full text of Closing Resolution	Closed cases only on post-transition CRs	CHAR	50	722-771
Denial Reason	DENY_REASON	Full text of Denial Reason	Denials only on post-transition CRs	CHAR	50	772-821
Authorization Status	AUTH_STATUS	Authorized/Denied	Denials only on post-transition CRs	CHAR	1	822-822
Units Requested	UNIT_REQ	Units Requested in this CR		INT	3	823-825
Units Approved	UNIT_APPR	Units Approved in this CR		INT	3	826-828
CPT 1 Code	CPT1_CODE	First CPT Code of CR		CHAR	5	829-833
CPT 1 Units	CPT1_UNITS	Units for this CPT code in this CR		INT	3	834-836
CPT 1 Modifier 1	CPT1_MOD1			CHAR	2	837-838
CPT 1 Modifier 2	CPT1_MOD2			CHAR	2	839-840
CPT 2 Code	CPT2_CODE	Second CPT Code of CR		CHAR	5	841-845

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
CPT 2 Units	CPT2_UNITS	Units for this CPT code in this CR		INT	3	846-848
CPT 2 Modifier 1	CPT2_MOD1			CHAR	2	849-850
CPT 2 Modifier 2	CPT2_MOD2			CHAR	2	851-852
CPT 3 Code	CPT3_CODE	Third CPT Code of CR		CHAR	5	853-857
CPT 3 Units	CPT3_UNITS	Units for this CPT code in this CR		INT	3	858-860
CPT 3 Modifier 1	CPT3_MOD1			CHAR	2	861-862
CPT 3 Modifier 2	CPT3_MOD2			CHAR	2	863-864
CPT 4 Code	CPT4_CODE	Fourth CPT Code of CR		CHAR	5	865-869
CPT 4 Units	CPT4_UNITS	Units for this CPT code in this CR		INT	3	870-872
CPT 4 Modifier 1	CPT4_MOD1			CHAR	2	873-874
CPT 4 Modifier 2	CPT4_MOD2			CHAR	2	875-876

Appendix AF

17P Preterm Birth History FILE LAYOUT

Document Date: 02/04/2016
Subject to Change

PART 1: ULM FILE SUBMISSIONS

File submissions should occur quarterly. Exact time each quarter is yet to be determined.
File submission will be to the Molina sFTP site in the following folder: SAS_WORK\ULM\DATA\HEDIS\Preterm_Birth_Mothers
This file will be archived by Molina and put in the SAS_PROD\Outbound folder where it will be captured for the processing on the mainframe computer by Molina.

ULM File submission naming convention: **Preterm_Birth_History.txt**
The submission file has a fixed-length record format. Each record is 76 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields are optional (O). If a field is optional, then a value of spaces is acceptable. The file does use delimiters (^) and is formatted as an ASCII text file.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***

1	1-13	Original Recipient ID	num(13)	R	Original Medicaid recipient ID of the mother.
2	14-14	delimiter	char(1)	R	Constant value of “^”.
3	15-27	Current Recipient ID	num(13)	R	Current Medicaid recipient ID of the mother. This could be the same as field 1.
4	28-28	delimiter	char(1)	R	Constant value of “^”
5	29-36	Date of Birth	num(8)	R	The Date of Birth of the infant. In the format of YYYYMMDD.
6	37-37	delimiter	char(1)	R	Constant value of “^”.
7	38-39	Infants Gestational Age	num(2)	R	Gestaional age of the child in weeks.
8	40-40	delimiter	char(1)	R	Constant value of “^”.
9	41-41	Plurity Number	num(1)	R	Plurity of Birth. 1 = Singleton 2 = Twins 3 = More than 2
10	42-42	delimiter	char(1)	R	Constant value of “^”.
11	43-57	State File Number	char(15)	R	Should match to State File number reported on the LEERS data file. Format of: 119YYYYVVV00CCC Y=Year; V=Volume; C=Certificate NOTE: The length of this field on the LEER data file is 18 with 3 spaces at the end of the field. Also for data prior to LEERS the number can be a 4 or 6 digit number.

12	58-58	delimiter	char(1)	R	Constant value of "^".
13	59-59	Abruption Ind	char(1)	O	Abruption occurred during This pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
14	60-60	delimiter	char(1)	R	Constant value of "^".
15	61-61	Hypertension Ind	char(1)	O	Hypertension occurred during this pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
16	62-62	delimiter	char(1)	R	Constant value of "^".
17	63-68	Birth History Measurement Begin Period	char(6)	R	The starting time frame for the data collection (Measurement Year). In the format of YYYYMM.
18	69-69	delimiter	char(1)	R	Constant value of "^".
19	70-75	Birth History Measurement End Period	char(6)	R	The ending time frame for the data collection (Measurement Year). In the format of YYYYMM.
20	76-76	delimiter	char(1)	R	Constant value of "^".

END OF RECORD LAYOUT

PART 2: Molina Processing and forwarding of file to MCO's

Molina will capture the file sent by ULM. Molina will run the information against the plan enrollment and based on the Birth History Begin and End Period determine which plan, if any , that the mother was enrolled. Plan enrollment for the "B" (Behavioral Health Program) will be ignore for this selection process. Depending on which plan the recipient was enrolled in during the time period all data for that recipient will be forwarded to that MCO.

File submission by Molina will be to the Molina sFTP site in the following folder: FTADATA\Data*plan node*\from_molina
plan node will be AETNA; LHC; UHCMCO; LACARE; and AMERIGROUP
The return text file will use the naming convention: **17P_Birth_History.YYYYMMDD.txt**
An e-mail will be sent to each plan when the file has been transmitted.

Below is the format of the return file. The file has a fixed-length record format. Each record is 76 characters in length, and uses the following record layout. This is an exact copy of the file from ULM..

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-13	Original Recipient ID	num(13)	R	Original Medicaid recipient ID of the mother.
2	14-14	delimiter	char(1)	R	Constant value of "^".
3	15-27	Current Recipient ID	num(13)	R	Current Medicaid recipient ID of the mother. This could be the same as field 1.
4	28-28	delimiter	char(1)	R	Constant value of "^"
5	29-36	Date of Birth	num(8)	R	The Date of Birth of the infant. In the format of YYYYMMDD.
6	37-37	delimiter	char(1)	R	Constant value of "^".
7	38-39	Infants Gestational Age	num(2)	R	Gestaional age of the child in weeks.
8	40-40	delimiter	char(1)	R	Constant value of "^".
9	41-41	Plurity Number	num(1)	R	Plurity of Birth.

					1 = Singleton 2 = Twins 3 = More than 2
10	42-42	delimiter	char(1)	R	Constant value of “^”.
11	43-57	State File Number	char(15) C=Certificate	R	Should match to State File number reported on the LEERS data file. Format of: 119YYYYVVV00CCC Y=Year; V=Volume; NOTE: The length of this field on the LEER data file is 18 with 3 spaces at the end of the field. Also for data prior to LEERS the number can be a 4 or 6 digit number.
12	58-58	delimiter	char(1)	R	Constant value of “^”.
13	59-59	Abruption Ind	char(1)	O	Abruption occurred during This pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
14	60-60	delimiter	char(1)	R	Constant value of “^”.
15	61-61	Hypertension Ind	char(1)	O	Hypertension occurred during this pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
16	62-62	delimiter	char(1)	R	Constant value of “^”.
17	63-68	Birth History Measurement Begin Period	char(6)	R	The starting time frame for

					the data collection (Measurement Year). In the format of YYYYMM.
18	69-69	delimiter	char(1)	R	Constant value of "^".
19	70-75	Birth History Measurement End Period	char(6)	R	The ending time frame for the data collection (Measurement Year). In the format of YYYYMM.
20	76-76	delimiter	char(1)	R	Constant value of "^".

END OF RECORD LAYOUT

Appendix AG

LEER Elective Deliveries FILE LAYOUT

Document Date: 03/09/2016
Subject to Change

PART 1: OPH FILE SUBMISSIONS

File submissions should occur nightly on each Thursday.
File submission will be to the LDH sFTP site in the following folder: MEDCAD\OUTGOING

OPH/Vital Records File submission naming convention: **LEERS-YYYYMMDD.TXT**
Whereas the YYYYMMDD represents the date of the file
The submission file has a fixed-length record format. Each record is 345 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields might be optional (O). If a field is optional, then a value of spaces is acceptable, unless otherwise noted. The file does use delimiters (^) and is formatted as an ASCII text file.
This is the third version of this extract as the original transmission was 189 characters in length, the second was 265 characters in length. Additional data was added to the end of each version of the file.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-30	Recipient's Last Name	Char(30)	R	Recipient's Last Name
2	31-31	delimiter	char(1)	R	Constant value of "^,"
3	32-40	Recipient's SSN	num(9)	R	SSN. All 8 is None; all 9 is Unknown.
4	41-41	delimiter	char(1)	R	Constant value of "^".
5	42-57	Recipient's Medicaid ID	char(16)	R	Recipient ID number (position 1-13) or CCN (position 1-16). All 9 is Unknown.

6	58-58	delimiter	char(1)	R	Constant value of “^”.
7	59-66	Recipient’s Date of Birth	num(8)	R	The Date of Birth of the mother. In the format of YYYYMMDD.
8	67-67	delimiter	char(1)	R	Constant value of “^”.
9	68-97	Recipient’s Resident City	char(30)	R	City of Residence.
10	98-98	delimiter	char(1)	R	Constant value of “^”.
11	99-100	Recipient’s Resident State	char(2)	R	State of Residence. State Postal Abbreviation.
12	101-101	delimiter	char(1)	R	Constant value of “^”.
13	102-106	Recipient’s Resident Zip	num(5)	R	Zip Code of Resdence.
14	107-107	delimiter	char(1)	R	Constant value of “^”.
15	108-115	Child’s Date of Birth	num(8)	R	The Date of Birth of the child. In the format of YYYYMMDD.
16	116-116	delimiter	char(1)	R	Constant value of “^”.
17	117-126	Facility NPI number	num(10)	R	National Provider Identificaiton Number for the Facility.
18	127-127	delimiter	char(1)	R	Constant value of “^”.
19	128-167	Facility Name	char(40)	R	Name of the Facility.
20	168-168	delimiter	char(1)	R	Constant value of “^”.
21	169-169	39-Week Gestation	char(1)	R	Was the Gestation under 39 weeks. Y-Yes; N-No.
22	170-170	delimiter	char(1)	R	Constant value of “^”.
23	171-171	Deliver Medically Indicated	char(1)	R	Was the Delivery medicated indicated. Y-Yes; N-No; R-Needs Medical Review.
24	172-172	delimiter	char(1)	R	Constant value of “^”.
25	173-176	Birth Weight	num(4)	R	Weight of Infant at Birth. All 9 is Unknown.
26	177-177	delimiter	char(1)	R	Constant value of “^”.
27	178-179	Gestational age	num(2)	R	Gestational Age of Infant at birth. All 9 is Unknown.
28	180-180	delimiter	char(1)	R	Constant value of “^”.
29	181-181	Smoking indicator	char(1)	R	Indicates if mother was smoking during

					pregnancy history. Y-Yes; N-No.
30	182-182	delimiter	char(1)	R	Constant value of “^”.
31	183-183	Preterm Birth	char(1)	R	History of Preterm Birth. Y-Yes; N-No.
32	184-184	delimiter	char(1)	R	Constant value of “^”.
33	185-185	Poor Pregnancy Outcome	char(1)	R	History of other Poor Pregnancy Outcome. Y-Yes; N-No.
34	186-186	delimiter	char(1)	R	Constant value of “^”.
35	187-187	Diabetes	char(1)	R	Gestational or other Diabetes. Y-Yes; N-No.
36	188-188	delimiter	char(1)	R	Constant value of “^”.
37	189-189	Hypertension	char(1)	R	Gestational or Pre-Pregnancy Hypertension. Y-Yes; N-No.
38	190-190	delimiter	char(1)	R	Constant value of “^”.
39	191-191	39 Week: Labor	char(1)	R	Spontaneous Active Labor. Y-Yes; N-No.
40	192-192	delimiter	char(1)	R	Constant value of “^”.
41	193-193	39 Week: Fetal Heart Rate/Distress	char(1)	R	Abnormal Fetal Heart Rate or Distress. Y-Yes; N-No.
42	194-194	delimiter	char(1)	R	Constant value of “^”.
43	195-195	39 Week: Abruption	char(1)	R	Abruption. Y-Yes; N-No.
44	196-196	delimiter	char(1)	R	Constant value of “^”.
45	197-197	39 Week: Cardiovascular Disease	char(1)	R	Cardiovascular Disease other than Hypertenseive Disorder. Y-Yes; N-No.
46	198-198	delimiter	char(1)	R	Constant value of “^”.

