Prepaid Inpatient Health Plan (PIHP)
Coordinated System of Care (CSoC)

Systems Companion Guide

December 2023
Version 22

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

The Department of Health and Hospitals (LDH) will provide maintenance of all documentation changes to this Guide using the Change Control Table as shown below.

Change Control Table

Author of Change	Sections Changed	Description	Reason	Date
Andrea Hollins/ Kerri Capello	Version 1.0			10/11/15
Kerri Capello	Appendix G	Updated Provider Types & Provider Specialties	LDH Provider Types & Provider Specialties missing from grid	10/13/15
Kerri Capello	Appendix J	Removed paragraph under LTC CSoC File layout	Isn't applicable to file	10/13/15
Kerri Capello	Appendix E	Removed the word Interim.	Reporting denied claims in encounter is not included in CSoC contract. Denied claims will be reported in the monthly claims report for this contract.	10/14/15
Jacques Kado	Appendix J	Updated the LTC LBHP/CSoC PIHP Segment Layout	Provided additional clarification	10/21/15
Andrea Hollins	Appendix L	Added the Lookup Taxonomy Table	Magellan requested the table be added	10/29/15
Andrea Hollins	Section 7	Removed Codes – H0018, T2048, S5145, and H2013	Codes are not covered services	10/29/15
Andrea Hollins/ Tamara Manuel	**Version 2**		**NOTE:** Appendices have been updated with new letters starting with Appendix C. Will be noted in the below entries.	11/18/15
Andrea Hollins	Section 2	Reporting Interest Payment	Explanation of how interest is to be reported	11/2/15
Tamara Manuel	Appendix C		Blank – Not Utilized in Version 1	11/18/15

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Author of Change	Sections Changed	Description	Reason	Date
Tamara Manuel	Appendix D	System Generated Reports	Changed Appendix letter to "C".	11/18/15
Tamara Manuel	Appendix E	PIHP Generated Reports	Changed Appendix letter to "D"	11/18/15
Tamara Manuel	Appendix F	Encounter Edit Codes	Changed Appendix letter to "E"	11/18/15
Tamara Manuel	Appendix G	Provider Directory/Network Provider and Sub Registry	Changed Appendix letter to "F"	11/18/15
Tamara Manuel	Appendix H	Test Plan	Changed Appendix letter to "G"	11/18/15
Tamara Manuel	Appendix I	Websites	Changed Appendix letter to "H"	11/18/15
Tamara Manuel	Appendix J	LTC CSoC PIHP Segment Layout	Changed Appendix letter to "I"	11/18/15
Tamara Manuel	Appendix K	Prior Authorization File	Changed Appendix letter to "J"	11/18/15
Tamara Manuel	Appendix L	Provider Type – Provider Specialty – Taxonomy Crosswalk	Changed Appendix letter to "K"	11/18/15
Andrea Hollins Tamara Manuel	Appendix M	Supplemental Claims History File Layout	Highlighted fields are the items used to identify BH services. TM – Changed Appendix letter to "L"	11/2/15 TM – 11/18/15
Tamara Manuel	Appendix N	Provider Supplemental Record Layout	Added the Provider Supplemental Record Layout Changed Appendix letter to "M"	11/4/15 TM – 11/18/15
Tamara Manuel	Appendix N	CSoC Chisholm Electronic File Layout	Added CSoC Chisholm Electronic File Layout	11/18/15
Andrea Hollins/ Tamara Manuel	Appendix **O**	Master File Exchange Schedule	Added Inbound/Outbound File Schedule Changed Appendix letter from N to "O". Updated schedules with new Inbound/Outbound files with naming conventions noted in yellow highlight.	11/2/15 TM - 11/18/15

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Author of Change	Sections Changed	Description	Reason	Date
Tamara Manuel	December 2015 - Version 2.1		See Updates Below starting with date 11/23/2015	11/23/15
Tamara Manuel	Section 3	Encounter Edit Codes	Deleted Edit Codes that were designated to be turned off or educational. Off – 001,004,012, 013,018, 019, 031, 065, 088, 089,100, 101, 108, 132, 143, 145, 146, 182, 207, 212, 219, 223, 224, 260 293, 294] [Educational – 011, 021, 022, 048, 063, 064,067, 084, 232, 272]	11/23/15 and 12/06/15
Tamara Manuel	Appendix E	Encounter Edit Codes	Added Edit Codes that designated as Deny. [141,149 255]	11/23/15 & 12/06/15
Tamara Manuel	Appendix M & Appendix O	Supplemental Claims History File Layout & Master File Exchange Schedule	Removed highlighted from text in each Appendix.	11/23/15
Tamara Manuel	Appendix **O**	Master File Exchange Schedule	Updated Outbound File Schedule to include the "Send on" information for the file.	11/23/15
Tamara Manuel	Appendix I	LTC CSoC PIHP SEGMENT LAYOUT	Updated Error Code 032 with additional criteria in red text. Added new Error Code 033 with criteria.	11/30/15 / 12/04/15
Tamara Manuel	Table of Contents	Footer	Updated Footer Information (Version 2.1 December 2015)	12/04/15
Tamara Manuel	Section 1 through Appendix 0	Page Numbering	Reformatted Section 1 Page Numbering sequence to start at #1 etc.	12/6/15
Tamara Manuel	Section 9	Department of Corrections (DOC) PMPM Recoveries	Added to Table of Contents	12/9/2015
Tamara Manuel	Appendix P	PIHP CSoC BATCH ELECTRONIC FILE LAYOUT for TPL INFORMATION	Added the TPL-BATCH-PLANID-CCYYMMDD.txt Layout	12/10/15
Tamara Manuel	Appendix M	Updated Provider Supplemental File Layout	Removed Prior Provider Supplemental File Layout and	12/11/15

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Author of Change	Sections Changed	Description	Reason	Date
			Added the UPDATED Provider Supplemental File Layout.	
Tamara Manuel	Appendix O	File Exchange Schedule	Incorporated the MCO Outbound/Inbound File Schedule into the PIPH Schedule.	12/14/15
Tamara Manuel	Appendix F	Provider Directory/ Network Provider and Sub Registry	Added Prescriber Indicator Codes 6, 7 and 8 with their Descriptions.	12/17/15
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the RECIPIENT_WEEKY_RETRO_YYYY MMDD.ZIP FILE and supporting information to the Outbound File Exchange.	01/07/16
Tamara Manuel	Appendix I	LTC CSoC PIHP SEGMENT LAYOUT	Update Plan File submission criteria for File number 8 to include the following: When edit 139 is used the end date must be ONE day prior to the begin date.	01/08/16
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the CSoC Monthly 820 file information in the Outbound File Schedule. Name of file: CAP-2177141-YYYMMDD-CSOC.txt	01/14/16
Tamara Manuel	Appendix Q	ELIG RECON FILE LAYOUT	Added the file layout for the *STOLA_MOLINA_RECON_YYYYM MDD.TAB* information.	01/27/16
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the following file to the Inbound File Exchange listing: Stola_Molina_Recon_YYYYMMD D.TAB	01/27/16
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the following return files to the Outbound File Exchange listing: WEEKLY_RECIP_RECON_RESP_{D AILY8}.TXT WEEKLY_RECIP_RECON_REPT_{D AILY8}.TXT WEEKLY_RECIP_RECON_REPT_FIL E_{DAILY8}.TXT	01/28/16

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Author of Change	Sections Changed	Description	Reason	Date
Tamara Manuel	Table of Contents	Footer	Updated Footer Information (Version 2.3 January 2016)	01/28/16
Tamara Manuel	Table of Contents	Appendix Q	Added Appendix Q & Naming Convention of Layout: Elig Recon File Layout with Page Number	01/28/16
Tamara Manuel	Appendix M	UPDATED Provider Supplemental Record Layout	Revised verbiage under the Notes Section to Columns 9-19 and 10-16 and then changed Column 20-26 from O = Optional to R = Required.	02/10/16
Tamara Manuel	Section 3	Encounter Edit Code(s): Deny (Repairable or Repairable Under Limited Circumstances):	Deleted the following codes that have been turned Off: 914, 930, 931, 933, 946, 949 and 980.	02/15/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Deleted the following "Informational" codes that have been turned Off: 651, 701, 711, 730, 790, 792, 795, 918, 921, 947, 961, 962, 969, 977 and 981.	02/15/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Deleted the following "Non Repairable Denials" Table that have been turned Off: 642, 673, 758, 791, 813, 942, 948, 951, 952, 954, and 972.	02/15/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Added the following codes to the "Informational" Table: 791 and 813.	02/15/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Added the following codes to the "Non-Repairable Denials" Table: 807, 851, 852, and 860.	02/15/16
Tamara Manuel	Table of Contents through Appendix Q	Reformatted/Page Numbering	Reformatted entire document for automatic processing of all type of headings and page numbering.	02/16/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Deleted the following "Informational" code 556.	02/23/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Added the following code to the "Non-Repairable Denials" Table: 556.	02/23/16
Tamara Manuel	Change Control Table	Column Dates	Corrected dates for the above entries for Encounter Edit Codes	02/23/16

Author of Change	Sections Changed	Description	Reason	Date
			starting after 02/10/2016. Changed all 12/15/16 dates to 02/15/16.	
Tamara Manuel	Table of Contents	Footer	Footer Information (Updated Draft to February 2016)	02/23/16
Tamara Manuel	Appendix M	UPDATED PROVIDER SUPPLEMENTAL RECORD LAYOUT	Changed the "License End Date 2 through 5" from R = Required to O = Optional.	02/29/16
Tamara Manuel	Appendix M	UPDATED PROVIDER SUPPLEMENTAL RECORD LAYOUT	Added verbiage for Part 1 Plan File Submission	03/15/16
Tamara Manuel	Table of Contents	Footer	Corrected Month of the Footer Information to MARCH 2016 Version 2.5.	03/15/16
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the following file to the Inbound File Exchange listing: **CCYYMMDD_xxxxxxx_Provider_ Suppl.txt**	03/21/16
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the following file to the Outbound File Exchange listing: **PROVIDER_SUPPLEMENTAL_xxx xxxx_ccyymmdd.txt** and the **MW-W-50-xxxxxxx- ccyymmdd.PDF**	03/21/16
Tamara Manuel	Table of Contents	Footer	Corrected Month of the Footer Information to APRIL 2016 Version 2.5.	04/04/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Deleted the following "Non-Repairable Denial" code 556.	04/04/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Added the following code to the "Educational" Table: 556.	04/04/16
Tamara Manuel	Section 2	Batch Submissions	Updated/Clarified verbiage to paragraphs.	04/12/16
Tamara Manuel	Section 12	Magellan CSoC Quarterly Retro Process for PMPM Adjustments	Added the business processes for the Magellan CSoC Qtrly. Retro Process for PMPM Adjustments	04/21/16
Tamara Manuel	Appendix C	SYSTEM GENERATED REPORTS - Subsection: 820 File (FI to PIHP)	Added the REF=Reference Information (1st occurrence) and the REF=Reference Information (2nd occurrence – used only for duplicate recipient recoveries)	04/26/16