47	199-199	39 Week: Pulmonary Disease	char(1)	R	Chronic Pulmonary Disease. Y-Yes; N-No.
48	200-200	delimiter	char(1)	R	Constant value of “^”.
49	201-201	39 Week: Chorioamnionitis	char(1)	R	Chorioamnionitis. Y-Yes; N-No.
50	202-202	delimiter	char(1)	R	Constant value of “^”.
51	203-203	39 Week: Coagulation	char(1)	R	Coagulation Defects in Pregnancy. Y-Yes; N-No.
52	204-204	delimiter	char(1)	R	Constant value of “^”.
53	205-205	39 Week: Malformation	char(1)	R	Fetal Malformation or Congenital anomaly or disorder. Y-Yes; N-No.
54	206-206	delimiter	char(1)	R	Constant value of “^”.
55	207-207	39 Week: HIV	char(1)	R	HIV. Y-Yes; N-No.
56	208-208	delimiter	char(1)	R	Constant value of “^”.
57	209-209	39 Week: Growth Restriction	char(1)	R	Intrauterine Growth Restriction. Y-Yes; N-No.
58	210-210	delimiter	char(1)	R	Constant value of “^”.
59	211-211	39 Week: Isoimmunization	char(1)	R	Isoimmunization. Y-Yes; N-No.
60	212-212	delimiter	char(1)	R	Constant value of “^”.
61	213-213	39 Week: Renal or Liver Disease	char(1)	R	Maternal Renal or Liver Disease. Y-Yes; N-No.
62	214-214	delimiter	char(1)	R	Constant value of “^”.
63	215-215	39 Week: Placenta	char(1)	R	Placenta or vasa previa. Y-Yes; N-No.
64	216-216	delimiter	char(1)	R	Constant value of “^”.
65	217-217	39 Week: Polyhydraminios	char(1)	R	Polyhydraminios or Oligohydramnios. Y-Yes; N-No.
66	218-218	delimiter	char(1)	R	Constant value of “^”.
67	219-219	39 Week: Previously Scarred	char(1)	R	Previously scarred Uterus other than

					Low transverse. Y-Yes; N-No.
68	220-220	delimiter	char(1)	R	Constant value of “^”.
69	221-221	39 Week: PROM	char(1)	R	Premature rupture of the membranes (PROM). Y-Yes; N-No.
70	222-222	delimiter	char(1)	R	Constant value of “^”.
71	223-223	39 Week: Preterm PROM	char(1)	R	Preterm Premature rupture of the Membranes (PPROM). Y-Yes; N-No.
72	224-224	delimiter	char(1)	R	Constant value of “^”.
73	225-225	39 Week: Diabetes -Prepregnancy	char(1)	R	Diabetes – Prepregnancy. Y-Yes; N-No.
74	226-226	delimiter	char(1)	R	Constant value of “^”.
75	227-227	39 Week: Diabetes-Gestational	char(1)	R	Diabetes - Gestational. Y-Yes; N-No.
76	228-228	delimiter	char(1)	R	Constant value of “^”.
77	229-229	39 Week: Hypertension-Prepregnancy	char(1)	R	Hypertension – PrePregnancy. Y-Yes; N-No.
78	230-230	delimiter	char(1)	R	Constant value of “^”.
79	231-231	39 Week: Hypertension-Gestational	char(1)	R	Hypertension - Gestational. Y-Yes; N-No.
80	232-232	delimiter	char(1)	R	Constant value of “^”.
81	233-233	39 Week: Hypertension-Eclampsia	char(1)	R	Hypertension - Eclampsia. Y-Yes; N-No.
82	234-234	delimiter	char(1)	R	Constant value of “^”.
83	235-235	39 Week: Fetal Presentation - Breech	char(1)	R	Fetal Presentation at Birth – Breech. Y-Yes; N-No.
84	236-236	delimiter	char(1)	R	Constant value of “^”.
85	237-237	39 Week: Fetal Presentation - Other	char(1)	R	Fetal Presentation at Birth – Other (Non-cephalic, does

					Not include vertex or cephalic). Y-Yes; N-No.
86	238-238	delimiter	char(1)	R	Constant value of “^”.
87	239-239	39 Week: Need Medical Review	char(1)	R	No reason given; Need Medical Review. Y-Yes; N-No.
88	240-240	delimiter	char(1)	R	Constant value of “^”.
89	241-241	39 Week: No Medical Reason	char(1)	R	No Medical Reason. Y-Yes; N-No.
90	242-242	delimiter	char(1)	R	Constant value of “^”.
91	243-260	State File Number	char(18)	R	Unique number assigned by Vital Records when birth record is registered. Format of 119YYYYVVV00CCC Y=Year; V=Volume; C-Certificate
92	261-261	delimiter	char(1)	R	Constant value of “^”.
93	262-262	Infant Sex	char(1)	R	Infant’s Sex. M-Male; F-Female; N-Not Yet Determined.
94	263-263	delimiter	char(1)	R	Constant value of “^”.
95	264-264	NICU Admission	char(1)	R	Was this NICU admission. Y-Yes; N-No.
96	265-265	delimiter	char(1)	R	Constant value of “^”.
97	266-266	Augmentation of Labor	char(1)	R	Was Augmention used in delivery. Y-Yes; N-No.
98	267-267	delimiter	char(1)	R	Constant value of “^”.
99	268-268	Induction of Labor	char(1)	R	Was Induction used in delivery. Y-Yes; N-No.
100	269-269	delimiter	char(1)	R	Constant value of “^”.
101	270-270	Final Route - Cesarean	char(1)	R	Was Method of Delivery Cesarean. Y-Yes; N-No.
102	271-271	delimiter	char(1)	R	Constant value of “^”.
103	272-272	Final Route – Vaginal/Forceps	char(1)	R	Was Forceps used for Delivery.

					Y-Yes; N-No.
104	273-273	delimiter	char(1)	R	Constant value of “^”.
105	274-274	Final Route – Vaginal/Spontaneous	char(1)	R	Was Delivery Spontaneous. Y-Yes; N-No.
106	275-275	delimiter	char(1)	R	Constant value of “^”.
107	276-276	Final Route – Vaginal/Vacuum	char(1)	R	Was Vacuum used for Delivery. Y-Yes; N-No.
108	277-277	delimiter	char(1)	R	Constant value of “^”.
109	278-307	Method of Delivery - Other	char(30)	R	Specify the Method of Delivery. Y-Yes; N-No.
110	308-308	delimiter	char(1)	R	Constant value of “^”.
111	309-309	Cephalic Presentation	char(1)	R	Was this Cephalic Presentation at Birth. Y-Yes; N-No.
112	310-310	delimiter	char(1)	R	Constant value of “^”.
113	311-311	Breech Presentation	char(1)	R	Was this Breech Presentation at Birth. Y-Yes; N-No.
114	312-312	delimiter	char(1)	R	Constant value of “^”.
115	313-313	Other Presentation	char(1)	R	Was Method of Presentation via Other methods. Y-Yes; N-No.
116	314-314	delimiter	char(1)	R	Constant value of “^”.
117	315-316	Plurality	num(2)	R	Number of births from this Pregnancy. Numeric (00–99) with 99 being Unknown.
118	317-317	delimiter	char(1)	R	Constant value of “^”.
119	318-319	Previous Live Birth - Living	num(2)	R	Number of previous Live Births that are now Living (Not including this child). Numeric (00–99) with 99 being Unknown.
120	320-320	delimiter	char(1)	R	Constant value of “^”.

121	321-322	Previous Live Birth – Now Dead	num(2)	R	Number of previous Live Births that are now Dead (Not including this child). Numeric (00–99) with 99 being Unknown.
122	323-323	delimiter	char(1)	R	Constant value of “^”.
123	324-325	Previous Other Pregnancy Outcomes	num(2)	R	Number of previous Other Pregnancy Outcomes. Numeric (00–99) with 99 being Unknown.
124	326-326	delimiter	char(1)	R	Constant value of “^”.
125	327-327	Previous C-Section	char(1)	R	Did mother have previous C-Section. Y-Yes; N-No.
126	328-328	delimiter	char(1)	R	Constant value of “^”.
127	329-330	Number of Previous C-Section	num(2)	R	Number of Previous C-Sections. Numeric (00–99) with 99 being Unknown.
128	331-331	delimiter	char(1)	R	Constant value of “^”.
129	332-332	Eclampsia	char(1)	R	Was there Eclampsia. Y-Yes; N-No.
130	333-333	delimiter	char(1)	R	Constant value of “^”.
131	334-334	Pre-Pregnancy Hypertension	char(1)	R	Was there Pre-Pregnancy Hypertension. Y-Yes; N-No.
132	335-335	delimiter	char(1)	R	Constant value of “^”.
133	336-336	Gestational Hypertension	char(1)	R	Was there Gestational Hypertension. Y-Yes; N-No.
134	337-337	delimiter	char(1)	R	Constant value of “^”.
135	338-338	Pre-Pregnancy Diabetes	char(1)	R	Was there Pre-Pregnancy Diabetes. Y-Yes; N-No.
136	339-339	delimiter	char(1)	R	Constant value of “^”.
137	340-340	Gestational Diabetes	char(1)	R	Was there Gestational Diabetes. Y-Yes; N-No.
138	341-341	delimiter	char(1)	R	Constant value of “^”.

139	342-342	Premature Rupture of Membranes	char(1)	R	Was there Premature rupture of membranes during onset of labor. Y-Yes; N-No.
140	343-343	delimiter	char(1)	R	Constant value of “^”.
141	344-344	Steriods Used for Fetal Lung	char(1)	R	Was Steroid (Glucocorticoids) used for Fetal Lung Maturation prior to Delivery. Y-Yes; N-No.
142	345-345	delimiter	char(1)	R	Constant value of “^”.

END OF RECORD LAYOUT

PART 2: Molina Processing and forwarding of file to MCO's

Molina will capture the file sent by OPH. Molina will process the file to capture the Original Recipient ID as that should be the uniform key for every recipient. Molina will also run the information against the plan enrollment and based the Date of Birth of the child determine which plan, if any, for which the mother was enrolled. This will be used to separate the data that is to be sent to the five MCO's. Only information that shows enrollment in the plan is sent to each plan. With this version of the layout all births for the mother will be sent for each recipient, so in the case of twins born on the same day both records will be sent. Or if there are multiple births in the data extract period then both records will be sent to the plan if the recipient is enrolled with that plan at the time of each birth.

File submission by Molina will be to the Molina sFTP site in the following folder: FTADATA\Data*plan node*\from_molina
plan node will be AETNA; LHC; UHCMCO; LACARE; and AMERIGROUP
The return text file will use the naming convention: **DHH_LEERS_EXPD_VER3_yyyymmdd.TXT**

Below is the format of the return file. The file has a fixed-length record format. Each record is 345 characters in length, and uses the following record layout. This is an exact copy of the file from **OPH/Vital Records**.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-30	Recipient's Last Name	Char(30)	R	Recipient's Last Name
2	31-31	delimiter	char(1)	R	Constant value of "^,"
3	32-40	Recipient's SSN	num(9)	R	SSN. All 8 is None; all 9 is Unknown.
4	41-41	delimiter	char(1)	R	Constant value of "^".
5	42-57	Recipient's Medicaid ID	char(16)	R	Recipient ID number (position 1-13) or CCN (position 1-16). All 9 is Unknown.
6	58-58	delimiter	char(1)	R	Constant value of "^".
7	59-66	Recipient's Date of Birth	num(8)	R	The Date of Birth of the mother. In the format of YYYYMMDD.
8	67-67	delimiter	char(1)	R	Constant value of "^".
9	68-97	Recipient's Resident City	char(30)	R	City of Residence.
10	98-98	delimiter	char(1)	R	Constant value of "^".
11	99-100	Recipient's Resident State	char(2)	R	State of Residence. State Postal

					Abbreviation.
12	101-101	delimiter	char(1)	R	Constant value of “^”.
13	102-106	Recipient’s Resident Zip	num(5)	R	Zip Code of Resdence.
14	107-107	delimiter	char(1)	R	Constant value of “^”.
15	108-115	Child’s Date of Birth	num(8)	R	The Date of Birth of the child. In the format of YYYYMMDD.
16	116-116	delimiter	char(1)	R	Constant value of “^”.
17	117-126	Facility NPI number	num(10)	R	National Provider Identificaiton Number for the Facility.
18	127-127	delimiter	char(1)	R	Constant value of “^”.
19	128-167	Facility Name	char(40)	R	Name of the Facility.
20	168-168	delimiter	char(1)	R	Constant value of “^”.
21	169-169	39-Week Gestation	char(1)	R	Was the Gestation under 39 weeks. Y-Yes; N-No.
22	170-170	delimiter	char(1)	R	Constant value of “^”.
23	171-171	Deliver Medically Indicated	char(1)	R	Was the Delivery medicated indicated. Y-Yes; N-No; R-Needs Medical Review.
24	172-172	delimiter	char(1)	R	Constant value of “^”.
25	173-176	Birth Weight	num(4)	R	Weight of Infant at Birth. All 9 is Unknown.
26	177-177	delimiter	char(1)	R	Constant value of “^”.
27	178-179	Gestational age	num(2)	R	Gestational Age of Infant at birth. All 9 is Unknown.
28	180-180	delimiter	char(1)	R	Constant value of “^”.
29	181-181	Smoking indicator	char(1)	R	Indicates if mother was smoking during pregnancy history. Y-Yes; N-No.
30	182-182	delimiter	char(1)	R	Constant value of “^”.
31	183-183	Preterm Birth	char(1)	R	History of Preterm Birth. Y-Yes; N-No.
32	184-184	delimiter	char(1)	R	Constant value of “^”.