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Author of Change	Sections Changed	Description	Reason	Date
Tamara Manuel	Section 13	PMPM Payment Recovery for Duplicate Recipient Medicaid IDs (Magellan)	Added criteria/business process for PMPM Payment Recoveries for Duplicate Recipient Medicaid IDs.	04/27/16
Tamara Manuel	Appendix R	RECIP-MULTIPLE-ID-RECORD FILE LAYOUT	Added the RECIP-MULTIPLE-ID-RECORD FILE LAYOUT	04/27/16
Tamara Manuel	Appendix O	Master File Exchange Schedule	Added the following file and file information to the Outbound File Exchange listing: Recipient Voided IDs.txt file.	04/27/16
Tamara Manuel	Appendix C	SYSTEM GENERATED REPORTS - Subsection: 820 File (FI to PIHP)	Removed "Sample: REF*ZZ*0101C~" Information.	04/28/16
Tamara Manuel	Table of Contents	Footer	Corrected Month of the Footer Information to May 2016 Version 3.	05/25/16
Tamara Manuel	Section 13	PMPM Payment Recovery for Duplicate Recipient Medicaid IDs (Magellan)	Removed verbiage "Effective May 2016" from 1st paragraph.	05/25/16
Tamara Manuel	Table of Contents	Title Page & Footer of Document	Corrected Month of the Footer Information to June 2016 Version 4.	06/02/16
Tamara Manuel	Appendix P	PIHP CSoC Batch Electronic File Layout for TPL Information	Updated highlighted text language in yellow.	06/03/16 & 6/10/16
Tamara Manuel	Appendix P	PIHP CSoC Batch Electronic File Layout for TPL Information	Added the TPL Scope of Coverage and the TPL Initiator Codes Tables.	06/03/16
Tamara Manuel	Title Page	LDH Logo	Added new Logo for LDH – Louisiana Department of Health.	06/08/16
Tamara Manuel	Appendix P	PIHP CSoC Batch Electronic File Layout for TPL Information	Added the TPL Carrier Code File Layout Table.	06/09/16
Tamara Manuel	Entire Document	PIHP CSoC System Companion Guide	Replaced DHH with LDH and Louisiana Dept. of Health and Hospitals with Louisiana Department of Health throughout the entire document.	06/09/16

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Author of Change	Sections Changed	Description	Reason	Date
Tamara Manuel	Table of Contents	Title Page & Footer of Document	Corrected Month of the Footer Information to July 2016 Version 5.	07/11/16
Tamara Manuel	Appendix P	PIHP CSoC Batch Electronic File Layout for TPL Information	Removed highlighted from text language.	07/20/16
Tamara Manuel	Section 2	Batch Submissions	Added The EDI Transmission Research Request Instructions and Form	07/20/16
Tamara Manuel	Table of Contents through Appendix R	Reformatted/Page Numbering	Reformatted entire document for automatic processing of all type of headings and page numbering.	07/20/16
Tamara Manuel	Appendix P	PIHP CSoC Batch Electronic File Layout for TPL Information	Added the TPL File Layout to Magellan with the following: 05 OTHER-INS-INITIATOR-CODE PIC x(02).	07/22/16
Tamara Manuel	Table of Contents	Title Page & Footer of Document	Corrected Month of the Footer Information to August 2016 Version 6.	08/02/16
Tamara Manuel	Appendix I	LTC CSoC PIHP SEGMENT LAYOUT	Updated PART 2: SUBMISSION EDIT PROCESS to include the new Error Code 060 ME CSOC Overlap and description.	08/03/16
Tamara Manuel	Appendix E	Encounter Edit Codes	Added the following code to the "Non-Repairable Denials" Table: 349 – Recipient not covered for this service.	08/11/16
Tamara Manuel	Appendix O	Inbound Files to Molina	Removed the "CCYYMMDD_PlanID_Provider_Suppl_ Monthly.txt" file information.	09/19/16
Tamara Manuel	Table of Contents	Title Page & Footer of Document	Corrected Month of the Footer Information to November 2016 Version 7	11/02/16
Tamara Manuel	Table of Contents	Title Page & Footer of Document	Corrected Month of the Footer Information to February 2017 Version 8	02/16/17
Tamara Manuel	Appendix S	Third Party Liability (TPL) Batch Full Reconciliation File Layout	Added the TPL Batch Full Reconciliation File Layout	02/16/17

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Author of Change	Sections Changed	Description	Reason	Date
Tamara Manuel	Table of Contents	Reformatted Document	Reformatted entire document for automatic processing several headings and page numbering.	02/20/17
Tamara Manuel	Appendix P	PIHP CSoC Batch Electronic File Layout for TPL Information	Removed the TPL File Layout to Magellan with the following: 05 OTHER-INS-INITIATOR-CODE PIC x(02), etc.	11/07/17
Tamara Manuel	Appendix T	Third Party Liability (TPL) File Layout to Magellan	Added the MBI Field to the TPL File Layout – Incremental & Reconciliation	11/07/17
Tamara Manuel	Appendix T	Third Party Liability (TPL) File Layout to Magellan	Added the Tables for the 2 character predetermined (assigned) field that denotes the initiator of the private insurance segments to Appendix T.	11/08/17
Tamara Manuel	Table of Contents	Title Page & Footer of Document	Corrected Month of the Footer Information to November 2017 Version 9	11/08/17
Tamara Manuel	Table of Contents	Reformatted Document	Reformatted entire document for automatic processing several headings and page numbering.	11/08/17
Nicola Carter	Appendix S	Third Party Liability (TPL) Batch Full Reconciliation File Layout	Added additional field identification for field numbers 11 through 20.	5/3/18
Nicola Carter	LDH Responsibilities	Update contact information	Update LDH contact information	5/9/18
Nicola Carter	Table of Contents	Title Page and Footer of Document	Corrected month of footer information to May 2018 Version 10	5/10/18
Nicola Carter	Appendix A	Definition	837 Format update to 5010	5/15/18
Nicola Carter	Appendix O	Master File Exchange Schedule	Deleted all file exchange information not pertaining to PIHP	6/7/18

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Author of Change	Sections Changed	Description	Reason	Date
Nicola Carter	Introduction	Updated text/document information	Adding wording to include "denied claims", "Provider-to-Payer-to-Provider COB.	9/25/18
Nicola Carter	Encounter Definition	Updated text/document information	Added PIHP must report all paid and denied claims	9/25/18
Nicola Carter	Contract Requirements	Updated text/document information	Added PIHP shall submit all encounter data at least weekly, and no later than the week following the week in which they were processed and approved/paid or denied, including approved/paid encounters reflecting a zero dollar paid amount ($0.00) and claims in which the PIHP has a capitation arrangement with a provider	9/25/18
Nicola Carter	Implementation Date	Updated text/document information	Added within sixty (60) days of operation, the PIHP's Systems shall be ready to submit encounter data to LDH's FI in a HIPAA compliant Provider-to-Payer-to-Provider COB format	9/25/18
Nicola Carter	FI Responsibilities	Updated text/document information	Added LDH's FI will be responsible for accepting, editing and storing PIHP 837 encounter data.	9/25/18
Nicola Carter	X12 Reporting	Updated text/document information	Added: The TA1 acknowledgment response file is used to report receipt of an 837 file and notify the sender that the 837 included a valid envelope or that there were problems with the interchange control structure	9/25/18
Nicola Carter	Proprietary Reports	Appendix Update	Appendix corrected from "D" to "C"	9/25/18
Nicola Carter	Prepaid Inpatient Health Plan (PIHP) Resp.	Appendix Update	Appendix corrected from "E" to "D"	9/25/18

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Author of Change	Sections Changed	Description	Reason	Date
Nicola Carter	Transaction Set Supplemental Instructions-Intro	Updated text/document information	Added updated 837 formats and location to find information/guidance.	9/25/18
Nicola Carter	Table of Contents	Page Numbers Updated	Page Numbers Updated	9/26/18
Nicola Carter	CMS Approval FI Companion Guide and Billing Instructions	Updated text/document information	Introduction updated. LDH Supplemental Instructions updated.	9/26/18
N. Carter	Identifying Atypical Providers	Updated text/document information	Atypical providers may not be assigned an NPI. If a provider has an NPI, the PIHP must send the NPI in Loop 2010AA NM109 (the typical place to send the Billing Provider's NPI in 837s). When the provider does not have an NPI, the provider's LA Medicaid Legacy Provider ID, is sent in Loop 2010BB REF*G2	9/26/18
N. Carter	PIHP Internal Character Number	Updated text/document information	Updated character 2	9/26/18
N. Carter	Financial Fields	Updated text/document info	Added: This amount is stored on the encounter in COB data	9/26/18
N. Carter	Interest Paid Amount	Updated text/document info	Added: In the Claim Interest set of COB Loops, use value INT996 (instead of using the PIHP unique LDH Carrier Code – 999996) as the payer id in Loop 2330B NM109 and in Loop 2430 SVD01 when reporting at the service-line level	9/26/18
N. Carter	Category II CPT Codes	Updated text/document info	Added: When there are no billed charges, then use value 0 as the charge amount.	9/26/18
N. Carter	Behavioral Health Provider Types, Specialties, and Taxonomy	Grid Added	Grid Added	9/26/18

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Author of Change	Sections Changed	Description	Reason	Date
N. Carter	Electronic Data Interchange	Updated text/document info	Updated appendix location	9/26/18
N. Carter	Encounter Data Certification	Updated text/document info	Update to wording	9/26/18
N. Carter	Appendix	Removed LTX Table		10/11/18
N. Carter	Behavioral Health Provider Types, Specialties, and Taxonomy	Grid Updated	Grid Updated	12/11/18
N. Carter	Behavioral Health Provider Types and Specialties	Grid Updated	Removed Taxonomy and Taxonomy Descriptions from grid. Added CSoC services and notes.	1/9/19
N. Carter	Tracking of Evidence Based Practices (EBP)	Additional Encounter Requirements	Added Tracking of Evidence Based Practices Instructions and Table	1/9/19
N. Carter	Provider Specialty Types	Provider added	Methadone Clinic added	1/31/20
N. Carter	Behavioral Health Provider Types, Provider Specialties and Provider Subspecialties	Provider added	Methadone Clinic added	1/31/20
N. Carter	Tracking of Evidence Based Practices (EBP)	Updated table	Added two new EBP codes	3/3/20
N. Carter	Behavioral Health Provider Types, Provider Specialties and Provider Subspecialties	Updated table	Added taxonomy codes	9/30/22
A.Marshall	Behavioral Health Provider Types, Provider Specialties and Provider Subspecialties	Updated table	Corrected typo on table.	10/6/22

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Author of Change	Sections Changed	Description	Reason	Date
N. Carter	Provider Specialty Types	To remove Provider Type AG	To remove Provider Type AG	5/25/23
N. Carter	Behavioral Health Provider Types (PT), Provider Specialties (PS) and Provider Subspecialties (PSS) Grid	Update	Update table	5/30/23
N. Carter	PIHP Internal Control Number (ICN)	Update "Character 1"	Update description	12/6/23

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Overview

Introduction

The Department of Health (LDH) is an administrative department within the Executive Branch of State government in Louisiana. The administrative head of LDH is the Secretary, who is appointed by the Governor. The mission of LDH is to protect and promote health and ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana (State). LDH is dedicated to fulfilling its mission through direct provision of quality services, development and stimulation of services for others, and utilization of available resources in the most effective manner.

LDH is comprised of the Bureau of Health Services Financing/Medical Vendor Administration (BHSF/MVA), Office of Behavioral Health (OBH), the Office for Citizens with Developmental Disabilities (OCDD), the Office of Aging and Adult Services (OAAS), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to LDH. LDH, in addition to the program offices, has an administrative office (Office of the Secretary), a financial office (Office of Management and Finance), and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

BHSF/MVA and the Office of Behavioral Health (LDH-OBH) share oversight of the Coordinated System of Care (CSoC). The CSoC is a research-based model that is part of a national movement to develop family and youth-driven care and keep children with severe behavioral health needs at home, in school, and out of the child welfare and juvenile justice system. The CSoC also creates partnerships with public and private providers to form a multi-agency, multi-disciplinary system of care. The system of care model involves collaboration among agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services for CSoC youth and families.

LDH, based on Federal Guidelines, requires the PIHP to report encounters for all CSoC enrolled recipients. Reporting of these encounters must include all paid and denied claim records for services provided to CSoC recipients who receive services under the CSoC contract.

The PIHP will be required to submit encounters to the Fiscal Intermediary (FI) using HIPAA compliant Provider-to-Payer-to-Provider Coordination of Benefits (COB) 837I (Institutional) and 837P (Professional) transactions. LDH has provided as quick references in Appendix A - Definitions of Terms and Appendix B Frequently Asked Questions.

Encounter Definition

Encounters are records of medically related services rendered by the PIHP provider to Medicaid enrollees eligible for contracted services with the PIHP on the date of service. It includes all services for which the PIHP has any financial liability to a provider. An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. The PIHP must report all paid and denied claims processed under the PIHP Contract as an encounter. Covered services under this contract include, but are not limited to the following:

- Mental Health Hospitals (free standing or distinct part psychiatric unit)
- Mental Health Clinics
- Physicians, Advance Practice Registered Nurses (APRN)
- Licensed Psychologists
- Licensed Clinical Social Workers

- Licensed Professional Counselors
- Licensed Marriage & Family Therapists
- Licensed Addiction Counselors
- Substance use and Alcohol use Centers
- Behavioral Health Rehabilitation Agencies or Providers
- Therapeutic Group Homes
- Family Support Organizations
- Transition Coordination Agencies
- Respite Care Services Agencies
- Crisis Receiving Centers
- Behavioral Health Rehabilitation Provider Agencies
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)
- HCBS 1915c Waiver Services for Children

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

> The PIHP must comply with encounter reporting requirements in accordance with the ASC X12 Standards Implementation (837IG) and the PIHP Systems Companion Guide, including payment withholding provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.

> For complete and accurate encounter data submissions, the PIHP shall submit all encounter data at least weekly, and no later than the week following the week in which they were processed and approved/paid or denied, including approved/paid encounters reflecting a zero dollar paid amount ($0.00) and claims in which the PIHP has a capitation arrangement with a provider.

Quality Management and Improvement

The CSoC program operated by the PIHP is a Medicaid program partially funded by CMS. The PIHP is required to collect and report performance measures (PM) data that demonstrates adherence to clinical practice and/or improvement in patient outcomes. These measures as defined by LDH, are reflected in the current PIHP contract. LDH will use encounter data to evaluate the performance of the PIHP and to audit the validity and accuracy of the reported measures.

Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Managed Care

According to the Balanced Budget Act (BBA), a written quality strategy plan is required to serve as the guiding principles for assessing the quality, effectiveness, and efficiency of services rendered to Medicaid enrollees. The goal of the quality strategy plan is to purchase the best value health care and services for LDH beneficiaries, to improve access to services for underserved and vulnerable beneficiary populations, and to protect them from substandard care. The objectives of the plan are to assess, monitor, and measure the improvement in health care and behavioral health services provided directly or through referrals to Medicaid CSoC beneficiaries, and to ensure the accuracy in claim payments for services rendered.

Continuous quality improvement focuses on measuring and improving the quality of the encounter data available to LDH. Data from the PIHP will continue to undergo data quality checks beyond the minimum criteria used in the edit process.

Implementation Date

Within sixty (60) days of operation, the PIHP's Systems shall be ready to submit encounter data to LDH's FI in a HIPAA compliant Provider-to-Payer-to-Provider COB format. Prior to submitting production encounters, the PIHP will test system changes using the state's FI submitter self-test system.

LDH Responsibilities

LDH is responsible for administering the Coordinated System of Care Program. Administration includes data analysis, feedback to the   PIHP, ensuring data confidentiality, and the contents of this   PIHP Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Bryan Hardy, Bryan.hardy@la.gov , 225.342.8216

Angela Marshall, Angela.marshall3@la.gov , 225.342.0332

Nicola Carter, Nicola.carter@la.gov , 225.342.1786

LDH is responsible for the oversight of the PIHP contract and PIHP activities. LDH's responsibilities include coordination with Medicaid's FI on the development and

production of the Systems Companion Guide, dissemination of the Systems Companion Guide to the PIHP, the initiation and ongoing discussion of data quality improvement with the PIHP, and facilitation of PIHP   training. LDH-OBH will notify the PIHP of all updates and provide the PIHP with the most current version of the Systems Companion Guide (as it is revised throughout the contract).

LDH reserves the right to revise the PIHP Systems Companion Guide at any time during the contract.

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with LDH to provide Louisiana Medicaid Management Information System (LMMIS) services including the acceptance of electronic encounter and claim reporting from the PIHP. LDH's FI will be responsible for accepting, editing and storing PIHP 837 encounter data. The FI will also provide technical assistance to the PIHP during the 837 testing process.

The PIHP will receive a listing of Medicaid eligible recipients at the beginning of each month and daily files for updates in a proprietary format.

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 999 Functional Acknowledgement. The TA1 acknowledgment response file is used to report receipt of an 837 file and notify the sender that the 837 included a valid envelope or that there were problems with the interchange control structure.

After claim adjudication, an ANSI ASC X12N 835 Remittance Advice (835) will be delivered to the   PIHP   if requested by the   PIHP. The   PIHP must prearrange for receipt of 835 transactions.

Proprietary Reports

The FI will also provide the PIHP with a monthly financial reconciliation report. The file layout can be found in Appendix C of this Guide.

These files include:

- Encounter Claims Summary
- Encounter Edit Disposition Summary
- Edit Code Detail
- 820 File
- SMO-O-005 and SM-W-010

Prepaid Inpatient Health Plan (PIHP) Responsibilities

The PIHP is responsible for submitting accurate and complete encounter data.

The PIHP must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by its providers. With regard to provider

identification, the PIHP is responsible for ensuring that the appropriate NPI, taxonomy, and 9-digit zip code are submitted in each transaction.

The PIHP is expected to investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are identified, the PIHP must document and track all denials including a listing of the issues, any action steps, responsible parties, and projected resolution dates. This tracking document, and successive updates, will be provided to LDH upon request.

The PIHP shall 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 (FTP) over a secure connection such as Virtual Private Network (VPN), that are in use at the start of the Systems readiness review activities.

On a monthly, quarterly, and yearly basis, the PIHP is required to provide LDH with PIHP Generated Reports as addressed in Appendix D of this Guide.

Transaction Set Supplemental Instructions

Introduction

The 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. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs) located on the CMS website. The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

The 837 formats used for LDH-OBH are the 837 Institutional (837I) and 837 Professional (837P) Provider-to-Payer-to-Provider Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

The ASC X12 (837 IGs) contain most of the information needed by the PIHP to complete this mapping. The PIHP Systems Companion Guide and the Louisiana Medicaid specific 837 Companion Guides (https://www.lamedicaid.com/provweb1/HIPAA/HIPAAindex.htm) contain the remaining information.

The PIHP shall create their 837 transactions for LDH using the HIPAA IG Version 5010. On January 16, 2009, HHS published final rules to adopt updated HIPAA standards; these rules are available at the Federal Register.

January 1, 2012, HHS adopted X12 Version 5010 for HIPAA transactions for all covered entities.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide.

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

Transformed Medicaid Statistical Information System (T-MSIS)

Introduction

Effective November 1, 2014, LDH, based on the Center for Medicare and Medicaid Services (CMS) mandate, is required to report on a monthly basis, ALL data elements submitted via 837 transaction as submitted by the PIHP. Reporting of the data elements will be done thru Transformed Medicaid Statistical Information System (T-MSIS).

The PIHP is expected to fully comply with T-MSIS system changes and testing. The PIHP is required to fully populate 837 data elements in accordance with the existing 5010 Implementation Guide.

The PIHP is required to perform testing thru the FI of Tier 1 and Tier 2 data elements in 2 Phases. Upon approval from the FI, the SMO must integrate the approved data elements into their system within 30 days of notification by and as designated by LDH.

Tier 1 Data Elements

Tier 1 is comprised of 143 data elements that are required to be reported by LDH, thru its FI, to CMS.

Phase I

The PIHP is required to utilize the 837 Mapping layouts (to test data elements currently being captured by the SMO but are not being sent to the FI.

Phase II

The PIHP is required to utilize the 837 Mapping layouts to integrate data elements not currently being captured by the SMO and sent to the Medicaid FI.

The FI and/or LDH will provide feedback regarding the status of the data elements tested to the PIHP via the MCO T-MSIS Test Tracking Document.

Feedback will include comment(s) for data element(s) that FAILED the test. The PIHP must correct, provide the reason for the FAILED data elements, and resubmit the corrected data elements to the FI (within the timelines designated by LDH-OBH) for re-testing until approval of FAILED Data Elements is received from the FI.

Data elements that receive "PASS" status from the FI will receive approval and/or comments from LDH and/or FI to integrate the data elements into the SMO's System.

Tier 2 Data Elements

CMS has advised LDH that Tier 2 Data Elements will be addressed in the Operational stage of T-MSIS.

LDH will continue to provide additional information regarding T-MSIS as it becomes available.

> NOTE: Testing for T-MSIS has been completed, and T-MSIS will move into production pending CMS approval Fiscal Intermediary (FI) Companion Guides and Billing Instructions.

CMS Approval Fiscal Intermediary (FI) Companion Guide and Billing Instructions

Introduction

Molina, as LDH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 999 Functional Acknowledgement. The TA1 acknowledgment response file is used to report receipt of an X12 837 file and notify the sender whether the 837 included a valid envelope or whether there were problems with the interchange control structure. The FI HIPAA Companion Guides can be found at https://www.lamedicaid.com/provweb1/HIPAA/HIPAAindex.htm.

LDH Supplemental Instructions

LDH requires the PIHP 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 PIHP will be required to include information about the PIHP provider claim adjudication. In the first set of COB data, the PIHP shall place their unique LDH carrier code in loop 2330B, NM109. If there is Medicare TPL, the PIHP shall place Medicare's unique LDH carrier code, 999999, in the second set of COB loops. The PIHP shall provide LDH with any third-party payments, in subsequent COB loops. The PIHP 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.

PIHP and Medicare Unique LDH Carrier Code Assignment

Plan Name: PIHP (Magellan)   Assigned Carrier Code: 999996

Medicare   Assigned Carrier Code: 999999

Batch Submissions

The PIHP may submit up to 99 batch encounters files per day. Each file can include up to 20,000 encounter records, but a limit of 5,000 records per file is recommended. Up to a total of 50,000 encounters can be sent per day. The daily cutoff is at 12:00 noon (Central); so the EDI daily limits are calculated from 12:01 PM to 12:00 PM. The combined total for Saturday and Sunday should not exceed 50,000. If more than the 50,000 per day limit is needed, then the PIHP shall establish a submission schedule with the Molina EDI department.

Files must be ASC X12N 837 format compliant.

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

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

EDI Transmission Research Request

PURPOSE

The EDI Transmission Research Request Form is for Medicaid Managed Care Plans to use when submitting a request to Molina for research regarding files and/or 835 responses. This form allows Molina 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 Bryan.Hardy@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 Molina (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 Molina	Provide the file name as sent to Molina.
Date you sent the file to Molina	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 Molina ICN or Date of 835 which can be indicated by N/A in those fields. Attach a spreadsheet 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

MOLINA®
Medicaid Solutions

EDI Transmission Research Request Form

Date: _____

Plan Name: _____
Trading Partner ID: _____

Problem Description:

Transmission Information	
Filename of the file you sent to Molina	
Date you sent the file to Molina	
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 Molina 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								
Molina ICN	Date of 835	Patient Control Number [CLM01]	Billing Provider NPI	Recipient Name	Recipient Medicaid ID	Claim Date of Service	Procedure Code	Problem Description

Version 22 – December 2023

Split Billing Claims

The PIHP may refer to the Hospital Services Manual for LDH policy on split billing located on the www.lamedicaid.com website.

COB Model of 837 with TPL

In 837 files, TPL is sent in the Coordination of Benefits (COB) set of segments. For Inpatient records, the TPL data should be sent at the Claim-Doc level; for all other types of records, if the TPL data is available at the Service-Line level then it should be sent at the Service-Line level.

Part of the COB data is always at the ClaimDoc level; it begins with the SBR segment of Loop 2320, it includes segments in Loop 2330A and this part ends with segments from Loop 2330B.