33	185-185	Poor Pregnancy Outcome	char(1)	R	History of other Poor Pregnancy Outcome. Y-Yes; N-No.
34	186-186	delimiter	char(1)	R	Constant value of “^”.
35	187-187	Diabetes	char(1)	R	Gestational or other Diabetes. Y-Yes; N-No.
36	188-188	delimiter	char(1)	R	Constant value of “^”.
37	189-189	Hypertension	char(1)	R	Gestational or Pre-Pregnancy Hypertension. Y-Yes; N-No.
38	190-190	delimiter	char(1)	R	Constant value of “^”.
39	191-191	39 Week: Labor	char(1)	R	Spontaneous Active Labor. Y-Yes; N-No.
40	192-192	delimiter	char(1)	R	Constant value of “^”.
41	193-193	39 Week: Fetal Heart Rate/Distress	char(1)	R	Abnormal Fetal Heart Rate or Distress. Y-Yes; N-No.
42	194-194	delimiter	char(1)	R	Constant value of “^”.
43	195-195	39 Week: Abruption	char(1)	R	Abruption. Y-Yes; N-No.
44	196-196	delimiter	char(1)	R	Constant value of “^”.
45	197-197	39 Week: Cardiovascular Disease	char(1)	R	Cardiovascular Disease other than Hypertenseive Disorder. Y-Yes; N-No.
46	198-198	delimiter	char(1)	R	Constant value of “^”.
47	199-199	39 Week: Pulmonary Disease	char(1)	R	Chronic Pulmonary Disease. Y-Yes; N-No.
48	200-200	delimiter	char(1)	R	Constant value of “^”.
49	201-201	39 Week: Chorioamnionitis	char(1)	R	Chorioamnionitis. Y-Yes; N-No.
50	202-202	delimiter	char(1)	R	Constant value of “^”.

51	203-203	39 Week: Coagulation	char(1)	R	Coagulation Defects in Pregnancy. Y-Yes; N-No.
52	204-204	delimiter	char(1)	R	Constant value of “^”.
53	205-205	39 Week: Malformation	char(1)	R	Fetal Malformation or Congenital anomaly or disorder. Y-Yes; N-No.
54	206-206	delimiter	char(1)	R	Constant value of “^”.
55	207-207	39 Week: HIV	char(1)	R	HIV. Y-Yes; N-No.
56	208-208	delimiter	char(1)	R	Constant value of “^”.
57	209-209	39 Week: Growth Restriction	char(1)	R	Intrauterine Growth Restriction. Y-Yes; N-No.
58	210-210	delimiter	char(1)	R	Constant value of “^”.
59	211-211	39 Week: Isoimmunization	char(1)	R	Isoimmunization. Y-Yes; N-No.
60	212-212	delimiter	char(1)	R	Constant value of “^”.
61	213-213	39 Week: Renal or Liver Disease	char(1)	R	Maternal Renal or Liver Disease. Y-Yes; N-No.
62	214-214	delimiter	char(1)	R	Constant value of “^”.
63	215-215	39 Week: Placenta	char(1)	R	Placenta or vasa previa. Y-Yes; N-No.
64	216-216	delimiter	char(1)	R	Constant value of “^”.
65	217-217	39 Week: Polyhydraminios	char(1)	R	Polyhydraminios or Oligohydramnios. Y-Yes; N-No.
66	218-218	delimiter	char(1)	R	Constant value of “^”.
67	219-219	39 Week: Previously Scarred	char(1)	R	Previously scarred Uterus other than Low transverse. Y-Yes; N-No.
68	220-220	delimiter	char(1)	R	Constant value of “^”.
69	221-221	39 Week: PROM	char(1)	R	Premature rupture of the membranes (PROM). Y-Yes; N-No.

70	222-222	delimiter	char(1)	R	Constant value of "^".
71	223-223	39 Week: Preterm PROM	char(1)	R	Preterm Premature rupture of the Membranes (PPROM). Y-Yes; N-No.
72	224-224	delimiter	char(1)	R	Constant value of "^".
73	225-225	39 Week: Diabetes -Prepregnancy	char(1)	R	Diabetes – Prepregnancy. Y-Yes; N-No.
74	226-226	delimiter	char(1)	R	Constant value of "^".
75	227-227	39 Week: Diabetes-Gestational	char(1)	R	Diabetes - Gestational. Y-Yes; N-No.
76	228-228	delimiter	char(1)	R	Constant value of "^".
77	229-229	39 Week: Hypertension-Prepregnancy	char(1)	R	Hypertension – PrePregnancy. Y-Yes; N-No.
78	230-230	delimiter	char(1)	R	Constant value of "^".
79	231-231	39 Week: Hypertension-Gestational	char(1)	R	Hypertension - Gestational. Y-Yes; N-No.
80	232-232	delimiter	char(1)	R	Constant value of "^".
81	233-233	39 Week: Hypertension-Eclampsia	char(1)	R	Hypertension - Eclampsia. Y-Yes; N-No.
82	234-234	delimiter	char(1)	R	Constant value of "^".
83	235-235	39 Week: Fetal Presentation - Breech	char(1)	R	Fetal Presentation at Birth – Breech. Y-Yes; N-No.
84	236-236	delimiter	char(1)	R	Constant value of "^".
85	237-237	39 Week: Fetal Presentation - Other	char(1)	R	Fetal Presentation at Birth – Other (Non-cephalic, does Not include vertex or cephalic). Y-Yes; N-No.
86	238-238	delimiter	char(1)	R	Constant value of "^".
87	239-239	39 Week: Need Medical Review	char(1)	R	No reason given; Need Medical

					Review. Y-Yes; N-No.
88	240-240	delimiter	char(1)	R	Constant value of “^”.
89	241-241	39 Week: No Medical Reason	char(1)	R	No Medical Reason. Y-Yes; N-No.
90	242-242	delimiter	char(1)	R	Constant value of “^”.
91	243-260	State File Number	char(18)	R	Unique number assigned by Vital Records when birth record is registered. Format of 19YYYYVVV00CCC Y=Year; V=Volume; C-Certificate
92	261-261	delimiter	char(1)	R	Constant value of “^”.
93	262-262	Infant Sex	char(1)	R	Infant’s Sex. M-Male; F-Female; N-Not Yet Determined.
94	263-263	delimiter	char(1)	R	Constant value of “^”.
95	264-264	NICU Admission	char(1)	R	Was this NICU admission. Y-Yes; N-No.
96	265-265	delimiter	char(1)	R	Constant value of “^”.
97	266-266	Augmentation of Labor	char(1)	R	Was Augmention used in delivery. Y-Yes; N-No.
98	267-267	delimiter	char(1)	R	Constant value of “^”.
99	268-268	Induction of Labor	char(1)	R	Was Induction used in delivery. Y-Yes; N-No.
100	269-269	delimiter	char(1)	R	Constant value of “^”.
101	270-270	Final Route - Cesarean	char(1)	R	Was Method of Delivery Cesarean. Y-Yes; N-No.
102	271-271	delimiter	char(1)	R	Constant value of “^”.
103	272-272	Final Route – Vaginal/Forceps	char(1)	R	Was Forceps used for Delivery. Y-Yes; N-No.
104	273-273	delimiter	char(1)	R	Constant value of “^”.

105	274-274	Final Route – Vaginal/Spontaneous	char(1)	R	Was Delivery Spontaneous. Y-Yes; N-No.
106	275-275	delimiter	char(1)	R	Constant value of “^”.
107	276-276	Final Route – Vaginal/Vacuum	char(1)	R	Was Vacuum used for Delivery. Y-Yes; N-No.
108	277-277	delimiter	char(1)	R	Constant value of “^”.
109	278-307	Method of Delivery - Other	char(30)	R	Specify the Method of Delivery. Y-Yes; N-No.
110	308-308	delimiter	char(1)	R	Constant value of “^”.
111	309-309	Cephalic Presentation	char(1)	R	Was this Cephalic Presentation at Birth. Y-Yes; N-No.
112	310-310	delimiter	char(1)	R	Constant value of “^”.
113	311-311	Breech Presentation	char(1)	R	Was this Breech Presentation at Birth. Y-Yes; N-No.
114	312-312	delimiter	char(1)	R	Constant value of “^”.
115	313-313	Other Presentation	char(1)	R	Was Method of Presentation via Other methods. Y-Yes; N-No.
116	314-314	delimiter	char(1)	R	Constant value of “^”.
117	315-316	Plurality	num(2)	R	Number of births from this Pregnancy. Numeric (00–99) with 99 being Unknown.
118	317-317	delimiter	char(1)	R	Constant value of “^”.
119	318-319	Previous Live Birth - Living	num(2)	R	Number of previous Live Births that are now Living (Not including this child). Numeric (00–99) with 99 Being Unknown.
120	320-320	delimiter	char(1)	R	Constant value of “^”.
121	321-322	Previous Live Birth – Now Dead	num(2)	R	Number of previous Live Births that are

					now Dead (Not including this child). Numeric (00–99) with 99 being Unknown.
122	323-323	delimiter	char(1)	R	Constant value of “^”.
123	324-325	Previous Other Pregnancy Outcomes	num(2)	R	Number of previous Other Pregnancy Outcomes. Numeric (00–99) with 99 being Unknown.
124	326-326	delimiter	char(1)	R	Constant value of “^”.
125	327-327	Previous C-Section	char(1)	R	Did mother have previous C-Section. Y-Yes; N-No.
126	328-328	delimiter	char(1)	R	Constant value of “^”.
127	329-330	Number of Previous C-Section	num(2)	R	Number of Previous C-Sections. Numeric (00–99) with 99 Being Unknown.
128	331-331	delimiter	char(1)	R	Constant value of “^”.
129	332-332	Eclampsia	char(1)	R	Was there Eclampsia. Y-Yes; N-No.
130	333-333	delimiter	char(1)	R	Constant value of “^”.
131	334-334	Pre-Pregnancy Hypertension	char(1)	R	Was there Pre-Pregnancy Hypertension. Y-Yes; N-No.
132	335-335	delimiter	char(1)	R	Constant value of “^”.
133	336-336	Gestational Hypertension	char(1)	R	Was there Gestational Hypertension. Y-Yes; N-No.
134	337-337	delimiter	char(1)	R	Constant value of “^”.
135	338-338	Pre-Pregnancy Diabetes	char(1)	R	Was there Pre-Pregnancy Diabetes. Y-Yes; N-No.
136	339-339	delimiter	char(1)	R	Constant value of “^”.
137	340-340	Gestational Diabetes	char(1)	R	Was there Gestational

					Diabetes. Y-Yes; N-No.
138	341-341	delimiter	char(1)	R	Constant value of “^”.
139	342-342	Premature Rupture of Membranes	char(1)	R	Was there Premature rupture of membranes during onset of labor. Y-Yes; N-No.
140	343-343	delimiter	char(1)	R	Constant value of “^”.
141	344-344	Steriods Used for Fetal Lung	char(1)	R	Was Steroid (Glucocorticoids) used for Fetal Lung Maturation prior to Delivery. Y-Yes; N-No.
142	345-345	delimiter	char(1)	R	Constant value of “^”.

END OF RECORD LAYOUT

Appendix AH

ESRD Report

File submission by Molina will be to the Molina sFTP site in the following folder: FTADATA\Data*plan node*\from_molina
plan node will be AETNA; LHC; UHCMCO; LACARE; and AMERIGROUP
The return text file will use the naming convention: **ESRD_FEE_SCHED_yyyymmdd.TXT**

Appendix AI

LDH AAC Drug File (sent by Molina to HLA MCO Plans)

Document Date: 7/20/2018

This file represents drug records with AAC rates, and it is sent to HLA MCO Plans on daily and weekly bases.

Daily files are incremental.
Weekly files are full comprehensive.

Part A. Plan sFTP Preferences

Molina will send the files to the plans via Molina's **non-EDI sFTP site**.
Some plans want Molina to send the files directly to their contracted PBM; others want Molina to send the files directly to the plan. Molina is working with each plan to identify their preference.

ACLA - Send to PerformRx
HLB - Send to HLB
LHCC - n/a
UHC - n/a
Aetna - n/a

Part B. File Naming Convention

The naming convention for the **daily file** is:

2162934_AACRATES_CCYYMMDD.TXT	ACLA
2162845_AACRATES_CCYYMMDD.TXT	LHC
2376985_AACRATES_CCYYMMDD.TXT	UHC
2377167_AACRATES_CCYYMMDD.TXT	AETNA
2162519_AACRATES_CCYYMMDD.TXT	HB

Where CCYYMMDD is the 8-digit date of the day the file is sent.

The naming convention for the **weekly file** is:

2162934_AACWKLY_CCYYMMDD.TXT	ACLA
2162845_AACWKLY_CCYYMMDD.TXT	LHC
2376985_AACWKLY_CCYYMMDD.TXT	UHC
2377167_AACWKLY_CCYYMMDD.TXT	AETNA
2162519_AACWKLY_CCYYMMDD.TXT	HB

Where CCYYMMDD is the 8-digit date of the day the file is sent.