- For Inpatient records, all of the TPL data will be sent (at the Claim Doc level) in the Loop 2320 through Loop 2330B segments.
- For non-Inpatient records where there is Service-Line level TPL data, in addition to the Claim- Doc level COB data segments, the Service-Line level specific TPL data should be sent in the Loop 2430 segments.

When TPL data is being reported at the Claim-Doc level:

- The LA Medicaid 6-digit TPL Carrier Code value is sent in Loop 2330B NM109;
- The TPL amount paid is sent in the Loop 2320 AMT*D segment;
- The TPL payment date is sent in the Loop 2330B DTP segment; and
- Any Claim Level Adjustments are sent in Loop 2320 CAS segments.

When TPL data is being reported at the Service-Line level:

- The LA Medicaid TPL Carrier Code value is sent in both Loop 2330B NM109 and in Loop 2430 SVD01;
- The TPL amount paid is sent in Loop 2430 SVD02;
- The TPL payment date is sent in the Loop 2430 DTP segment; and
- Any Line Adjustments are sent in Loop 2430 CAS segments.

Identifying Atypical Providers

Atypical providers may not be assigned an NPI. If a provider has an NPI, the PIHP must send the NPI in Loop 2010AA NM109 (the typical place to send the Billing Provider's NPI in 837s). When the provider does not have an NPI, the provider's LA Medicaid Legacy Provider ID, is sent in Loop 2010BB REF*G2.

File Splitting Criteria

Encounter files must be submitted using the following file extension criteria.

See Next Page

Transaction.	Claim Type	Name	File Extension	Sample File Name
837P	09	Durable Medical Equip. Provider Type=40	DME	H4599999.DME
837P	04	Physician, Pediatric Day Health Care Professional Identify all 837P claims including EPSDT services, and excluding Rehab	PHY	H4599999.PHY
837P	05	Rehabilitation Provider Type=65, 59	REH	H4599999.REH
837P	07	Ambulance Transportation EMT: Provider Type=51	TRA	H4599999.TRA
837P	08	Non-Emergency Medical Transportation NEMT Provider Type =	NAM	H4599999.UB9
837I	01 & 03	Hospital IP/OP Inpatient: Identify by Place of Service: 1st 2 digits of Bill Type =11 or 12. Outpatient Identify by Place of Service: 1st 2 digits of Bill Type 13, 14, 73	UB9	H4599999.UB9
NCPDP Batch	12	NCPDP Batch Pharmacy Provider Type = 26		H4599999.NCP
837I	06	Home Health Bill Type 1st 2 digits of Bill Type=32.	HOM	H4599999.HOM

BHT06

The BHT06 is used to indicate the type of billed service being sent: fee-for-service (claim) or encounter.

- Use a value of CH when the entire ST-SE envelop contains FFS Claims.
- Use a value of RP when the entire ST-SE envelope contains encounters. RP is used when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim.

- If the RP value is not used, either the entire batch of encounters will be rejected, or the batch will be processed as claims, which will result in the denial of every claim.

Accepting and Storing Encounters

LDH's FI will be responsible for accepting, editing and storing PIHP 837 encounter data.

PIHP Internal Control Number (ICN)

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

The plan ICN length can be up to 30 characters. The ICN shall be modified to contain a 4-digit prefix as follows:

Character 1: Claim submission media type. Standard types would be 'P' to indicate a paper, 'E' to indicate an electronic claim, 'W' to indicate a claim submitted over a web portal, 'L' to indicate In Lieu Of Service (ILOS) billed to the MCE via paper form, 'U' to indicate ILOS billed to the MCE via EDI, and 'B' to indicate ILOS billed to the MCE via web portal. If other types are submitted, the PIHP must provide a data dictionary.

Character 2: Claim Status. Use value "P" for this character position when the claim was paid by the PIHP; also use value "P" for zero-paid conditions. Use value "D" for this character position when the claim was denied by the PIHP'.

Character 3–4: Vendor information. The PIHP shall provide a data dictionary that indicates which vendor or organization the claim was paid by. As vendors are changed, the PIHP is required to provide an update to the data dictionary.

Billing Provider Patient Control Number

The Billing Provider Patient Control Number (PAT-Ctrl-No) is to be populated in Loop 2300 CLM01.

The PIHP must echo the Provider Patient Control number from the claim in 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 Separator
~   Tilde   Segment Terminator

Paper Claims submitted without the Patient Control Number shall be submitted using "NOT SUPPLIED" in the CLM01 field.

Financial Fields

The financial fields that LDH requests the PIHP to report include:

- Header and Line Item Submitted Charge Amount
- Header and Line Item   PIHP Paid Amount
- Header and Line Item Adjustment Amount

Header and Line Item Submitted Charge Amount — The PIHP shall report the provider's charge or billed amount. The value may be "$0.00" if the PIHP contract with the provider is capitated and the PIHP permits zero as a charged amount. If the submitted charge is billed as "$0.00", the MMIS will calculate the paid amount as zero since LDH pays the lesser of the submitted charge or the calculated fee amount. A value other than "$0.00" must be submitted when the provider bills on a FFS basis.

Header and Line Item   PIHP Paid Amount — If the PIHP paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the PIHP or was covered under a sub-capitation arrangement, "$0.00" is the appropriate Paid Amount. This amount is stored on the encounter in COB data.

Header and Line Item Adjustment Amount — If the Paid Amount reflects any adjustments to the Submitted Line Item Charge Amount, the adjustment amounts must be reported. Any time the charge amount does not equal the paid amount, the   PIHP is required to report both the Adjustment Amount and the adjustment reason code (found at http://www.wpc-edi.com/codes/). The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Claim Received Date

The PIHP is required to submit the Plan's Claim Received Date in 837-P and 837-I encounter data.

The Claim Received Date will be sent in Loop 2300 in the REF*D9 Segment using date format yyyymmdd.

For Original Encounter records, the Claim Received Date value should be the date that the   PIHP received the Claim record from the Billing Provider.

For Adjustment Encounter records, if the Adjustment was initiated by the Billing Provider, then the Claim Received Date value should be the date that the   PIHP received the Claim Adjustment record from the Billing Provider. If the Adjustment was initiated by the   PIHP, then the Claim Received Date value should be the same as the Claim Paid Date of the Adjustment.

For Void Encounter records, if the Void was initiated by the Billing Provider, then the Claim Received Date value should be the date that the PIHP received the Claim Void record from the Billing Provider. If the Void was initiated by the   PIHP, then the Claim Received Date value should be the date that the   PIHP processed the Void record.

If a void or adjustment is requested by LDH or Molina, the original PIHP Claim received date would remain.

Claim Paid Date

Claim paid date is defined as the date the payment is released to the provider.

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

For Inpatient records, the Claim Paid Date will be sent in Loop 2330B in the DTP*573 Segment.

For non-Inpatient records, the Claim Paid Date will be sent in Loop 2430 in the DTP*573 Segment.

Interest Paid Amount

Interest Paid by the PIHP is required to be submitted in the Claim Interest Amount along with the Paid Date in 837P and 837I Encounter Data.

In the Claim Interest set of COB Loops, use value INT996 (instead of using the PIHP unique LDH Carrier Code – 999996) as the payer id in Loop 2330B NM109 and in Loop 2430 SVD01 when reporting at the service-line level.

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.

Professional Identifiers

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

Supplementation of CMS-1500 and UB-04

Certain information may be required that is not routinely present on the UB-04 or CMS-1500. In these circumstances, the PIHP must obtain valid medical records to supplement the UB-04 or use logic from the paper claim to derive the required additional information for the 837 transactions.

Category II CPT Codes

LDH requires the use of applicable Category II CPT Codes or HCPCS Level II G 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. In conjunction with the Category II CPT Codes, the PQRI quality-data codes (QDCs) follow current rules for reporting other CPT and HCPCS codes.

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 is SV101-2 "Product/Service ID." Note that it is also necessary to identify in this segment that you are supplying a Category II CPT/HCPCS Level II G-code by submitting the "HC" code for data element SV101-1. Necessary data elements (or fields) include, but are not necessarily limited to, the following:

- Date of service;
- Place of service;
- PQRI QDC(s), along with modifier (if appropriate);
- Diagnosis pointer;
- Submitted charge ($0.00 shall be entered for PQRI codes);
- Rendering provider number (NPI).

The submitted charge field cannot be left blank. When there are no billed charges, then use value 0 as the charge amount.

Transaction Type

The following tables provide guidance on the use of 837s. This guidance is subject to change. Please note that the following tables contain LDH provider types and are outlined consistent with the services manual included in the PIHP contract.

At present, the following provider types use 837I:

Provider Type	Description
44	Home Health Agency
54	Ambulatory Surgical Center
55	Emergency Access Hospital
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center
69	Hospital – Distinct Part Psychiatric Unit
76	Hemodialysis Center
77	Mental Health Rehabilitation
80	Nursing Facility

The following provider types use 837P:

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

Provider Type	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt - Infants & Toddlers (in-state only)
08	Case Mgmt - Elderly (in-state only)
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
22	Waiver Personal Care Attendant
23	Independent Lab
Provider Type	Description
24	Personal Care Services (LTC/PCS/PAS) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
27	Dentist and Dental Group
28	Optometrist and Optometrist Group
29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only) (for Waiver Services ONLY)
45	Case Mgmt - Contractor (in-state only)
46	Case Mgmt - HIV (in-state only)
47	Case Mgmt - CMI

48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
54	Ambulatory Surgical Center (in-state only)
61	Venereal Disease Clinic
62	Tuberculosis Clinic
65	Rehabilitation Center
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
70	LEA and School Board (EPSDT Health Services) (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
Provider Type	Description
83	Respite Care (Center Based)- Waiver (in-state only)
84	Substitute Family Care - Waiver (in-state only)
87	Rural Health Clinic (Independent) (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
95	American Indian / Native Alaskan "638" Facilities
97	Adult Residential Care
98	Supported Employment - Waiver (in-state only)
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC).

AL	Community Choices Waiver Nursing
AM	Home Delivered Meals
AN	Caregiver Temporary Support

Behavioral Health Provider Types (PT), Provider Specialties (PS) and Provider Subspecialties (PSS) Grid

Louisiana Specialized Behavioral Health Provider Types (PT), Provider Specialties (PS), and Provider Subspecialties (PSS) Grid (Revised 5.30.2023)				
Service	**Provider Description**	**PT**	**PS**	**PSS**
Crisis Stabilization - Youth	Center Based Respite	83	8E	
	Crisis Receiving Center	AF	8E	
	Therapeutic Foster Care	AR	9F	
Crisis Stabilization - Adult	Crisis Receiving Center	AF	8E	
Outpatient Crisis Response Services - Adults	Mental Health Rehabilitation Agency	77	78	
	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	8E
	Crisis Receiving Center	AF	8E	
Behavioral Health Rehabilitation Services	Mental Health Rehabilitation Agency	77	78	
	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	8E
	Assertive Community Treatment Team (ACT Services)	AA	8E	
	Multi-Systemic Therapy Agency (MST Services)	12	5M	
	Non-Licensed Behavioral Health Staff[1]	NB	8E	
	Peer Support Specialist[1]	PS	8E	
	Provisionally Licensed Professional Counselor (PLPC)[1] Effective 1/1/23	AK	LL	
	Provisionally Licensed Marriage and Family Therapist (PLMFT)[1] Effective 1/1/23	AH	LL	
	Licensed Master Social Worker (LMSW)[1] Effective 1/1/23	73	LL	
	Certified Social Worker (CSW)[1] Effective 1/1/23	73	LL	
	Psychology Intern[1] Effective 1/1/23	31	LL	
Peer Support Services (PSS)	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	8E
	Peer Support Specialist[1]	PS	8E	
Individual Placement and Support (IPS)	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	8E
	Non-Licensed Behavioral Health Staff[1]	NB	8E	
	Peer Support Specialist[1]	PS	8E	
	Provisionally Licensed Professional Counselor (PLPC)[1] Effective 1/1/23	AK	LL	
	Provisionally Licensed Marriage and Family Therapist (PLMFT)[1] Effective 1/1/23	AH	LL	
	Licensed Master Social Worker (LMSW)[1] Effective 1/1/23	73	LL	
	Certified Social Worker (CSW)[1] Effective 1/1/23	73	LL	
	Psychology Intern[1] Effective 1/1/23	31	LL	
Personal Care Services (PCS) - Behavioral Health	PCS - Long Term Care, Behavioral Health	24	5A	8E
	PCS - Long Term Care, EPSDT, Behavioral Health	24	5D	8E
	PCS - Behavioral Health	24	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	8E
	Non-Licensed Behavioral Health Staff[1]	NB	8E	
	Peer Support Specialist[1]	PS	8E	
	Provisionally Licensed Professional Counselor (PLPC)[1] Effective 1/1/23	AK	LL	
	Provisionally Licensed Marriage and Family Therapist (PLMFT)[1] Effective 1/1/23	AH	LL	
	Licensed Master Social Worker (LMSW)[1] Effective 1/1/23	73	LL	
	Certified Social Worker (CSW)[1] Effective 1/1/23	73	LL	
	Psychology Intern[1] Effective 1/1/23	31	LL	
Psychiatric Residential Treatment Facility	Psychiatric Residential Treatment Facility	96	9B	
	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	77	78	
	Mental Health Clinic (Legacy MHC) - **Reserved for LGEs**	74	70	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
	Psychologist - Clinical	31	6A	6X, 6Y, 6Z[2]
	Psychologist - Counseling	31	6B	6X, 6Y, 6Z[2]
	Psychologist - School	31	6C	6X, 6Y, 6Z[2]
	Psychologist - Developmental	31	6D	6X, 6Y, 6Z[2]
	Psychologist - Non-Declared (General)	31	6E	6X, 6Y, 6Z[2]
	Psychologist - Other	31	6F	6X, 6Y, 6Z[2]

	Medical Psychologist	31	6G	6X, 6Y, 6Z[2]
	Licensed Addiction Counselor	AJ	8E	6Y[2]
	Licensed Clinical Social Worker	73	73	6X, 6Y, 6Z[2]
	Licensed Professional Counselor	AK	8E	6X, 6Y, 6Z[2]
	Licensed Marriage and Family Therapist	AH	8E	6X, 6Y, 6Z[2]
	Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[2]
	Psychiatrist - Psychiatry, Addiction Psychiatry	20	2W	6X, 6Y, 6Z[2]
	Advanced Practice Registered Nurse - Nurse Practitioner	78	26	6X, 6Y, 6Z[2]
	Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[2]
	Physician Assistant	94	26	6X, 6Y, 6Z[2]
Substance Use Residential	Substance Use Residential Treatment Facility	AZ	8U	
Opioid Treatment Program (OTP)[3]	Opioid Treatment Program	68	70	8V
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	

[1] Legacy Mental Health Rehabilitation (MHR) providers are defined as accredited mental health rehabilitation providers enrolled in the Louisiana Medicaid program as of February 28, 2012.

[2] Staff providing mental health rehabilitation (MHR) services, peer support services (PSS) and Individual Placement and Support (IPS) must operate under an agency license issued by LDH. These services may not be performed by an individual, who is not under the authority of an agency license.

[3] Provider Subspecialties to be used to identify providers who specialize in pregnancy-related and postpartum depression or related mental health disorders (6X); pregnancy-related and postpartum substance use disorders (6Y); or pregnancy-related and postpartum mental health and substance use disorders (6Z). Licensed Addiction Counselors may only specialize in pregnancy-related and postpartum substance use disorders (6Y).

[4] Opioid Treatment Programs (OTPs) are federally approved by SAMHSA and the DEA, and regulated by LDH, which includes OBH and HSS and are authorized to dispense methadone as part of a clinically-monitored Medication for Opioid Use Disorder (MOUD).

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

Louisiana Specialized Behavioral Health Provider Types (PT), Provider Specialties (PS), Provider Subspecialties (PSS), and Taxonomies Grid (Revised 9.26.2022)					
Provider Description	Provider_Type	Specialty	Subspecialty	Facility_Indiv	Taxonomy
Multi-Systemic Therapy Agency (MST Services)	12	5M		F	261QM0855X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084B0002X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084B0040X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084F0202X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084H0002X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084P0005X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084P0015X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084P0301X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084P0804X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084P0805X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084P2900X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084S0010X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084S0012X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084V0102X
Psychiatrist - Psychiatry	20	26	6X, 6Y, 6Z[1]	I	2084N0600X
Psychiatrist - Psychiatry, Addiction Psychiatry	20	2W	6X, 6Y, 6Z[1]	I	2084A0401X
Psychiatrist - Psychiatry, Addiction Psychiatry	20	2W	6X, 6Y, 6Z[1]	I	2084P0802X
PCS - Long Term Care, Behavioral Health	24	5A	8E	F	253Z00000X
PCS - Long Term Care, Behavioral Health	24	5A	8E	F	311Z00000X
PCS - Long Term Care, EPSDT, Behavioral Health	24	5D	8E	F	253Z00000X
PCS - Long Term Care, EPSDT, Behavioral Health	24	5D	8E	F	311Z00000X
PCS - Behavioral Health	24	8E		F	253Z00000X
Psychologist - Clinical	31	6A	6X, 6Y, 6Z[1]	I	103G00000X
Psychologist - Clinical	31	6A	6X, 6Y, 6Z[1]	I	103GC0700X
Psychologist - Clinical	31	6A	6X, 6Y, 6Z[1]	I	103TC0700X
Psychologist - Counseling	31	6B	6X, 6Y, 6Z[1]	I	103TC1900X
Psychologist - School	31	6C	6X, 6Y, 6Z[1]	I	103TS0200X
Psychologist - Developmental	31	6D	6X, 6Y, 6Z[1]	I	103TA0700X
Psychologist - Developmental	31	6D	6X, 6Y, 6Z[1]	I	103TB0200X
Psychologist - Developmental	31	6D	6X, 6Y, 6Z[1]	I	103TM1800X
Psychologist - Non-Declared (General)	31	6E	6X, 6Y, 6Z[1]	I	103T00000X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	102L00000X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TA0400X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TE1000X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TE1100X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TF0000X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TF0200X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TH0004X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TH0100X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TM1700X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TP0814X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TP2700X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TP2701X
Psychologist - Other	31	6F	6X, 6Y, 6Z[1]	I	103TR0400X
Medical Psychologist	31	6G	6X, 6Y, 6Z[1]	I	103TP0016X
Psychology Intern[2]	31	LL		I	102L00000X
Psychology Intern[2]	31	LL		I	103G00000X
Psychology Intern[2]	31	LL		I	103GC0700X
Psychology Intern[2]	31	LL		I	103T00000X
Psychology Intern[2]	31	LL		I	103TA0400X
Psychology Intern[2]	31	LL		I	103TA0700X
Psychology Intern[2]	31	LL		I	103TB0200X
Psychology Intern[2]	31	LL		I	103TC0700X
Psychology Intern[2]	31	LL		I	103TC1900X
Psychology Intern[2]	31	LL		I	103TE1000X
Psychology Intern[2]	31	LL		I	103TE1100X
Psychology Intern[2]	31	LL		I	103TF0000X
Psychology Intern[2]	31	LL		I	103TF0200X
Psychology Intern[2]	31	LL		I	103TH0004X
Psychology Intern[2]	31	LL		I	103TH0100X

Psychology Intern[2]	31	LL		I	103TM1700X
Psychology Intern[2]	31	LL		I	103TM1800X
Psychology Intern[2]	31	LL		I	103TP0814X
Psychology Intern[2]	31	LL		I	103TP2700X
Psychology Intern[2]	31	LL		I	103TP2701X
Psychology Intern[2]	31	LL		I	103TR0400X
Psychology Intern[2]	31	LL		I	103TS0200X
School Based Health Center	38	70		F	261QS1000X
Free Standing Psychiatric Hospital	64	86		F	283Q00000X
Opioid Treatment Program (Methadone Clinic)	68	70	8V	F	261QM2800X
Substance Abuse and Alcohol Abuse Center (Outpatient)	68	70		F	261QR0405X
Distinct Part Psychiatric Unit	69	86		F	273R00000X
Federally Qualified Health Center	72	42	8E	F	261QF0400X
Licensed Clinical Social Worker	73	73	6X, 6Y, 6Z[1]	I	104100000X
Licensed Clinical Social Worker	73	73	6X, 6Y, 6Z[1]	I	1041C0700X
Licensed Clinical Social Worker	73	73	6X, 6Y, 6Z[1]	I	1041S0200X
Licensed Master Social Worker (LMSW)[2]	73	LL		I	104100000X
Licensed Master Social Worker (LMSW)[2]	73	LL		I	1041C0700X
Licensed Master Social Worker (LMSW)[2]	73	LL		I	1041S0200X
Mental Health Clinic (Legacy MHC) - Reserved for LGEs	74	70	8E	F	251S00000X
Mental Health Clinic (Legacy MHC) - Reserved for LGEs	74	70	8E	F	261QM0801X
Mental Health Rehabilitation Agency (Legacy MHR[1])	77	78		F	261QM0801X
Advanced Practice Registered Nurse - Nurse Practitioner	78	26	6X, 6Y, 6Z[1]	I	363LP0808X
Rural Health Clinic (Provider Based)	79	94	8E	F	261QR1300X
Center Based Respite	83	8E		F	385HR2055X
Center Based Respite	83	8E		F	385HR2060X
Rural Health Clinic (Independent)	87	94	8E	F	261QR1300X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0807X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0808X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0809X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0810X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0811X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0812X
Advanced Practice Registered Nurse - Clinical Nurse Specialist	93	26	6X, 6Y, 6Z[1]	I	364SP0813X
Psychiatric Residential Treatment Facility Other Specialization	96	8R		F	323P00000X
Psychiatric Residential Treatment Facility Addiction	96	8U		F	323P00000X
Psychiatric Residential Treatment Facility	96	9B		F	323P00000X
Assertive Community Treatment Team (ACT Services)	AA	8E		F	261QM0850X
Behavioral Health Rehab Agency (Non-Legacy MHR)	AG	8E		F	261QM0801X
Licensed Marriage and Family Therapist	AH	8E	6X, 6Y, 6Z[1]	I	106H00000X
Provisionally Licensed Marriage and Family Therapist (PLMFT)[2]	AH	LL		I	106H00000X
Licensed Addiction Counselor	AJ	8E	6Y[1]	I	101YA0400X
Licensed Professional Counselor	AK	8E	6X, 6Y, 6Z[1]	I	101Y00000X
Licensed Professional Counselor	AK	8E	6X, 6Y, 6Z[1]	I	101YM0800X
Provisionally Licensed Professional Counselor (PLPC)[2]	AK	LL		I	101YP1600X
Provisionally Licensed Professional Counselor (PLPC)[2]	AK	LL		I	101YP2500X
Provisionally Licensed Professional Counselor (PLPC)[2]	AK	LL		I	101YS0200X
Therapeutic Foster Care	AR	9F		F	253J00000X
Therapeutic Group Home	AT	5X		F	320800000X
Substance Use Residential	AZ	8U		F	324500000X
Substance Use Residential	AZ	8U		F	3245S0500X
Non-Licensed Behavioral Health Staff[2]	NB	8E		I	171M00000X
Non-Licensed Behavioral Health Staff[2]	NB	8E		I	172V00000X
Peer Support Specialist[2]	PS	8E		I	175T00000X
Short-Term Respite - Personal Care Attendant (PCA) Agency	82	8E		F	253Z00000X
Family Support Organization (Parent/Youth Support and Training)	AC	5L	8E	F	251S00000X
Independent Living/Skills Building - Individual	AD	5U	8E	I	171M00000X
Independent Living/Skills Building - Agency/Business	AD	5V	8E	F	251S00000X
Short-Term Respite - Respite Care Services Agency	AE	8E		F	385HR2055X
Short-Term Respite - Respite Care Services Agency	AE	8E		F	385HR2060X
Short-Term Respite - Personal Care Attendant (PCA) Agency	82	8E		F	253Z00000X
Short-Term Respite - Crisis Receiving Center	AF	8E		F	385H00000X
Short-Term Respite - Crisis Receiving Center	AF	8E		F	385HR2055X
Short-Term Respite - Child-Placing Agency (Therapeutic Foster Care)	AR	9F	8E	F	253J00000X
Short-Term Respite - Supervised Independent Living (SIL) Agency	89	8E		F	251S00000X
Wrap-Around Agency	WA	70		F	251S00000X

[1] Provider Subspecialties used to identify providers who specialize in pregnancy-related and postpartum depression or related mental health disorders (6X); pregnancy-related and postpartum substance use disorders (6Y); or pregnancy-related and postpartum mental health and substance use disorders (6Z). Licensed Addiction Counselors may only specialize in pregnancy-related and postpartum substance use disorders (6Y).