Part C. File Record Layout:

Each record in the file is 90 bytes long.

Field ID	Field Positions	Field Name	Format	Length	Description
1	1-11	NDC-OUT	Character	11	National Drug Code
2	12	Delimiter	Character	1	Value is tab
3	13-42	TRADENAME-OUT	Character	30	Trade name of the drug
4	43	Delimiter	Character	1	Value is tab
5	44-53	STR-DESC-OUT	Character	10	Strength Description
6	54	Delimiter	Character	1	Value is tab
7	55-64	DOSAGE-DESC-OUT	Character	10	Dosage Description
8	65	Delimiter	Character	1	Value is tab
9	66	B-OR-G-OUT	Character	1	Brand or Generic Indicator: **B**=Brand, **G**=Generic
10	67	Delimiter	Character	1	Value is tab
11	68-79	RATE-OUT	Numeric	12	AAC Rate. Format is **nnnnnn.nnnnn**, decimal is included.
12	80	Delimiter	Character	1	Value is tab
13	81-88	EFFDT-OUT	Numeric	8	Rate Effective Date.

					Format is YYYYMMDD
14	89	Delimiter	Character	1	Value is tab
15	90	WAC-IND	Character	1	WAC indicator: Space if no WAC available, **W** if WAC is available.

Appendix AJ

IMD LONG-STAY, HLA PLAN FILE RECORD LAYOUT

Document Date: 12/4/2018

NOTES: File is monthly and comprehensive each month.
File is sent at the end of each month, during the last week of the month, via the DXC non-EDI sFTP server.
Filename=**IMD-LongStay-nnnnnnn-yyyymm.TXT**
where **nnnnnnn** is the Plan ID (2162519, 2162845, 2162934, 2376985, 2377167) and **yyyymm** is the process month of the file.

Record Columns	Field Name	Length	Format	Description and Other Notes
1-6	**IMD_PROCESS_MONTH**	6	Numeric	Run/process month, format=yyyymm
7	delimiter	1	Character	Value is ^
8-20	**IMD_ELIG_ID**	13	Character	Original Medicaid ID
21	delimiter	1	Character	Value is ^
22-34	**IMD_CURR_ID**	13	Character	Current Medicaid ID
35	delimiter	1	Character	Value is ^
36-41	**IMD_EFF_MONTH**	6	Numeric	IMD Effective month, format=yyyymm. For the recipient this is the month that the IMD Long-Stay is in effect.
42	delimiter	1	Character	Value is ^
43	**IMD_PLAN_TYPE_IND**	1	Character	MCO Plan Type: **H**=HLA
44	delimiter	1	Character	Value is ^
45-48	**IMD_STAY_DAYS**	4	Numeric	Total IMD days in effective month. Left-filled with zeros.

49	delimiter	1	Character	value is ^
50	**IMD_SUD_TYPE**	1	Character	TYPE: I=IMD
51	delimiter	1	Character	Value is ^
52-56	**IMD_NEW_CAP_CODE**	5	Character	NEW IMD Long-Stay PMPM CAP CODE for HLA MCO. Will be one of the following: **IMDPH** = Full Medical, regular Medicaid, **IMDBH** = Behavioral only, regular Medicaid, **IMDPX** = Full Medical, Medicaid Expansion, **IMDBX** = Behavioral only, Medicaid Expansion, **IMDDH** = Behavioral only, Medicare Dual (TBD).
57	delimiter	1	Character	Value is ^
58-62	**IMD_OLD_CAP_CODE**	5	Character	OLD HLA MCO PMPM CAP CODE
63	delimiter	1	Character	Value is ^
64-65	**IMD_RECIP_AGE_IN_YEARS**	2	Numeric	RECIPIENT AGE IN EFFECTIVE MONTH
66	delimiter	1	Character	Value is ^
67-73	**IMD_PLAN_ID**	7	Numeric	PLAN ID in effective month
74	delimiter	1	Character	Value is ^
75-87	**IMD_OLD_PMPM_ICN**	13	Character	DXC ICN OF OLD PMPM
88	delimiter	1	Character	Value is ^
89	**IMD_ENROLL_TYPE**	1	Character	ENROLL TYPE: P or B in effective month. P=full medical, B=behavioral only.
90	delimiter	1	Character	value is ^
91-92	**Null Field**	2	Character	Value is spaces.
93	delimiter	1	Character	value is ^
94-96	**Null Field**	3	Character	Value is spaces.
97	delimiter	1	Character	value is ^
98	**Null Field**	20	Character	Value is spaces.

118	delimiter	1	Character	value is ^
119	**Adult_Child_Ind**	1	Character	Adult/child indicator: A=adult, C=child. Value is always **A** for IMD Long-Stay.
120	delimiter	1	Character	value is ^
121-130	**OLD_PMPM_Payment_Amt**	10	num(10,2)	Old HLA MCO PMPM payment. Decimal is included.
131	delimiter	1	Character	value is ^
132-141	**NEW_PMPM_Payment_Amt**	10	num(10,2)	New HLA MCO IMD Long-Stay PMPM payment. Decimal is included.
142	endofrecord	1	Character	end of record indicator, value is ^
		Total Record Length:	142	

Appendix AK

MMIS INQUIRY FORM

DOCUMENT DATE: 07/31/2019

NOTES: Use form when requesting a MMIS Investigation.

Complete as many fields and details as possible to expedite the investigation.

Once completed, email this document to mmisinquiries@la.gov.

Title	
Requestor	
Requestor Contact *Email and Direct Phone*	
Date of Submission	
Edit Code(s)	
Claim Type(s)	
Provider Type(s)	
Procedure/ Revenue Code(s)	
Diagnosis Code(s)	
Description of Issue *Please provide a brief description of the issue needing investigation.*	
Examples *Please provide at least 5 examples using the Molina ICN*	1. ICN 1 2. ICN 2 3. ICN 3 4. ICN 4

	5. ICN 5

ARCHIVE CHANGE REQUEST LOG:

Author of Change	Section Changed	Description	Reason	Date
Darlene White	2	Added sub-section for Identifying Encounters for EPSDT Non-covered Services	To provide instructions to MCO's for identifying these services in their encounters	10/2014
Darlene White	Appendix D	Added sequential column range for Taxonomy to reflect 10-digit length – 56-65	Correction	10/2014
Darlene White	Appendix R	Added Prior Authorization Data Elements Instructions and File Layout	To provide directions to MCO for submitting files	10/2014
Darlene White	Appendix G	Added list of Network Providers by Specialty Type and Taxonomy	To provide direction to MCO for coding of provider specialty and taxonomy for network providers	10/2014
Darlene White	Appendix S	Added Supplement to Fee Schedule File - includes Extract Record Layout, Sample Fee Schedule Extract, and DED	To provide information from DHH's Procedure Formulary that is not included in the Department's Fee Schedule	10/2014
Darlene White	Appendix G	Updated Error Codes for MCO Batch Electronic File Layout for PCP Linkage		11/2014
Darlene White	Appendix G	Added Provider Supplemental Record Layout	Correction – removed from Appendix J	11/2014
Darlene White	Appendix J	Removed Provider Supplemental Record Layout	Correction – added to Appendix G	11/2014

Darlene White	**Appendix L**	**Added: New Region Codes; Region Code Crosswalk; and Revised MCO Capitation Codes**	**To provide new Rate Cell Codes, description, and CAP codes to MCOs.**	**11/2014**
Darlene White	**Appendix R**	**Added instructions for Submitter ID's Usage Notes**		**11/2014**
Darlene White	**Section 2**	**Added instructions for Billing Provider's Patient Control Number**		**12/2014**
Darlene White	**Section 2**	**Corrected Loop and Reference for billing MCO Line Item Control Number (LICN)**		**12/2014**
Darlene White	**Section 2**	**Re-added naming convention for NCPDP Batch Pharmacy**		**12/2014**
Darlene White	**Section 2**	**Added loop for billing value code 54 for New Birth Weight.**		**12/2014**
Darlene White	**Appendix D**	**Added E-CP-O-90-D Report AND E-CP-O-90-E Report**		**12/2014**
Darlene White	**Appendix E**	**Removed expired link for 416 Reports; added current link**		**12/2014**
Darlene White	**Appendix E**	**Removed obsolete Report 174 FQHC/RHC Encounter File**		**12/2014**
Darlene White	**Appendix H**	**Added Phase to each Tier of the EDI Test Plan explanation.**		**12/2014**
Darlene White	**Appendix H**	**Added EDI Test Plan**		**12/2014**
Darlene White	**Appendix H**	**Added Schedules for Outbound files from Molina to MCO and Inbound files from MCO to Molina**		**12/2014**

Darlene White	**Appendix K**	**Added CCN TPL Carrier File Layout**		**12/2014**
Dianne Griffin	**Appendix F**	**Updated disposition of Edits 410, 414,416,417, and 860 to Deny**		**1/2015**
Dianne Griffin	**Cover Page**	**Changed version to 2.0 March 2015**		**2/2015**
Dianne Griffin	**Appendix H**	**Added Item 5i – Test Provider Supplemental File to EDI Test Plan**		**2/2015**
Dianne Griffin	**Section 2**	**Added Guidelines for submitting encounters for NEMT providers**		**2/2015**
Dianne Griffin	**Appendix D**	**Added PA Type 67 for NEMT to Prior Authorization File**		**2/2015**
Dianne Griffin	**Appendix K**	**Replaced TPL Batch Electronic File Layout. Updated document provides TPL Initiator Code Values for Field Number 9 for MCOs including Aetna and UHC**		**2/2015**
Dianne Griffin	**Appendix L**	**Expanded explanation of Capitation Fee Payments. Added Member Parish to Region Code Crosswalk**		**2/2015**
Dianne Griffin	**Appendix T**	**Added Hospice Enrollment File Layout (FI to MCO)**		**2/2015**
Dianne Griffin	**Appendix U**	**Added verbiage: MCO is not required to submit weekly Hospice file to FI at this time.**		**2/2015**
Dianne Griffin	**Section 2**	**Added instructions for submitting**		**2/2015**

		receive date for Historical Encounter Data		
Dianne Griffin	**Appendix V**	**Added file layout for submitting Receive Date in Historical Encounter Data**		**2/2015**
Dianne Griffin	**Appendix W**	**Added Retro Enrollment Disenrollment File Layout**		**2/2015**
Dianne Griffin	**Appendix G**	**Added Provider Type 27 (Dentist) and Provider Type 38 (School-Based Health Center)**		**3/2015**
Dianne Griffin	**Appendix X**	**Added Magellan-Provider Registry**	**To provide directive for submission of Magellan provider listing and/or any changes/updates**	**3/2015**
Dianne Griffin	**Appendix D**	**820 file – Added REF-Reference Information (5th Occurrence)**	**Directive to MCOs for reporting FMP amount.**	**3/2015**
Dianne Griffin	**Appendix Y**	**Added SRI Chisholm PA Extract Layout**	**To provide comprehensive data captured by the MCO and the FI**	**3/2015**
Dianne Griffin	**Appendix H**	**Added file exchange information for SRI Chisholm PA data to Outbound File Exchange Schedule**		**3/2015**
Dianne Griffin	**Section 2**	**Added indicators Q, F, and V to identify Value Added services in Character 1 of MCO ICN prefix**	**Directive to MCOs for submitting encounters for Value Added services**	**4/2015**
Dianne Griffin	**Appendix G Appendix J**	**Added Behavioral Health Provider Types: AC-AH; AJ-AK; Added Behavioral Health Provider Specialty/Type Codes: 5J/1;**		**5/2015**

		5V/1; **5X thru 5Z/1;** **8E/1,2;** **8P/1;** **Updated description for Provider Types:** **08 – OAAS Case Management;** **11 – Shared Living (Waiver);** **13 – Pre-Vocation Habilitation – (Waiver);** **21 – Third Party Billing Agent/Submitter;** **22 – Personal Care Attendant Waiver;** **29 – Early Steps;** **39 – Speech/Language Therapist;** **58 – Not Assigned;** **90 – Certified Nurse-Midwife** **The following existing Provider types are now in use:** **53 – Self-Directed/Direct Support;** **56 – Prescriber ONLY for MCO; 57 – OPH Registered Nurse; 99 – Greater New Orleans Community Health Connections** **Added the following Provider Types: AA thru AB**	**Provided complete updated list of Provider Types and Specialties**	

		AI; AL thru AN; AQ thru AS; AU thru AY; BC; BI; IP; MI; MW; SP; XX		
Dianne Griffin	**Appendix G Appendix J**	**Added the following Provider Specialties, Sub-Specialty/Type Codes 1Q thru 1R/2 1U/2; 2Q/1; 3D thru 3H/2; 3J thru 3N/2; 3P/1; 3Q-3S/2; 3T/1; 3U/2; 3W thru 3Y/1; 4G thru 4H/1; 4J thru 4L/1; 4M/2; 4P/1; 4U/1; 4W/1; 4Y/2; 5I; 5K thru 5N/1; 5T thru 5U/1; 5W/2; 6T/2; 6U thru 6W/1 7G – 7H/2; 7P/1; 7R/1; 7T/1 7U/2**		**05/2015**