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/

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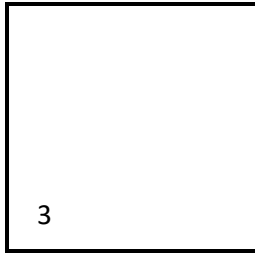
Encounter Edit Code(s) Disposition Logic

Introduction

LDH has modified edits for encounter processing. In order to ensure LDH has the most complete data for rate setting and data analysis, the PIHP is required to correct all repairable edit codes when applicable and to submit corrected encounters to the FI for reprocessing.

Encounter Edits

The FI's responsibility is to receive and process quality Encounter Data as submitted by the PIHP. To accomplish this, the Medicaid Management Information System applies a series of Edits based on claim type and/or procedure codes. Edit disposition are subject to change. Each edit has been assigned one (1) of the following Dispositions:

- Educational Edits
- Deny Edits
  - Repairable - Under Limited Circumstances Deny
  - Deny - Repairable
  - Deny- Not Repairable

Educational Edits

Encounters set to the "Educational" (E) disposition are "informational only", and are in an approved status. The PIHP does not need to make a correction to the encounter for edits with this disposition. LDH may determine that the disposition of certain Educational Edits may/will be temporary in some instances for a specified period of time. In these instances, the PIHP will be notified when the disposition of an edit changes and will be provided additional instructions regarding the change.

Deny-Repairable Edits

Encounters that are set to the "Deny-Repairable" disposition are encounters that must be corrected. The PIHP is required to correct these encounters and resubmit them to the FI for processing.

A list of Deny Edits – Repairable can be found at the end of this section. The list of repairable deny edits are subject to change and may not be limited to the edits identified at the end of this section.

Encounters that are set to the "Deny-Not Repairable" disposition are encounters that are not correctable. The PIHP may not resubmit these encounters to the FI for processing.

Deny-Not Repairable Edits

A list of Deny-Not Repairable Edits can be found in Appendix E of this Guide. The list of non-repairable deny edits are subject to change and may not be limited to the edits identified at the end of this section.
System logic for some edits will be added to the guide upon update. The PIHP may request in writing the system logic for edits not included in this Guide.

Encounter Correction Process

LDH's FI will send edit code reports to the PIHP the day after they are produced by the MMIS adjudication cycle via the web.

Resubmissions

The PIHP may make corrections to the service line(s) to which a repairable edit code was applied.

If an encounter is denied in its entirety, the PIHP may resubmit the encounter once it has been corrected.

The table below represents the edit codes that may be corrected by the PIHP.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
002	INVALID PROVIDER NUMBER
003	INVALID RECIPIENT NUMBER
005	INVALID STATEMENT FROM DATE
006	INVALID STATMENT THRU DATE
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
015	ACCIDENT INDICATOR MUST BE Y N SPACE
016	ACCIDENT INDICATOR NOT Y N OR SPACE
017	EPSDT INDICATOR NOT Y N OR SPACE
023	RECIPIENT NAME IS MISSING
024	BILLING PROVIDER NUMBER NOT NUMERIC
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC

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

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
028	INVALID MISSING PROCEDURE CODE
040	ADMISSION DATE MISSING OR INVALID
041	ADMISSION DATE GREATER THAN SERVICE FROM DATE
043	INVALID ATTENDING PHYSICIAN
045	PATIENT STATUS CODE INVALID OR MISSING
046	PATIENT STATUS DATE MISSING OR INVALID
047	PATIENT STATUS DATE GREATER THAN THRU DATE
055	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID
068	INVALID POINT OF ORIGIN
069	INVALID OCCURRENCE DATE
071	STATEMENT COVERS FROM DATE INVALID
072	STATEMENT COVERS THRU DATE INVALID
073	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
074	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
081	INVALID OR MISSING PATIENT STATUS DATE
082	INVALID PATIENT STATUS CODE
085	INVALID OR MISSING UNITS VISITS AND STUDIES
093	REVENUE CODE MISSING/INVALID
095	CONDITION CODE 40 FROM THROUGH NOT EQUAL
096	REVENUE CHARGE MISSING OR INVALID
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
114	INVALID OR MISSING HCPCS CODE
115	HCPCS CODE NOT ON FILE
120	QUANTITY INVALID/MISSING
126	REFILL CODE MISSING NOT NUMERIC OR GREATER THAN 5
127	NDC INVALID/MISSING
131	PRIMARY DIAGNOSIS NOT ON FILE
180	THE ADMISSION DATE WAS NOT A VALID DATE
183	SURGICAL PROCEDURE NOT ON FILE
186	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER
206	BILLING PROVIDER NOT ON FILE
211	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	RECIPIENT NOT ON FILE
269	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD
273	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST
289	INVALID PROVIDER NUMBER WHEN DENY APPLIED

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
301	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY
307	SURGICAL PROCEDURE MISSING
309	DATE OF SURGERY MISSING
310	DATE OF SURGERY LESS THAN SERVICE FROM DATE
311	DATE OF SURGERY GREATER THAN SERVICE THRU DATE
376	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS
430	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT
444	MISSING/INVALID SERVICE PROVIDER
506	SUBMITTING PROVIDER IS NOT A CCN
513	HCPCS REQUIRED
539	CLAIM REQUIRES DETAILED BILLING
702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
983	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE

4

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from the PIHP is treated as HIPAA-compliant transactions by LDH and its FI. As such, the PIHP 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 PIHP is requested to send real transmission data (NOTE: If the PIHP is testing prior to contract go-live, the PIHP may use mock encounter data in coordination with the Medicaid FI. Once the contract goes live, the PIHP will use real encounter data). The FI does not define the number of encounters in the transmission; however, LDH will require a minimum set of encounters for each transaction type based on testing needs.

If a PIHP rendering contracted provider has a valid NPI and taxonomy code, the PIHP will submit those values in the 837. If the provider is an atypical provider, the PIHP must follow 837 atypical provider guidelines.

Prior to testing, the PIHP must supply LDH with documentation of provider information publicly available through the Freedom of Information Act (FOIA) from the National Provider and Plan Enumeration System (NPPES). The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. In addition, LDH will provide the PIHP with a list of provider types and specialties. The PIHP is to provide the provider type and specialty in addition to the data elements available through NPPES.

Test Process

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

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

Electronic Data Interchange (EDI)

Enrollment as an EDI submitter is achieved through the completion of the LDH/FI approval process and the successful testing of provider encounters of a particular claim type. The FI EDI Coordinator is available to assist in answering questions, but enrollment and participation proceed through the following steps:

- Upon request from the PIHP, the FI will provide application and approval forms for completion by the submitter. When completed, these forms must be submitted to the FI Provider Enrollment Unit.
- During the authorization process, the PIHP can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the potential submitter develops and tests application software to create EDI encounters.
- Molina requires the PIHP to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
- When the submitter is ready to submit a file of test encounters, the test encounters shall 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 formats. 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, additional test encounters will be submitted until an acceptable test run is completed.
  NOTE: This test submitter number (4509999) shall be used for submission of test 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, the submitter will be notified that EDI encounters may be submitted.

Once the PIHP becomes an approved EDI submitter, the billing process will be as follows:

- Upon receipt of the submission, the FI's EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
- If the certification form is complete, the EDI Department enters the submitted encounters into a pre-processor production run. The pre-processor generates an encounter data file and one report. The Claims Transmittal Summary report, which lists whether a provider's batch of encounters has been accepted or rejected, is generated for each submission. If a provider's encounters are rejected, the provider number, dollar amount, and number of encounters are listed on the report.

The PIHP will submit to LDH and its FI a test plan with systematic plans for testing the ASC X12N 837 COB. The plan consists of three (3) tiers of testing, which are outlined in Appendix G.

Timing

The PIHP may initiate EDIFECS testing at any time. LDH's FI Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides for specific instructions, located at:
www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm

Editing and Validation Flow Diagram

The following process flow chart depicts an incoming ANSI ASC X12N 837 transaction validation for syntax of the FI Electronic Data Interchange (EDI).

Molina Electronic Data Interchange (EDI):
Incoming ANSI ASC X12N 837
Transaction Validation for Syntax
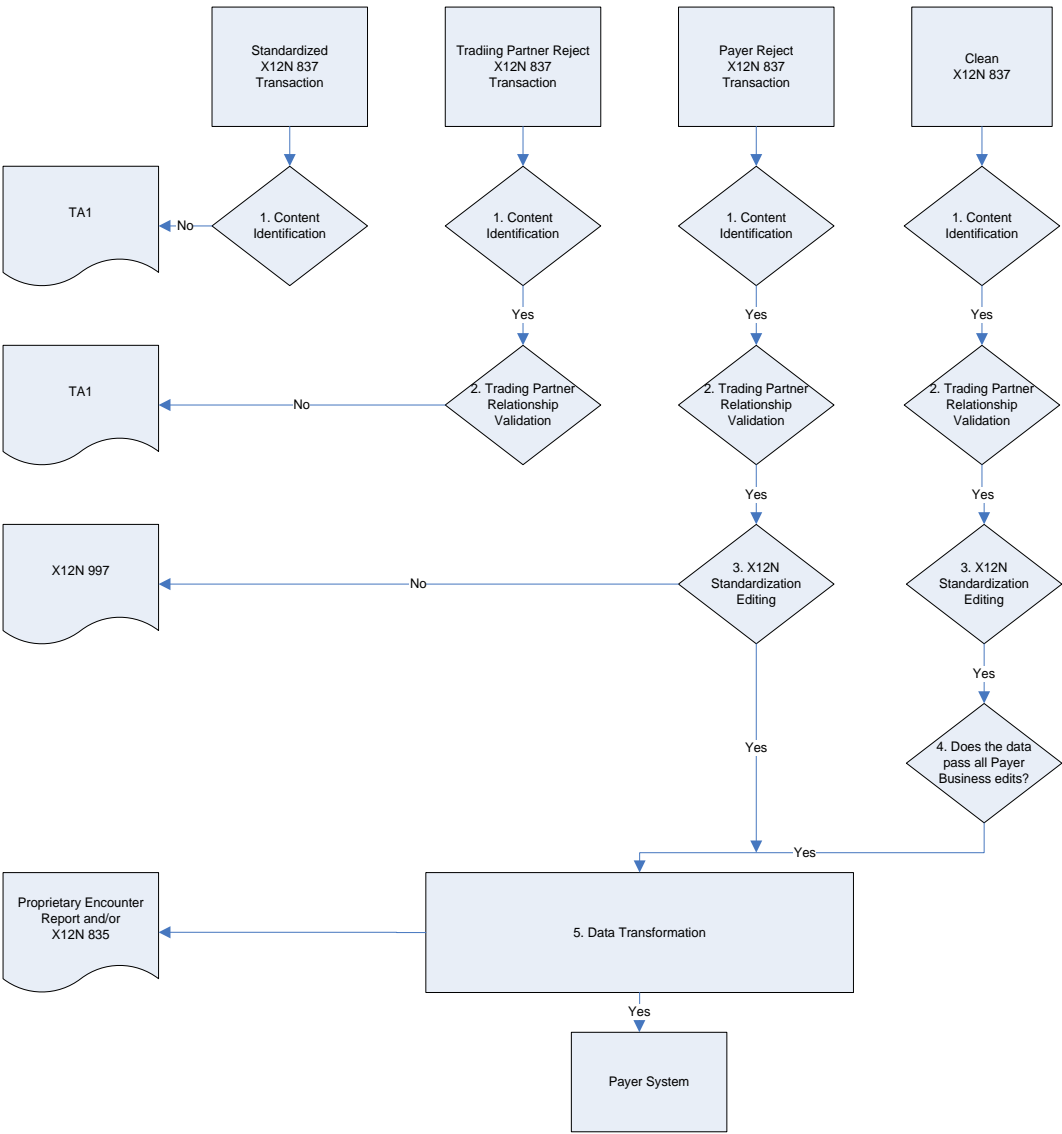
Encounter Data Certification