		7V/1 7X thru 7Z/1; 8D/1; 8F thru 8J/2; 8K thru 8M/1; 8N/2; 8O/1; 8Q/2; 8S/2 9A/2; 9F thru 9G/1; 9M/1; 9P/1; 9R/2 9S/1; 9T/2; 9Y/1; XX/1		
Dianne Griffin	**Appendix Z**	**Added the LEERS file Layout**	**Provides list of deliveries for enrollees linked to MCO**	**06/20/15**
Dianne Griffin	**Appendix AA**	**Psychiatric Residential Treatment Facility File Layout**	**Provides list of members in facility**	**06/20/2015**
Dianne Griffin	**Section 2**	**Updated hyperlink for 5010 transactions**		**06/2015**
Dianne Griffin	**Appendix H**	**Updated File Exchange Schedule – Outbound Files to include the LEERS File**		**06/2015**
Dianne Griffin	**Appendix H**	**Updated File Exchange Schedule – Outbound Files to include the Psychiatric Residential Treatment Facility**		**06/2015**
Dianne Griffin	**Appendix K**	**Removed MCO's individual Plan ID numbers from the TPL Batch**		**06/2015**

		Submission File Layout		
Dianne Griffin	**Appendix H**	**Updated File Transfer Schedule – Outbound Files – to include Third Party Liability (TPL) Batch Full Reconciliation File**	**To provide file transfer information to the MCOs**	**06/15**
Dianne Griffin	**Appendix AB**	**Added Third Party Liability (TPL) Batch Full Reconciliation File Layout**	**To provide directive to MCOs for reconciliation of TPL information between the MCOs and DHH/FI**	**06/2015**
Dianne Griffin	**Cover Page**	**Updated to Version 6 for July 2015**		**07/2015**
Dianne Griffin	**Appendix G**	**Updated Provider Registry File Layout to reflect changes to Prescriber Information for Columns 777-780**	**Directive for submitting Prescriber information in Registry**	**07/2015**
Dianne Griffin	**Appendix G**	**Added updated Look Up Taxonomy Table (LTX) which includes Provider Types 78 & 94; Provider Specialty 26 (for both provider types)**		**7/2015**
Dianne Griffin	**Cover Page**	**Updated version to 7.0 August 2015**		**08/2015**
Dianne Griffin	**Section 2**	**Added instructions for submitting Value Added Services – Dental – on the 837P when DX not submitted by the provider**		**08/2015**
Dianne Griffin	**Section 2**	**Added instructions for Value Added Services – Dental- on the 837 P when submitting Tooth Numbers**		**08/2015**
Dianne Griffin	**Appendix F**	**Added Encounter Edits 133, 227, 228,**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**

		229, & 555 – Disposition "O" for Behavioral Health **Added Encounter Edit 556 with disposition "E" for Behavioral Health (NOTE: Disposition to be changed to "D" effective 10-20-2015)**		
Dianne Griffin	**Appendix F**	**Added Behavioral Health Encounter Edits 133, 227, 228, 229, & 555 to Non-Repairable Edits Table**	**Effective 12-1-2015 for Behavioral Health**	**08/20/15**
Dianne Griffin	**Appendix F**	**Updated disposition for Edit 735 from "D" to "O"**		**08/2015**
Dianne Griffin	**Appendix W**	**Corrected file name to BYU Retro Cancellations/Closures File Layout**		**08/2015**
Dianne Griffin	**Appendix H**	**Added BYU Cancellations/Closures File to Outbound File Exchange Schedule**		**08/2015**
Dianne Griffin	**Appendix H**	**Added Magellan Prior Authorization File from FI to MCO to Outbound File Exchange Schedule NOTE: Frequency TBD**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Appendix H**	**Added Magellan Prior Authorization File from Magellan to FI to Inbound File Exchange Schedule NOTE: Frequency TBD**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Appendix AC**	**Added Behavioral Health Provider**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**

		Types, Provider Specialties, and Taxonomy **Includes NEW Provider Types "AT" – Therapeutic Group Home; and "AZ" – Substance Use Residential**		
Dianne Griffin	**Appendix AD**	**Added Magellan Prior Authorization (PA) File Layout and instructions**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Section 2**	**Added MCO and Medicare Unique DHH Carrier Code Assignments**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Cover Page**	**Updated version to: v8.0 September 2015**		**09/2015**
Dianne Griffin	**Section 1**	**Updated Medicaid Deputy Director and contact information**		**09/2015**
Dianne Griffin	**Appendix F**	**Changed BH edit codes from 227, 228, & 229 to 425,426 & 456 respectively.** **Added Edit Code 507 Submit Claim to BYU Plan**	**Effective 12-1-2015 for Behavioral Health**	**09/2015**
Dianne Griffin	**Appendix F**	**Added Edit Code 507 to (Submit Claim to BYU Plan) to Non-Repairable Edits List**	**Effective 12-1-2015 for Behavioral Health**	
Dianne Griffin	**Appendix F**	**Added Edit 556 (Attending Servicing Provider Not Linked to Bayou Health Plan) to Edits Repairable Under Limited Circumstances Table**	**Effective 12-1-2015 for Behavioral Health**	**09/2015**

Dianne Griffin	**Appendix J**	**Added Claim Type Table**		**09/2015**
Dianne Griffin	**Section 3**	**Added statement from discussion with CMS regarding their agreement to/for reporting encounter files on the Encounter Data Certification Form based on CFR**§438.606		**09/2015**
Dianne Griffin	**Appendix L**	**Added Member Border Cities by Zip Code to Parish/Region Code Crosswalk**		**09/2015**
Dianne Griffin	**Appendix W**	**Updated naming convention for Retro Cancellation/Closure File to PPLANID_YYYYMM.TXT**		**09/2015**
Dianne Griffin	**Section 2**	**Added instructions for submitting CMS approved modifiers for NEMT Services**	**Implementation date TBD**	**09/2015**
Dianne Griffin	**Appendix H**	**Updated File Naming Convention for Retro Cancellation/Closure File to PPLANID_YYYYMM.TXT on Out Bound File Exchange Schedule**		**09/2015**
Dianne Griffin	**Appendix AA**	**Removed spaces between item numbers in Psychiatric Residential Treatment Facility File Layout**		**09/2015**
Dianne Griffin	**Appendix J**	**Added Parish 65 to Parish Codes**		**09/2015**
Andrea Hollins	**Appendix AD**	**Updated Magellan PA File Layout**		**10/2015**

Andrea Hollins	**Appendix H**	**Updated Schedules for Outbound files from Molina to MCO and Inbound files from MCO to Molina**		**10/2015**
Andrea Hollins	**Appendix K**	**Updated TPL Batch electronic file layout**	**Removed field numbers 55 and 56**	**10/2015**
Andrea Hollins	**Section 2**	**Added instructions for Value Added Services – Dental- when submitting Tooth Numbers**		**10/2015**
Andrea Hollins	**Cover Page**	**Updated Version to 9.0 October 2015**		**10/2015**
Andrea Hollins	**Appendix F**	**Removed BH edit codes 425,426 & 456**		**10/2015**
Andrea Hollins	**Appendix F**	**Removed Edit Code 507 (Submit Claim to BYU Plan)**		**10/2015**
Andrea Hollins	**Appendix F**	**Changed the Effective date for Edit 556 (Attending Servicing Provider Not Linked to Bayou Health Plan) to 11/3/2015**		**10/2015**
Andrea Hollins	**Appendix D**	**Added Provider Type 17 indicator to Prior Authorization File FI to MCO layout**	**Molina sends PA type 17 in the weekly MCO PA file but it was not reflected in the layout**	**11/2015**
Yolanda Chanet	**Appendix Y**	**Remove The SRI-Chisholm-PA-YYYYMMDD file**	**Removed because it was a onetime file sent to BYU in Jan. 2015. It is not a recurring file.**	**11/2015**
Yolanda Chanet	**Appendix F**	**Update: removed 001, 013, 138, 248. Change to E 011, 092, 182, 232. Change to D 022, 026, 028, 041, 042, 053, 055, 060, 068, 077, 084, 085, 087, 089, 093, 095, 097,098, 113, 114, 115,126,132, 136,**	**Update the Encounter Edit code list**	**11/2015**

		141,149,231, 234, 235, 236, 254, 255, 263, 268		
Yolanda Chanet	**Section 3**	**Encounter Data Certification Text addition**	Update	**11/2015**
Yolanda Chanet	**Appendix Z**	**Name Change**	Change file name to DHH_LEERS_EXPD	**11/2015**
Yolanda Chanet	**Appendix H**	**Name change on Outbound File Exchange Schedule**	Change file name to DHH_LEERS_EXPD	**11/2015**
Yolanda Chanet	**Appendix Y**	**Added Chisholm File Layout for CSOC**	Used Appendix for to Chisholm File Layout for CSOC	**11/2015**
Yolanda Chanet	**Section 2**	**Value Added Services: Added verbiage: ICD-10 diagnosis code Z01.20**	Added info	**11/2015**
Andrea Hollins	**Cover Page**	**Updated Version to 11.0 December 2015**		**12/2015**
Andrea Hollins	**Appendix F**	**Updated edit 556**	Disposition changed to D Effective 3/31/16	**12/2015**
Andrea Hollins	**Appendix D**	**Updated Prescriber Indicator**	Update	**12/2015**
Andrea Hollins	**Cover Page**	**Updated Version to 11.1 December 2015**	Changes made after the monthly release	**12/2015**
Andrea Hollins	**Appendix G**	**Updated Provider Supplemental File Layout**	Removed prior Provider Supplemental File Layout and Added the UPDATED Provider Supplemental File Layout Implementation Date determined to be 3/7/2016	**12/2015**
Andrea Hollins	**Appendix L**	**MCO Capitation Codes**	Updated MCO Capitation codes for NEMT and SBH Effective Date 12/1/2015	**12/2015**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule**	Incorporated the PIHP/CsoC Outbound/Inbound File Schedule into the MCO Schedule	**12/2015**
Andrea Hollins	**Appendix F**	**Encounter Edit Codes – Comprehensive List**	Edit 275 changed from 'D' to 'E'	**12/2015**
Andrea Hollins	**Appendix Q**	**Louisiana Health Information Exchange**	Changed LaHIE to Pharmacy Encounters Supplemental File	**12/2015**

Andrea Hollins	**Appendix Q**	**Added Pharmacy Encounters Supplemental File Layout**	Added the Pharmacy Encounters Supplemental File Layout…**Appendix Q** Implementation Date determined to be 2/15/2016	**12/2015**
Andrea Hollins	**Appendix Q**	**Louisiana Health Information Exchange**	Changed Appendix letter to "R"	**12/2015**
Andrea Hollins	**Appendix R**	**Prior Authorization Requests Data Elements**	Changed Appendix letter to "S"	**12/2015**
Andrea Hollins	**Appendix S**	**Supplement to Fee Schedule**	Changed Appendix letter to "T"	**12/2015**
Andrea Hollins	**Appendix T**	**Hospice Enrollment File Layout**	Changed Appendix letter to "U"	**12/2015**
Andrea Hollins	**Appendix U**	**Hospice Linkage Information File Layout**	Changed Appendix letter to "V"	**12/2015**
Andrea Hollins	**Appendix V**	**Receive Data for Historical Encounter Data File Layout**	Changed Appendix letter to "W"	**12/2015**
Andrea Hollins	**Appendix W**	**Retro Cancellation/Closure File Layout**	Changed Appendix letter to "X"	**12/2015**
Andrea Hollins	**Appendix X**	**Magellan Provider Registry**	Changed Appendix letter to "Y"	**12/2015**
Andrea Hollins	**Appendix Y**	**Chisholm Electronic File Layout for CsoC Information**	Changed Appendix letter to "Z"	**12/2015**
Andrea Hollins	**Appendix Z**	**LEERS File Layout**	Changed Appendix letter to "AA"	**12/2015**
Andrea Hollins	**Appendix AA**	**Psychiatric Residential Treatment Facility File Layout**	Changed Appendix letter to "AB"	**12/2015**
Andrea Hollins	**Appendix AB**	**Third Party Liability (TPL) Batch Full Reconciliation File Layout**	Changed Appendix letter to "AC"	**12/2015**
Andrea Hollins	**Appendix AC**	**Behavioral Health Provider Types, Specialties, and Taxonomy**	Changed Appendix letter to "AD"	**12/2015**
Andrea Hollins	**Appendix AD**	**Magellan Prior Authorization (PA) File Layout**	Changed Appendix letter to "AE"	**12/2015**