The Federal Balanced Budget Act (BBA) requires that when State payments to the PIHP are based on data that is submitted by the PIHP, 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. Encounter files submitted by the PIHP, which are used to create payments and/or develop/support capitated rates, must be certified by a completed signed Data Certification form, which is required to be submitted concurrently with each encounter submission. The data must be certified by one of the following individuals:

- PIHP's Chief Executive Officer (CEO); or
- PIHP'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.

LDH-LA 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**

Magellan DATA Certification Statement

On behalf of the above-named PIHP, I attest, based on best knowledge, information and belief that all data submitted to the LDH - LA Department of Health 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 Magellan Plan 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

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   PIHP Chief Executive   Signature
           Officer/Delegate
           Name & Title

_____   _____   _____

Date   PIHP Financial   Signature
           Officer/Delegate

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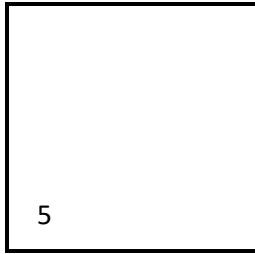
Data Management and Error Correction Process

Introduction

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

Rejection Criteria

Incoming 837s may be rejected either at the FI's Electronic Data Interchange (EDI) or during the MMIS encounter processing. At the FI's Electronic Data Interchange (EDI), there are four levels (batch, syntax, claim header or service line) where edits (data validation processes) are present. Rejection of an entire batch or a single encounter is designated by the edit level in which the error occurs. Line level errors may also occur in the MMIS processing system. LDH will require The PIHP to correct certain MMIS line level errors.

Entire File

Rejection of an entire batch is designated by the edit level in which the error occurs. Interchange Level Errors will result in the rejection of an entire batch and the generation of a TA1 Rejection Report.

The TA1 is an ANSI ASC X12N Interchange Acknowledgement segment that is used to report receipt of individual envelopes. An interchange envelope contains the sender, receiver, and data type information for the header. If the syntactical analysis of the interchange header and trailer is invalid, the interchange will reject and a TA1 will be forwarded to the Molina Call Center. In this scenario, the entire transaction is rejected at the header level.

Once the transaction has passed interchange edits, it shall be subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N 997.

Claim

Transactions with errors at the ST or SE level segments are rejected in their entirety. However, if the functional group consists of additional transactions without errors, these transactions are processed. The 999 transaction contains ACCEPT or REJECT information.

If the file contains syntactical errors, the segment(s) or elements(s) where the error(s) occurred are reported.

Once the transaction has passed through syntactical edits, the transaction is edited according to implementation guide rule sets and payer-specific requirements. Any errors that occur at this level will result in the data content within that encounter being rejected. The ANSI ASC X12N 824 may be used to report those errors.

Service Line

Data that passes the FI's edits will proceed to the data transformation step for processing. In this step, certain data elements are converted into a format that is acceptable for claims processing. During processing, the MMIS will apply specific edits to the encounters. Depending upon the level of edit, an individual encounter may deny at the header or at a single detailed line.

A listing of encounter edits is contained in Appendix F. After processing, an 835 Remittance Advice is returned to the sender.[2]

Encounter Correction Process

The PIHP is required to correct and resubmit any transactions or encounters that are rejected or denied and are Repairable. For service line rejections, the PIHP is required to correct and resubmit errors that are known to be "repairable". A list of repairable denials is contained in Section 3 of this Guide.

Reports

On a weekly basis, the FI will provide the following weekly edit code reports to the PIHP:

- SMO-W-005-–Summarization of Edit Codes for Encounters Processing
- SMO-W-010 – Weekly list of all Encounters and their Error Codes for Encounter processing

The reports are available to the PIHP one (1) day after production by the MMIS adjudication cycle. The PIHP may access the reports via the lamedicaid.com website.

Upon reviewing the above weekly reports, the PIHP is required to make the necessary correction(s) to encounter(s) in which a Repairable Edit is applied, and in accordance with an approved Quality Improvement Plan. The PIHP is required to resubmit the corrected encounter to the FI for processing.

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[2] If requested by the PIHP and prearranged with LDH

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Electronic Notifications

The PIHP may receive one or more of the following electronic notifications from the FI for any HIPAA EDI file rejection(s) or encounter denial(s):

- EDIFECS File Processing Error In Production Environment
- EMC Translation Error in Production File
- Translation Failure
- Back End Rejections

The PIHP is required to make correction(s) to all service line(s) to which a repairable edit code was applied.

If an encounter is denied in its entirety, the PIHP is required to correct all lines of the encounter to which Repairable Edit code(s) is/are applied. The corrected encounter must be resubmitted to the FI for re-processing.

Entire File

The PIHP will receive either a TA1 or X12N 999 error report. The PIHP is required to work with the FI's Business Support Analysts to determine the cause of the error.

Claim

The PIHP will receive either an X12 835 or proprietary reports for header level rejections. The PIHP is responsible for adherence to the implementation guide, code sets, and looping structures for the transaction. The PIHP will also be responsible for adhering to the LDH payer-specific data rules, as defined in the FI's Companion Guide and Section 2 of this Guide.

Service Line

The PIHP will receive an X12N 835 for transaction claims that have processed through the MMIS. If the service line fails MMIS encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the CAS segment of loop 2110.

This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01).

The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

Each adjustment reason is associated with a particular MMIS edit code. The PIHP is presented with an edit code report to assist them in identifying repairable errors. The PIHP is responsible for correcting and resubmitting service line denials.

Outstanding Issues

After implementing the data management and error correction process and any processing error(s) remaining unresolved, the PIHP may present the outstanding issue(s) to LDH-OBH and LDH's FI for clarification or resolution. LDH-OBH and its FI will review the issue(s) and triage the issue(s) to the appropriate entity for resolution and respond to the PIHP with their findings. If the outcome is not agreeable to the PIHP, the PIHP can re-submit the outstanding issue(s) with supporting documentation to LDH for reconsideration. The outcome determined by LDH will prevail.

Dispute Resolution

The PIHP has the right to file a dispute regarding rejected encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. The PIHP may believe that a rejected encounter is the result of a "FI error". A FI error is defined as a rejected encounter that (1) the FI acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to MMIS reference tables, or further research by the FI, and therefore requires FI resolution to process the rejection.

The PIHP must notify LDH-OBH in writing within thirty (30) calendar days if it believes that the resolution of a rejected encounter rests on the FI rather than the PIHP. The FI, on behalf of LDH, will respond in writing within thirty (30) days of receipt of such notification. LDH encourages the PIHP to provide written notice as soon as possible. The FI response will identify the status of each rejected encounter problem or issue in question.

For ease in filing written requests, the PIHP may use the Edit Reports provided by the FI. The PIHP shall highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

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Adjustment Process and Void Process

Introduction

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

www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm.

To adjust an encounter or claim with a line level denial, make the correction(s) to the encounter or claim and resubmit via 837 transaction file using the instructions below.

Line Adjustment Process

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	Claim Frequency Type Code To adjust a previously accepted record, submit a value of "**7**". See also 2300/REF02. To void a previously submitted claim, submit a value of "**8**". See also 2300/REF02
2300	REF01	128	Reference Identification Qualifier To adjust or void a previously accepted record, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	Original Reference Number To adjust a previously accepted record, please submit the **13-digit ICN** assigned by the adjudication system and printed on the remittance advice, for the previously accepted record that is being adjusted or voided by this claim.

For claim level denials, make the correction(s) and resubmit.

Molina ICN Format

The format of the Molina ICN is as follows:

- Digit 1 = Last digit of year of receipt
- Digits 2-4 = Julian day* of the year of receipt
- Digit 5 = Media Code with value of 1(EDI)
- Digits 6-8 = 3 digit batch number
- Digits 9-11 = 3 digit sequential number in batch
- Digit 12-13 = claim line number

* Julian day - A calendar notation in which the date is represented by one number. For example, the Julian date for December 11, 1942 is 2430705; while December 12, 1942 is 2430706.

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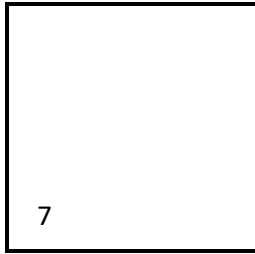
Managed Care Behavioral Health Crossover Claims

The Medicaid FI will process all crossover claims. Claims payment for Dual Eligible covered services including CSoC Waiver Services, Community Psychiatric Support and Treatment (including the evidence-based practices), Psychosocial Rehabilitation, Crisis Intervention, and Substance Use Treatments is the responsibility of the   PIHP. These services are considered Medicaid-unique, as the services are not covered by Medicare.

The services include the following HCPCS:

S5110, H0038, H2014, S5150, H0045, H2017, S9485, H2011, H0036, H0039, H2033, H0001, H0004, H0005, H0011, H0012, H0015, H0019, H2034, H2036, H0049, and H0050.

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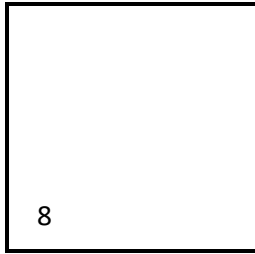
Medicare Recovery Process

On a monthly basis, the Fiscal Intermediary will run a Medicare Recovery Process. This process identifies recipients who are retrospectively enrolled in Pure Medicare (i.e., QMB, SLMB, QDWI, QI-1, or QI-2.), but do not also qualify for full Medicaid including PMPM payments and generates voids to recover payments.

The process takes the Fiscal Intermediary two weeks – the first week to identify the recipients who are retrospectively enrolled, and the second week to process the voids.

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs monthly on the following schedule:

- Last week of January and first week of February
- Last week of April and first week of May
- Last week of July and first week of August
- Last week of October and first week of November

The 820 File Layout can be found in **Appendix D** of this Guide.

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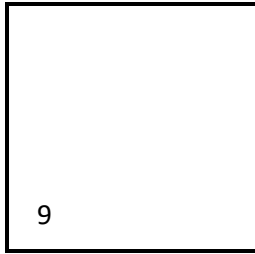
Department of Correction (DOC) PMPM Recoveries

On a monthly basis, the Fiscal Intermediary will run a Recovery Process for members whose incarceration period encompassed the entire month. Members are identified via lock-in code 5 or 6.

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs monthly on the following schedule:

- Last week of January and first week of February
- Last week of April and first week of May
- Last week of July and first week of August
- Last week of October and first week of November

The 820 File Layout can be found in **Appendix D** of this Guide.