Andrea Hollins	**Appendix D**	**Provider File FI to MCO**	Added three (3) new Prescriber Indicators Column 490 6 = CCN Prescriber (see PT=56) 7 =EHR Incentive Program 8 = No Prescriptive Authority	**12/2015**
Andrea Hollins	**Appendix L**	**MCO Capitation Codes**	Removed Column 1 Combined Category of Aid Code	**12/2015**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule**	Added the RECIPIENT_WEEKY_RETRO_YYYYMMDD.ZIP FILE and supporting information to the Outbound File Exchange.	**01/2016**
Andrea Hollins	**Appendix K**	**Third Party Liability Batch File Submission and File Layout**	Add TPL Resource File – Medicare Coverage Additions/Updates	**01/2016**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule**	Added the CsoC Monthly 820 file information in the Outbound File Schedule. Name of file: CAP-2177141-YYYMMDD-CSOC.txt	**01/2016**
Andrea Hollins	**Cover Page**	**Updated Version to 13.0 February 2016**		**02/2016**
Andrea Hollins	**Appendix K**	**Third Party Liability Batch File Submission and File Layout**	Add Rules for Processing TPL Records	**02/2016**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule – Outbound**	Added 3 return files: WEEKLY_RECIP_RECON_RESP_{DAILY8}.TXT; WEEKLY_RECIP_RECON_REPT_{DAILY8}.TXT; WEEKLY_RECIP_RECON_REPT_FILE_{DAILY8}.TXT .	**02/2016**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule – Inbound**	Stola_Molina_Recon_YYYYMMDD.TAB	**02/2016**
Andrea Hollins	**Appendix L**	**MCO Capitation Codes**	New Cap Codes for Foster Care Children, SBH, HCBS, LAP effective 02/01/2016	**02/2016**
Andrea Hollins	**Appendix G**	**Provider Supplemental File**	9-18 NPI 20-26 Managed Care Medicaid Assigned ID	**02/2016**
Andrea Hollins	**Appendix AF**	**17P Pre-Term Birth History File Layout**	Added new 17P Pre-term Birth History File Layout: 2 new fields added to the end of each record to designate the Measurement Year	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	042, 056, 070 – Must be a valid carrier code if submitted. Do not	**02/2016**

			submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, DHH decided edit 042, 056, 070 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.	
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Note added: If you receive an empty response file, then that is an indication that all records on the submitted file are accepted with no errors.	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Added plan ICN to end of error file, field 24. See Part 2 information.	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Note Added: So, the 2nd compound segment may experience edits 090 through 094; the 3rd compound segment may experience edits 095 through 099, etc.	**02/2016**
Andrea Hollins	**Appendix F**	**Edit Disposition**	615, 622, 689, 705, 727, 740, 774, 802, 813, 815, 832, 842, 851, 852, 862, 864, 896, 897, 899, 906, and 926 (effective May 9, 2016	**02/2016**
Andrea Hollins	**Appendix F**	**Edit Dispositions**	Removed Change and Effective date columns (per Bryan Hardy, Krystal Berthelot, and Kerri Capello)	**02/2016**
Andrea Hollins	**Appendix G**	**Provider Registry File Layout**	Added R description; required when the Provider has a License, otherwise optional	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Field 37 “flat tax field” PAID: Should be $0.10 since the provider fee should be paid on every claim to the pharmacy whether it is billed or not. If the MCO is a secondary payer however, only then would a zero would be acceptable in this field.	**03/2016**
Andrea Hollins	**Appendix F**	**Edit Disposition**	306, 316, 317, 328, 330, 332, 334, 336, 337, 338, 340, 351, 390, 400, 402, 405, 408, 429, 490, 492, 522, 523, 532, 539, (effective March 1, 2016)	**03/2016**
Andrea Hollins	**Appendix J**	**Provider Type**	Added AT, AZ	**03/2016**
Andrea Hollins	**Appendix J**	**Provider Specialty, Sub-Specialty**	Added Specialties 8U, 8R, 6B, 6C, 6G	**03/2016**

Andrea Hollins	**Appendix G**	**Provider Supplemental File Layout Error Codes**	Error Codes (A=Accepted, R=Rejected): 000=(A) No errors found 001=® Missing/Invalid NPI 003=® Provider record must include taxonomy 004=® Numeric field contains characters 005=® Invalid Ownership Code. Must be 01-19,88. 006=® Invalid Business Email Address format. Must contain "@" and ".". 007=® Invalid Physical Location Email Address format. Must contain "@" and ".". 009=® Invalid Plan ID 010=® Invalid License Type (must be 1,2,3,4,5.) 011=® Missing License or Accreditation Number 012=® Missing License Issuing ID 013=® Invalid License Effective Date 014=® Invalid License End Date or License End Date before License Effective Date 015=® Invalid MCO Enrollment Begin Date 016=® Invalid MCO Enrollment End Date or MCO Enrollment End Date before MCO Enrollment Begin Date 017=® Invalid MCO Enrollment Termination Code 018=® Invalid FIPS State or Parish 022=® Medicaid Assigned ID was not found on Provider Registry File 023=® Invalid Date of Birth Date 029=® Provider does not exist on Provider Registry 030=® Duplicate record was submitted	**03/2016**
Andrea Hollins	**Appendix H**	**File Exchange Schedule**	Add LEERS 17P Birth History File incoming and outgoing	**03/2016**
Andrea Hollins	**Appendix K**	**TPL**	Changed "weekly" to "daily "	**03/2016**
Andrea Hollins	**Appendix AG**	**LEER Elective Deliveries File Layout**	New addition, positions after 265 are new fields	**04/2016**
Andrea Hollins	**Appendix F**	**Encounter Edit Codes**	Edit 114 will be turned to "Deny" (date TBD)	**04/2016**

			Edit 212 turned off (4/4/16) Edit 556 will remain "Educational"	
Andrea Hollins	**Appendix H**	**File Exchange Schedule**	TPL-BATCH-PLANID-CCYYMMDD.txt Changed weekly to daily	**04/2016**
Andrea Hollins	**Section 9**	**PMPM Payment Recovery for Duplicate Recipient Medicaid IDs**	New	**04/2016**
Andrea Hollins	**Appendix D**	**System Generated Reports – 820 File**	Updated to include PMPM Recovery Payments 5th Occurrence – REF*ZZ*00000.00~ - Hospital 6th Occurrence – REF*ZZ*00000.00~ - Physician 7th Occurrence – REF*ZZ*00000.00~ - Ambulance 8th Occurrence – REF*ZZ*123456789123~ - Current Recipient ID of the correct record	**04/2016**
Andrea Hollins	**Appendix G**	**Provider Registry File Layout – Language Indicators 580, 582, 584, 586, and 588**	Added 6 = American Sign Language	**04/2016**
Andrea Hollins	**Appendix H**	**File Exchange Schedule**	Recipient Voided IDs.txt to Outbound Files	**04/2016**
Andrea Hollins	**Section 9**	**PMPM Payment Recovery for Duplicate Recipient Medicaid IDs**	Updated language	**05/2016**
Andrea Hollins	**Appendix L**	**Medicaid Expansion Capitation Codes**	New Addition	**05/2016**
Andrea Hollins	**Appendix K**	**Bayou Health Batch Electronic File Layout for TPL Information**	Rules for TPL batch electronic file submissions have been updated	**06/2016**
Andrea Hollins	**Appendix H**	**File Exchange Schedule**	MW-W-21D	**06/2016**
Andrea Hollins	**Appendix K**	**Scopes of Coverage**	Edit Scope of Coverage 19 and 20 descriptions	**06/2016**
Andrea Hollins	**Appendix K**	**Rules for Processing TPL Records**	Add Phase 1 and Phase 2 duplicate information	**06/2016**
Andrea Hollins	**Cover Page**	**Logo**	Department of Health and Hospitals changed to Department of Health	**06/2016**
Andrea Hollins	**Cover Page**	**Version Change**	Version 18 July 2016	**07/2016**
Andrea Hollins	**Appendix D**	**EDI Transmission Research Request Form**	To simplify handling requests for "missing" claims and/or 835 research	**07/2016**

Andrea Hollins	**Appendix K**	**TPL Batch Electronic File Layout**	Updated version 4.1 to include initiator code 2	**07/2016**
Andrea Hollins	**Appendix D**	**Prior Authorization File FI to MCO**	Update PA file columns 113, 149-161; change status from a one-time file to a weekly file	**07/2016**
Andrea Hollins	**Appendix F**	**Pharmacy Encounter Edits**	346 to D 393 to D 535 to D 536 to D 537 to E 831 to D 860 to D 861 to D	**08/2016**
Andrea Hollins	**Cover Page**	**Version Change**	Version 19 September 2016	**09/2016**
Andrea Hollins	**Appendix AH**	**ESRD Report**	Tab delimited file	**09/2016**
Andrea Hollins	**Appendix F**	**Medical Encounter Edits**	Removed: 15, 16, 17, 46, 47, 63, 126, 133, 318, 319, 506, 507, 550, 555, 563, 578, 618, 620, 631, 663, 673, 679, 689, 711, 721, 735, 753, 757, 758, 802, 832, 842, 852, 862, 864, 896, 897, 899, 926, 946, 948, 951, 952, 957, 970, 973, 980, 991 Added: 112, 151, 152, 303, 349, 456, 883 Changed: 41 to E 114 to E 254 to E 334 to E 340 to D	
Andrea Hollins	**Appendix D**	**Edit Code Detail CCN-W-010**	The CCN-W-010 file has (10) Error Code fields, each field is 4 characters. The new format prefix codes are as follows: the first character is, 1 for Edit codes that caused the Encounter to Deny and 2 for Edit codes that just represent an educational edit for the Encounter record. 0 for None For the (10) Error Codes, the Notes column states the following:	**09/2016**

			1st – 10th error code. Last 3 digits are error code number. First digit value: 1=Deny, 2=Educational, 0=none	
Andrea Hollins	**Appendix F**	**Pharmacy Encounter Edits**	Added: 002, 003, 005, 006, 007, 008, 011, 021, 022, 024, 030, 120, 121, 122, 123, 124, 125, 126, 127, 129, 130, 141, 142, 149, 151, 152, 201, 211, 215, 216, 217, 231, 262, 272, 273, 275, 299, 311, 315, 330, 364, 414, 421, 422, 434, 436, 438, 448, 452, 454, 455, 462, 465, 472, 489, 491, 521, 556, 796, 797, 798, 799, , 843, 898, 918, 988	**09/2016**
Andrea Hollins	**Cover Page**	**Version Change**	Version 20 October 2016	**10/2016**
Andrea Hollins	**Appendix G**	**Provider Supplemental File Error Layout Codes**	Added: **039=®** Zip Codes must be numeric without a hyphen **040=®** A ^, CR, TAB or LF was found in a text field. Please verify the positions of the delimiter fields **041=®** Invalid value for prescriber indicator field: valid values are space,0,1,2,3,4,5,6,7,8.	**10/2016**
Andrea Hollins	**Section 8**	**Medicaid Administrative Retroactive Enrollment Correction Process**	Language/process updated	**10/2016**
Andrea Hollins	**Cover Page**	**Version Change**	Version 21 November 2016	**11/2016**
Andrea Hollins	**Appendix K**	**Third Party Liability (TPL) Batch File Submission and File Layout**	TPL Batch File layout updated to version 4.4 11/02/2016 – EDITS HIGHLIGHTED	**11/2016**
Andrea Hollins	**Appendix AD**	**Behavioral Health Provider Types, Specialties, and Taxonomies**	Updated Behavioral Health Provider Types PS 8E PT 19 PS 2W PT 20 PS 2W	**11/2016**
Andrea Hollins	**Section 2**	**Encounter Reporting of Financial Fields: Adjustment Amount**	Text Updated	**11/2016**

Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 22 December 2016	**12/2016**
Andrea Hollins	**Section 2**	**Special PA to bypass Duplicate Ambulance Trip Edit 828**	Added New Subsection	**12/2016**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 23 January 2017	**01/2017**
Andrea Hollins	**Appendix L**	**Louisiana Medicaid Recipient Aid Category Codes**	Update Aid Category: 40 Family Planning Waiver or LBHP/ CSoC Added Medicaid Expansion Codes: 50 ME Adults 51 ME Incarcerated Adults	**01/2017**
Andrea Hollins	**Appendix L**	**Louisiana Medicaid Recipient Type Case Codes**	Removed Non-Effective Codes: 004 SSI SNF-Skilled Nursing Facility 006 12 Months Continuous Eligibility 010 SSI in ICF (II) – Medical 011 SSI Villa SNF 016 Deceased Recipient – LTC 017 Deceased Recipient – LTC (not Auto) 041 OAA, ANB or DA (GERI HP-ICF(I) SSI-No) 042 OAA, ANB or DA (GERI HP-ICF(I) SSI Pay) 044 OAA, ANB, or DA (GERI HP-ICF(2) SSI-Pay) 066 AFDC-Private ICF DD – 3 Month Limit 067 AFDC or IV-E (1) Private ICF DD 068 SSI-M Determination of Disability for Medicaid Eligibility 073 Recipient (65 Plus) Eligible SSI/Ven Pay Hospital 074 Description not available 087 LaCHIP Parents 089 AFDC/SSI Cash-Habitation Services 091 Villa Feliciana/Skilled Nursing 092 SSI/SNF 098 SSI/ICF-II	**01/2017**

			Removed Inactive Codes: 012 Presumptive Eligible PW 045 SSI/PCA Waiver 046 PCA Waiver 049 QI2 (Program Terminated 12/31/02) 054 Reinstated 4913 069 Roll-down 072 LAMI Pseudo Income 075 TEFRA 082 SSI DD Waiver 085 Grant Review 093 MR/DD Waiver Added Codes: 210 Former Foster Care 211 Provisional Medicaid 212 Family Planning 550 Adults – Medicaid Expansion	
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 24 February 2017	**02/2017**
Andrea Hollins	**Appendix AC**	**Third Party Liability (TPL) Batch Full Reconciliation File Layout**	LA=LaHIPP Removed “no longer used”	**02/2017**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 25 March 2017	**03/2017**
Andrea Hollins	**Appendix K**	**TPL Batch File Submission and File Layout**	Updated preamble information	**03/2017**
Andrea Hollins	**Appendix K**	**Bayou Health Batch Electronic File Layout for TPL Information**	Updated File Layout to Version 4	**03/2017**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 25.1	**03/2017**
Andrea Hollins	**Appendix J**	**Provider Specialty Types**	Add Provider Type 39 to Provider Specialty 71	**03/2017**
Andrea Hollins	**Appendix G**	**Provider Registry File Layout**	Remove “X=Remove” (effective 7/22/2016)	**03/2017**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 26 April 2017 Logo Changed	**04/2017**
Andrea Hollins	**Appendix F**	**Encounter Edit Codes**	Edit Disposition 275 changed to ‘D’	**04/2017**
Andrea Hollins	**Appendix G**	**Provider Types**	*Changes Highlighted in Yellow	**04/2017**

			PT 64 Freestanding Psychiatric Hospital PT 68 Substance Abuse and Alcohol Abuse Center (Outpatient) PT 69 Hospital – Distinct Part Psychiatric Unit PT 73 – Licensed Clinical Social Worker PT 74 – Mental Health Clinic – (Legacy MHC) (Reserved for LGEs) PT 77 – (Legacy MHR) PT 78 – Advanced Practice Registered Nurse PT AE – Center Based Respite PT AG – Behavioral Health Rehab Provider Agency (Non-Legacy MHR)	
Andrea Hollins	**Appendix G**	**Provider Specialty Types**	*Changes Highlighted in Yellow Changes to Associated Provider Types: PS 70 removed PT 20, added PT 38 PS 86 added PTs 64 and 69 PS 5M removed PT 1, added PT 12 PS 5X removed PT 1, added PT AT PS 8E removed PT 2, added PT AE, AF, AA, AG, AJ, AK, AH PS 8L removed PT 1, added PT 96 PS 9F removed PT 1, added PT AR PS 9G removed PT 1, added PT AQ Added: PT 2W Addition Specialist 19 & 20	**04/2017**

Andrea Hollins	**Appendix G**	**Lookup Taxonomy Table (LTX)**	*Changes Highlighted in Yellow Changes: PT 12 PS 5M to 261QM0855X PT 31 PS 6A to 103TC0700X PT 31 PS 6B to 103TC1900X PT 31 PS 6C to 103TS0200X PT 31 PS 6D to 103TM1800X PT 68 PS 70 to 261QR0800X PT 69 PS 86 to 273R00000X PT 73 PS 73 to 1014C0700X PT 77 PS 78 to 251S00000X PT 93 PS 26 to 364SP0808X PT AE to PS 8E PT AF PS 8E to 261QM0801X PT AR PS 9F to 253J00000X Additions: PT 19 PS 2W LTX 2084A0401X PT 20 PS 26 LTX 2084P0800X PT 20 PS 2W LTX 2084P0802X PT 31 PS 6G LTX 103TP0016X PT 38 PS 70 LTX 261QH0100X PT 96 PS 8R LTX 323P00000X PT 96 PS 8U LTX 323P00000X PT AA PS 8E LTX 261QM0850X PT AE PS 8E LTX 385HR2055X PT AT PS 5X LTX 320800000X PT AZ PS 8U LTX 324500000X Deletion: PT 96 PS 8P LTX 323P00000X	**04/2017**
Andrea Hollins	**Appendix J**	**Common Data Element Values: Types of Service**	*Changes Highlighted in Yellow Additions: Code 51 Code 57 Code 62	**04/2017**
Andrea Hollins	**Appendix J**	**Common Data Element Values: Provider Types**	*Changes Highlighted in Yellow Update: PT AE Description changed to Center Based Respite	**04/2017**

Andrea Hollins	**Appendix J**	**Common Data Element Values: Provider Specialty, Sub-Specialty**	*Changes Highlighted in Yellow Addition: PS 2W PS 6G PS 8R PS 8U Updates: PS 5M added 1 = Specialty PS 5N added 1 = Specialty PS 8L description Psychiatric Residential Treatment Facility Hospital Based	**04/2017**
Andrea Hollins	**Appendix J**	**Louisiana Medicaid Pricing Action Code (PAC)**	*Changes Highlighted in Yellow Addition: 8C0 – CCN Encounter Code, pay at zero	**04/2017**
Andrea Hollins	**Appendix AD**	**Behavioral health Provider Types, Specialties, and Taxonomy**	*Changes Highlighted in Yellow Add: Therapeutic Foster Care Change Taxonomy and Description: Assertive Community Treatment Team Multi-Systemic Therapy Agency Change PS for Outpatient Therapy Licensed Professional Counselor Add to Outpatient Therapy: Doctor of Osteopathic Medicine Psychiatrist	**04/2017**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 27 May 2017	**05/2017**
Andrea Hollins	**Section 1**	**Overview**	Introduction: COB Model Provider to Payer to Payer changed to Provider to Payer to Provider	**05/2017**

Andrea Hollins	**Section 2**	**Encounter Data Instructions** **Submission of 837s with TPL**	Introduction: COB Model Provider to Payer to Payer changed to Provider to Payer to Provider "SMO" changed to "MCO"	**05/2017**
Andrea Hollins	**Section 2**	**MCO Paid Amount**	The MCO Paid Amount is sent in the first set of COB data.	**05/2017**
Andrea Hollins	**Section 2**	**Interest Paid Amount**	Interest Paid by the MCO and the date of that Interest payment is required to be submitted in the second or third sets of COB data in the 837P and 837I Encounter Data.	**05/2017**
Andrea Hollins	**Appendix G**	**Lookup Taxonomy Table (LTX)**	CORRECTION PT 73 PS 73 1014C0700X CORRECTED: 1041C0700X	**05/2017**
Andrea Hollins	**Appendix G**	**Provider Specialty Types**	*See Highlighted Text	**05/2017**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 28 June 2017	**06/2017**
Andrea Hollins	**Cover Page Footer**	**Version Change**	Version 29 September 2017	**09/2017**
Andrea Hollins	**Appendix D**	**Provider Rates File**	Page 77 4 parts changed to 5 Added "Location" 27 bytes changed to 30 Added 2 new fields 175-176 and 177 Column value changed from 1228 to 1348	**09/2017**
Andrea Hollins	**Appendix G**	**Provider Registry File Layout** **Column 663-670: MCO Contract Begin Date** **Column 672-679: MCO Contract Term Date**	Effective: 11/1/2017 R = Required for participating providers O = Optional for non-participating providers	**09/2017**
Andrea Hollins	**Appendix G**	**Lookup Taxonomy Table (LTX)**	REMOVED	**09/2017**
Bryan Hardy	**Appendix K**	**TPL File Layout to Plan**	Added MBI to end of layout	**11/2017**
Bryan Hardy	**Appendix O**	**Encounter Data Certification Form**	Updated form now includes LDH logo	**12/2017**

Bryan Hardy	**Appendix G**	**Provider Types**	Removed PT 29	12/1/17
Bryan Hardy	**Appendix G**	**Provider Specialty Types**	Removed PT 29 from PS 71, Added PT 39 to PS 71	12/1/17
Bryan Hardy	**Appendix J**	**Provider Type**	Removed PT 29	12/1/17
Susan Bryson	**Appendix AF**	**Naming Convention**	Changed filename from 17P_Birth_History.txt **to** 17P_Birth_History.YYYYMMDD.txt	1/1/18
Susan Bryson	**OUTBOUND FILES FROM MOLINA**	**Naming Convention**	Changed filename from 17P_Birth_History.txt **to** 17P_Birth_History.YYYYMMDD.txt	1/1/18
Susan Bryson	**Pharmacy Encounter Edits 121**	**Disposition**	Changed Edit 121 disposition from 'D' to 'E'	2/1/18
Kerri Capello	**Appendix AD**	**Added ABA Provider Type/Provider Specialty/Taxonomy crosswalk**	ABA services carved into MCO effective 2/1/2018	3/5/2018
Kerri Capello	**Appendix G, page 146**	**Removed Provider Type BI**	BI Provider Type not is not a valid MCO Provider Type.	3/10/2018
Susan Bryson	**Appendix K**	**Field 29**	Use appropriate LA MMIS Carrier Code	3/16/18
Susan Bryson	**Appendix K**	**Edit Requirements**	Changed edit requirements for fields: 29, 30, 31, 32, 33, 34, 36, and 55.	3/16/18
Susan Bryson	**Appendix K**	**Edit Change Field 022**	Must enter 9-digit numberic value even if it is all zeros; use of all 9s is not permitted	3/16/18
Susan Bryson	**Appendix K**	**Clarified Edits**	**Edits:** 29, 36, 48, 53	3/16/18
Susan Bryson	**Appendix K**	**Added New Edit Codes**	**New Edit Codes:** **134 -** Invalid value for Field 34 (TPL_POLICY_NBR). **153 -** Invalid value for Field 53 (TPL_POLICY_NBR) - only applicable to Type 1 records. **253 -** Type 3 record attempting update to existing policy with Initiator 02 (Title IV-D) or Initiator 25 (LaHIPP).	3/16/18
Susan Bryson	**Appendix K**	**Changed Response (Error) File Layout in Part 2**	**Added Fields:** **8 -** TPL_PLAN_TRACE_NUMBER **9 -** TPL_PROCESS_TYPE **10 -** TPL_INSURANCE_NUMBER	3/16/18

			11 - TPL_POL_NUMBER **12 -** TPL_SCOPE_OF_COVERAGE_1 **13 -** TPL_BEGIN_DATE_YYMMDD 14 - TPL_END_DATE_YYMMDD **15 -** END-OF-RECORD INDICATOR	
Susan Bryson	**Appendix K**	**Added TPO13 File Information to Part 2**	**Special Note** at end of Part 2 - where to find TP13 Error file and naming convention	3/16/18
Susan Bryson	**Appendix K**	**Modified Fields**	**Field 54 -** TPL_SEQUENCE_NUMBER **Field 55** - TPL_PLAN_TRACE_NUMBER **Field 56 -** TPL_FILLER	3/16/18
Susan Bryson	**Appendix S**	**Added Field Required/Optional Column**		3/16/2018
		Plan Submitter ID	Required Must be a valid Plan Submitter ID	
		Plan Aurthorization Number	Required Cannot be Modified	
		Plan Aurthorization Line Number	Required Rule: To add new PA, file must have a row with line number = 1. Subsequent remittance of existing PA line numbers will be treated as update rows and all columns will be replaced.	
		Authorization Type	Currently, routine will add line with invalid type but will notify submitter with a warning.	
		Medicaid Recipient ID	Required Must be a valid recipient ID number, cannot be null, and is not an updateable column.	
		Plan Authorization Status	Currently, routine will add line with invalid status but will notify submitter with a warning.	
		Auth Denied Reason	Currently, routine will add line with invalid deny reason but will notify submitter with a warning.	
Susan Bryson	**Appendix K**	**Added TPO13 File Information to Part 2**	**Special Note** at end of Part 2 - where to find TP13 Error file and naming convention	3/16/18

Susan Bryson	**Apppendix S**	**Updated MCO to FI PA file layout**	All updates to PA file layout are documented in red 17 of 23 fields now designated 'Required' – in red text Added field 23:Documentation Received Date – highlighted yellow	5/23/2018
Susan Bryson	**Appendix E**	**Updated the Denied Claims Report Instructions**	Instructions updated to match the instructions in the monthly Managed Care Reporting Deliverables for the 173 Report (Prepaid Denied Claims Report).	5/23/0218
Susan Bryson	**Appendix S**	**Updates to MCO to FI PA file layout**	Updates to Instructions	6/21/2018
			Submitter ID – added list of IDs	
			Authorization Type – expanded types to include types used by ABA, Wells, Chisholm, Dental, Vision and Value Added Services (VAS) and clarifying notes under Purposes. Additions in red text.	
			Auth Type 91 – CSoC to be used by CSoC entity only	
			CPT/NDC/HICL/Therapeutic Class field updated to include GPI. Added clarifying notes under Purpose in red text	
			Auth Denied Reason field – added denial reason 99 – Timeline expired without decision	
			Added field 24: Tax Identification Number (TIN) – optional but cannot replace NPI – highlighted yellow	
Susan Bryson	**Appendix S**	**Updates to MCO to FI PA file layout**	Updates to Instructions – added item #2 to instructions regarding lines >1.	7/2/18

Susan Bryson	**Appendix AI**	**LDH AAC Drug File**	New Appendix – represents drug records with AAC rates to be sent to HLA MCOs daily and weekly. **Part A**. Plan sFTP Preferences **Part B.** File Naming Convention **Part C.** File Record Layout	**8/1/18**
Susan Bryson	**Section 2**	**File Naming Conventions**	Added new row for .NCD file extension to NCPDP Batch Pharmacy	**8/1/18**
Susan Bryson	**Preface – following Change Control Table**	**General Disclaimer**	Added general disclaimer for SCG content accuracy due to continual development	**8/2/18**
Susan Bryson	**Appendix G**	**Please Note**	The list of provider types and list of specialties are not exclusive nor exhaustive.	**8/2/18**
Susan Bryson	**Section 2**	**Encounter Data Instructions**	Added: **Plan DRG data for Inpatient Hospital Encounters** instructions (Sec. 2, pg 8)	**8/7/18**
Susan Bryson	**Appendix G**	**Please Note**	Please Note disclaimer removed with update of PT and PS	**11/9/18**
		Provider Types	Updated list of Provider Types	
		Provider Specialties	Updated list of Provider Specialties	
Susan Bryson	**Appendix**	**Magellan Provider Registry (FI to MCO)**	Updated table/repaired table	**11/9/18**
Susan Bryson	**Appendix S**	**Updates to MCO to FI PA File Layout**	Update to Auth Begin Date and Auth End Date to use 20991231 for both dates for Denied Auth Type 12 PAs	**11/19/18**
Susan Bryson	**Appendix S**	**Updates to MCO to FI PA File Layout**	Cancelled: Update to Auth Begin Date and Auth End Date to use 20991231 for both dates for Denied Auth Type 12 PAs	**12/04/18**
Susan Bryson	**Appendix S**	**Updates to MCO to FI PA File Layout**	Changed: CPT/NDC/HICL/THERAPEUTIC CLASS/GPI field to Service Codes field	**12/04/18**
			Updated Plan Authorization Status to include statuses when there is a Provider NPI and when no Provider NPI is available	

			Added: to Auth Begin Date conditional use of '0' for denied Auth Type 12 (only) PAs. Added: to Auth End Date conditional use of '0' for denied Auth Type 12 (only) PAs.	
Susan Bryson	**Appendix AJ**	**IMD Long-Stay, HLA Plan File Record Layout**	New Appendix: IMD Long-Stay, HLA Plan Record Layout for monthly file and comprehensive each month File naming convention	**12/04/18**
Susan Bryson	**Appendix AD**	**Behavioral Health Provider Types, Provider Specialties, Provider Subspecialties and Taxonomy Grid**	Replace table on page 377 with revised (12-10-18) table from OBH	**12/11/18**
Susan Bryson	**Section 2**	**Encounter Data Instructions, pg 8**	Molina will begin denying encounters for DRG on May 1, 2019.	**12/11/2018**
Susan Bryson	**Section 2**	**Additional Encounter Requirements**	Added Tracking of Evidence Based Practices Instructions and Table, pg 16	**01/07/2019**
Susan Bryson	**Appendix AD**	**Behavioral Health Provider Types, Provider Specialties, Provider Subspecialties and Taxonomy Grid**	Complete update of appendix; replaced table with revised table from OBH	**1/23/2019**
Susan Bryson	**Appendix G**	**Provider Specialty Types**	Updated Provider Specialty *E by adding Associated Provider Types AE, 82, AF, and 89, pg 153	**1/23/2019**
Susan Bryson	**Section 2**	**Encounter Data Instructions, pg 8**	**Remove:** DRG	**2/1/2019**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	**Edit 114** – changed disposition from "D" to "E" **Added Edits:** 185, 191 313, 505, 550	**3/13/2019**
Susan Bryson		**LDH Responsibilities**	Added: Mitzi Hochheiser as Medicaid Deputy Director with telephone number and email address	**3/13/19**
Susan Bryson	**Appendix Q**	**Part 1: Plan File Submissions**	Added: requirements for submission of Pharmacy Supplemental File	**3/26/2019**

Susan Bryson	**Appendix G**	**Provider Types**	Updated Provider Type table	**6/11/2019**
Susan Bryson	**Appendix G**	**Provider Specialty Types**	Updated Provider Specialty Type table	**6/11/2019**
Susan Bryson	**Appendix F**	**Added Edit 472**	Added Edit 472 - Manufacturer not in federal rebate agreement	**6/21/2019**
Susan Bryson	**Appendix G**	**Provider Specialty Types**	Added Provider Specialties no longer in use. Added PS 4T. Updated PS 70 with PT WA.	**6/26/19**
Susan Bryson	**Appendix J**	**Common Data Element Values:**	Removed Provider Type table – duplicate to Appendix G Removed Provider Specialty Table – duplicate to Appendix G	**6/26/19**
Susan Bryson	**Appendix AK**	**MMIS Inquiries Form**	Added the MMIS Inquiries form	**7/31/19**
Susan Bryson	**Appendix G**	**Provider Supplemental Record Layout**	Corrected: The record size is fixed to 1049 bytes from 683 bytes.	**8/7/19**
Susan Bryson	**Appendix G**	**Provider Type table** **Provider Registry File Layout**	Removed referral to Appendix J and corrected to Appendix G.	**8/8/19**
Susan Bryson	**Appendix D**	**Provider Rates File**	Removed referral to Appendix J and corrected to Appendix G.	**8/8/19**
Susan Bryson	**Appendix G**	**Provider Supplemental Record Layout Error Codes**	Added current code set	**8/8/19**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	Disposition of Edit 472 changed from “E” to “D” deny.	**9/3/19**
Susan Bryson	**Appendix AD**	**Behavioral Health Provider Types & Specialties**	Crisis Stabilization, Center Based Respite PT changed from AE to 83.	**9/10/19**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	REVERSED: Disposition of Edit 472 changed from “D” back to “E” deny.	**9/5/19**
Susan Bryson	**Section 2**	**Batch File Limitations**	Corrected typo to weekly deadline: changed from Thursday to Wednesday, 12:00 noon; no NCPDP submissions allowed on Thursdays.	**9/10/19**
Susan Bryson	**Inbound Files to Molina**	**Encounter Files**	Corrected typo to weekly deadline: changed from Thursday to Wednesday, 12:00 noon; no NCPDP submissions allowed on Thursdays.	**9/10/19**

Susan Bryson	**Appendix S**	**Prior Authorization Data Elements**	Updated deadline for weekly file submissions from 2 pm Friday to 5 pm Saturday	**11/08/19**
Susan Bryson	**Appendix E**	**416 Report**	Removed 416 Report – LDH stopped using self-reported data in 2018	**12/05/19**
Susan Bryson	**Appendix G**	**Provider Specialty Types**	Replaced list with list provided by Provider Enrollment in 09/2019	**12/6/19**
Susan Bryson	**Appendix D**	**Provider Rates File**	Removed referral to Appendix J and corrected to Appendix G.	**8/8/19**
Susan Bryson	**Appendix G**	**Provider Supplemental Record Layout Error Codes**	Added current code set	**8/8/19**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	Disposition of Edit 472 changed from “E” to “D” deny.	**9/3/19**
Susan Bryson	**Appendix AD**	**Behavioral Health Provider Types & Specialties**	Crisis Stabilization, Center Based Respite PT changed from AE to 83.	**9/10/19**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	REVERSED: Disposition of Edit 472 changed from “D” back to “E” deny.	**9/5/19**
Susan Bryson	**Section 2**	**Batch File Limitations**	Corrected typo to weekly deadline: changed from Thursday to Wednesday, 12:00 noon; no NCPDP submissions allowed on Thursdays.	**9/10/19**
Susan Bryson	**Inbound Files to Molina**	**Encounter Files**	Corrected typo to weekly deadline: changed from Thursday to Wednesday, 12:00 noon; no NCPDP submissions allowed on Thursdays.	**9/10/19**
Susan Bryson	**Appendix S**	**Prior Authorization Data Elements**	Updated deadline for weekly file submissions from 2 pm Friday to 5 pm Saturday	**11/08/19**
Susan Bryson	**Appendix E**	**416 Report**	Removed 416 Report – LDH stopped using self-reported data in 2018	**12/05/19**
Susan Bryson	**Appendix G**	**Provider Specialty Types**	Replaced list with list provided by Provider Enrollment in 09/2019	**12/6/19**
Susan Bryson	**Change Control Table**	**List of SCG changes prior to 8/8/19**	Moved previous change control table entries to end of document for ease of use.	**12/27/19**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	Edit 202 – change disposition from “E” to “D”	**12/27/19**

Susan Bryson	**Appendix G**	Provider Registry Edit File Layout	Remove Enroll Code 'X=Remove	**1/15/20**
Susan Bryson	**Appendix G**	Provider Registry Edit File Layout	Add 8V to Provider Specialty Types with associated Provider Type = 68	**2/5/20**
Susan Bryson	**Throughout**	Throughout SCG	Changed DHH to LDH where appropriate	**2/5/20**
Susan Bryson	**Throughout**	Throughout SCG	Changed Molina to DXC where appropriate	**2/5/20**
Susan Bryson	**Throughout**	Throughout SCG	Changed FTP to sFTP	**2/5/20**
Susan Bryson	**Section 2**	Tracking of Evidence Based Practice (EBP)	Add EBP Tracking Code 06 -Triple P- Standard Level 4	**3/6/20**
Susan Bryson	**Section 2**	Tracking of Evidence Based Practice (EBP)	Add EBP Tracking Code 07 - TF-CBT	**3/6/20**
Susan Bryson	**Appendix S**	**Prior Authorization Requests Data Elements**	Removed unnecessary, old highlights and updated text to black	**3/16/20**
Susan Bryson	**Appendix F**	**Encounter Edit Codes**	Change Edit 191 disposition from OFF to Deny	**5/5/20**
Susan Bryson	**Appendix S**	Prior Authorization File Layout	UPDATE: Clarify Service Code T1019 needs EP modifier and PT 24.	**5/8/20**
Susan Bryson	**Appendix S**	Prior Authorization File Layout	ADD: Field- Auth Days & Hours Codes at end of file layout	**5/8/20**
Susan Bryson	**Appendix G**	Provider Registry Edit Report	ADD: Updated Report view ADD: Error Code 42 – SETI	**5/8/20**
Susan Bryson	**Appendix S**	Prior Authorization	ADD: Prior Authorization Reconciliation File Layout (FI > MCO)	**6/5/20**
Susan Bryson	**Appendix S**	Prior Authorization	ADD: Prior Authorization Reconciliation Error File Layout (FI > MCO)	**6/5/20**
Susan Bryson	**Appendix S**	Prior Authorization	ADD: T1019 Criteria and Error Message Table	**6/5/20**
Susan Bryson	**Appendix F**	Encounter Edit Codes	Change Edit Dispositions for Edits 131, 141, 191, 316, 334, 336, 340, 387, 408, 472	**6/5/20**
Susan Bryson	**Appendix S**	Prior Authorization	Update: Provider NPI – required & T1019 must have PT = 24 Provider Taxonomy required for EPSDT PCS Provider Type = 24 CPT Modifiers 1 – T1019 must have EP modifier	**6/5/20**

			Plan Authorization Statuses E and B	
Susan Bryson	**Section 2**	Encounter Data Instructions	ADD: Atypical Providers – NEMT: added instructions for Southeastern Transportation Inc (SETI)	**7/6/20**
Susan Bryson	**Section 2**	Tracking of Evidence Based Practices (EBP)	ADD: EMDR Therapy – Eye Movement Desensitization and Reprocessing, tracking code, valid CPT/HCPCS codes and credentialing documentation to provide the EBP	**7/7/2020**
Susan Bryson	**Appendix Q**	Pharmacy Encounters Supplemental File Layout	Added: "Required" status to NCPDP field 423-DN. See Comment column.	**8/4/2020**
Susan Bryson	**Encounter Data Instructions**	File Naming Conventions	Add: NEAT to Ambulance Transportation – NEAT, EMT: Provider Type 51	**8/6/2020**
Susan Bryson	**Section 2**	Encounter Data Instructions	ADDED: FFS to Southeastern Transportation Inc. (SETI) - FFS shall:	**8/11/2020**
Susan Bryson	**Appendix D**	EDI TRANSMISSION RESEARCH REQUEST	. Changed Molina logo to DXC logo	**8/11/2020**
Susan Bryson	**Appendix F**	Encounter Edit Codes	. Change Edit 349 disposition from 'E' to 'D'	**8/18/20**
Susan Bryson	**Appendix F**	Pharmacy Encounter Edits	. ADD: Edit 939 with disposition "D"	**12/9/20**
Susan Bryson	**Appendix G**	Provider Supplemental Record Layout	. Change: 60-61 – FIPS State – Required; State – (R) equired; 63-65 – FIPS Parish = (R) equired	**12/9/20**

Policy/Procedure	Date Posted	Public Comment Due By	Status
Disposition of Edit 472 change from "E" to "D" deny.	9/10/19	10/25/19	Complete
Update: 416 Report information – LDH stopped using self-reported data in 2018 but LDH uses encounters	9/10/19	10/25/19	Complete

to generate the 416 report			
Change Disposition of Edit 202 from “E” to “D” in MCO System Companion Guide	01/07/2020	02/21/2020	Complete
Addition of new codes to Evidence Based Practice Codes: EB06 and EB07	03/06/2020	04/20/2020	Complete
Change Disposition of Edit 191 from “O” to “D”	5/5/2020	06/19/2020	Complete
Tracking of Evidence Based Practices (EBP)	7/28/2020	9/11/2020	Complete

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