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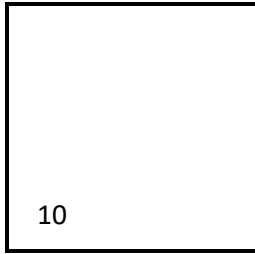
Date of Death (DOD) PMPM Recoveries

On a monthly basis, the Fiscal Intermediary will run a Recovery Process for deceased members based on date of death. The Recovery Process identifies deceased members for whom Medicaid has continued to pay a PMPM subsequent to the month of death.

The Fiscal Intermediary will generate an 820 file with the detail information regarding the voids for any past PMPM payments made to the Plan. The process runs monthly on the following schedule:

- Last week of January and first week of February
- Last week of April and first week of May
- Last week of July and first week of August
- Last week of October and first week of November

The 820 layout can be found in Appendix D of this guide.

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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 significantly impact paid claims and PMPMs. In an effort to correct audit trails.

The FI's monthly process for establishing PMPMs for retrospectively enrolled recipients is:

a. Identify eligible recipients who have retro enrollments in the month prior to the current month and have no PMPM.

b. Identify children who have retro enrollments in the month prior to the current month and have no PMPM.

A monthly report of affected members is given to SMOPIHP. This report includes detailed information to assist the SMOPIHP in anticipating claims which should be billed to them for their retro enrolled members including:

- Member name, Medicaid ID and voided claim detail;
- If applicable, original authorization (PA and Pre-cert) numbers;
- Identification of the entity that paid the original claim; and
- Identification of the correct entity responsible for prior paid claims due to the retro enrollment

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Magellan CSoC Quarterly Retro Process for PMPM Adjustments

1. This process will be performed on a quarterly basis, starting in April 2016. The April run will cover the time period December 2015 through February 2016. The next run will be in July 2016, which will cover the time period March 2016 through May 2016, etc. There is a month delay since the Fiscal Intermediary (FI) is paying CSOC on a month-delay basis rather than a prospective basis.

2. Therefore, the FI will modify the PMPM payment schedule to reflect the quarterly process.

3. The Fiscal Intermediary will do the following with each CSoC quarterly run:

   a. Review each month of the quarter in a similar manner as we used to generate the monthly CSoC PMPMs.

   b. The objective is to identify any changes (new enrollees, changed enrollments, etc.) that may require adjustments of previously paid PMPMs, recoveries of PMPMs where the recipient has been disenrolled so that the linkage is removed, and payments of new PMPMs for retro new enrollees.

   c. The process may possibly cause adjustments of CSOC1, CSOC2 cap codes in a given month in case the daily enrollment numbers change.

   d. The Fiscal Intermediary will generate a new report, CP-O-51-CSOC-ADJ that will reflect the effects of items a, b, and c above.

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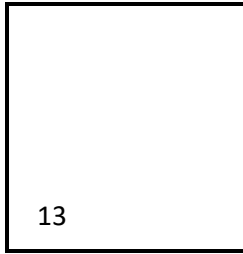
PMPM Payment Recovery for Duplicate Recipient Medicaid IDs (Magellan)

The Fiscal Intermediary (FI) will effectively begin a monthly PMPM recovery process for duplicate PMPM payments made to Magellan. The recoveries should go back to Magellan, 2.0 with PMPM DOS 3-1-2015 forward.

The FI will send Magellan a daily duplicate member recipient crosswalk file. The File Name is as follows: Recipient Voided IDs.txt. The Recip-Multple-ID-Record Layout can be found in Appendix R.

The FI will generate a new report **identifying recoveries for Magellan** using the same format using the same data elements as designated in the original file.

Magellan shall not recover claims payments for Invalidated IDs unless they identify duplicate claims payments (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.
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and may 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.
Centers for Medicare and Medicaid Services (CMS)	The agency within the U.S. Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).

Claim	A request for payment for benefits received or services rendered.
Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated 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 health plan 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.
Clean claim	A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or use or a claim under review for medical necessity.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the PIHP to Medicaid CSoC members as specified under the terms and conditions of the Contract and Louisiana Medicaid State Plan and waivers as outlined in the contract's service definition manual.
CMS 1500	A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.
CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.
BAYOU HEALTH Network	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.

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.
CSoC	Coordinated System of Care
CSoC eligible	Children and youth eligible for the CSoC
Co-payment	Any cost sharing payment for which the Medicaid PIHP member is responsible for in accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Corrective Action Plan (CAP)	A plan developed by the PIHP that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes 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.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a (PIHP) are based on data that is submitted by the BH 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.
Denied claim	A claim for which no payment is made to the network provider by the PIHP for any of

	several reasons, including but not limited to, the claim is for non-covered services, the provider or Member is ineligible, the claim is a duplicate of another transaction, or the claim has failed to pass a significant requirement (or edit) in the claims processing system.
Department (LDH)	The Louisiana Department of Health, referred to as LDH.
Department of Health and Human Services (LDHS; also HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The LDHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.
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.
Duplicate claim	A claim that is either a total or a partial duplicate of services previously paid.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal State Plan definition of "medical assistance". Note:

	1915(c) waiver services for children are not covered under EPSDT.
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 informational 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.
Eligible	An individual qualified to receive services through the PIHP
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Encounter data	Records of medically-related services rendered by a provider to the PIHP Member on a specified date of service. This data is inclusive of all services for which the PIHP has any financial liability to a provider PIHP
Enrollee	A Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in the CSoC.

Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an enrollee.
File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI) for Medicaid	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.
Fiscal Year (FY)	Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY).
Fraud	As it relates to the Medicaid Program Integrity, means 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.
Health Care Professional	A physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.
Health Care Provider	A health care professional or entity that provides health care services or goods.
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.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
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 (997)

	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.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
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 (LMMIS)	A 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 LDHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.

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)	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).
Medically Necessary Services	Health care services that are in accordance with generally accepted, evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a

	service in his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	Persons enrolled in the CSoC.
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 used in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a PIHP to supply a range of behavioral health care services. The term "provider network" may also be used.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the PIHP.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a PIHP member who has presentation of medical signs and symptoms, to a health care provider, and <u>not</u> requiring immediate medical attention.

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 (PCP)	An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. 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.
Primary Care Services	Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Prospective Review	Utilization review conducted prior to an admission or a course of treatment.
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 PIHP 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 a PIHP 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.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to the process where LDH assesses the PIHP's ability to fulfill the requirements of the provider agreement. Such review may include, but is not limited to, review of proper licensure, operational protocols, PIHP standards, and systems. The review may be completed 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 PIHP'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 997 (Functional Acknowledgement) will be returned to the submitter. The 997 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 PIHP, 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 "repairable edit code "code" to indicate that the encounter is repairable.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.
Risk	The chance or possibility of loss. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system.

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.
Shall	Denotes a mandatory requirement.
Should, May, Can	Denotes a preference but not a mandatory requirement.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Span of Control	Information systems and telecommunications capabilities that the PIHP itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with LDH-OBH. The span of control also includes systems and telecommunications capabilities outsourced by the PIHP
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
State	The state of Louisiana.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
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 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 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 Function Response Time	Based on the specific sub function being performed: • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the PIHP from the provider and/or switch vendor until the PIHP hands-off a response to the provider and/or switch vendor.
System Availability	Measured within the PIHP'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, 997. 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 (997) 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. The taxonomy codes and code descriptions that health care providers select when applying for NPIs may or may not be the same as the categorizations used by Medicare and other health plans in their enrollment and credentialing activities. The taxonomy code or code description information collected by NPPES is used to help uniquely identify health care providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Utilization Management (UM)	Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.
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.

Will	Denotes a mandatory requirement.

Appendix B

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 PIHP to adhere to HIPAA standards governing Medical data code sets. Specifically, the PIHP 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 PIHP 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 PIHP 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 LDHS, 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 LDHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals (ICD-10 will be implemented October 1, 2015):

- Prevention;
- Diagnosis;
- Treatment; and
- Management.

National Drug Codes (NDC), as maintained and distributed by LDHS, in collaboration with drug manufacturers, for the following:

- Drugs; and

- Biologics.

Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.

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:

- The services manual outlined in the PIHP contract,
- Physician services,
- Physical and occupational therapy services,
- Radiological procedures,
- Clinical laboratory tests,
- Other medical diagnostic procedures

In addition to the Category I codes described above, LDH requires that the PIHP 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 LDHS, 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.
- Other services, as applicable, in the manual outlined in the PIHP contract

Appendix C

System Generated Files and Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing LDH-OBH and the   PIHP   with a basic accuracy and completeness assessment of each claim after each encounter cycle in order 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 FI'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 summary and repairable edit codes reports and a summary report of the encounter data submitted. These edit codes are listed in Appendix D of this Guide. Those edit codes that assess encounters to be repairable for correction and resubmission by the   PIHP   are found in Section 6 of this Guide.

The following reports are generated by the MMIS system and have been selected specifically to provide the   PIHP   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 quality reports will also depict accuracy and completeness at a volume and utilization level.

ASC X12N 835

As discussed above, and in Section 5, the   PIHP   will receive an 835 for encounter data that has been processed through the MMIS if requested and arranged in advance. Adjustment reason code, adjustment amount, and adjustment quantity are returned via the CAS segment of loop 2110 if the service line fails MMIS encounter errors. CAS segments are also created for cutbacks to the submitted charge-for-fee schedule reductions, etc. All encounter data denials, including those that are repairable, are represented in the 835. TCNs are assigned by claim and can be located in the 835 specific to the encounter.

820 File (FI to PIHP)

See below.

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		
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*950.00*C*NON******1726011595******20120209~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON	S
		BPR05	Payment Format Code	NOT USED	S
		BPR06	(DFI) ID Number Qualifier	NOT USED	S

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.					
SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction.					
SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send.					
		BPR07	(DFI) Identification Number	NOT USED	S
		BPR08	Account Number Qualifier	NOT USED	S
		BPR09	Account Number		S
		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	S
		BPR13	(DFI) Identification Number	NOT USED	S
		BRP14	Account Number Qualifier	NOT USED	S
		BPR15	Account Number		
		BPR16	EFT Effective Date	Expressed CCYYMMDD	

TRN=Reassociation Trace Number					
Sample: TRN*3*1123456789**~					
	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

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (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* PIHP Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	
		REF03	Description	' PIHP Fee Payment'	S
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
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

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D

1000A PREMIUM RECEIVER'S NAME

N1=Premium Receiver's Name

Sample: N1*PE* PIHP   of Louisiana*FI*1123456789~

Loop	Segment	Field	Description	Valuation	
1000A	N101		Entity ID Code	"PE" – Payee	
1000A	N102		Name	Information Receiver Last or Organization Name	
1000A	N103		Identification Code Qualifier	"FI" – Federal	
1000A	N104		Identification Code	Receiver Identifier	

1000B PREMIUM PAYER'S NAME

N1=Premium Payer's Name

Sample: N1*PR*Louisiana Department of Health*FI*1123456789~

Loop	Segment	Field	Description	Valuation	
1000B	N101		Entity ID Code	"PR" – Payer	
1000B	N102		Name	Premium Payer Name	
1000B	N103		ID Code Qualifier	"FI" - Federal Taxpayer ID number	
1000B	N104		Identification Code	Premium Payer ID	

2000B INDIVIDUAL REMITTANCE

ENT=Individual Remittance

Sample: ENT*1*2J*34*123456789~

Loop	Segment	Field	Description	Valuation	
2000B	ENT01		Assigned Number	Sequential Number assigned for differentiation within a transaction set	
2000B	ENT02		Entity Identifier Code	"2J" - Individual	
2000B	ENT03		Identification Code Qualifier	"34" - Social Security Number	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	2000B	ENT04	Identification Code	Individual Identifier - SSN	

2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	"QE" - Policyholder (Recipient Name)	
	2100B	NM102	Policyholder	"1" - Person	
	2100B	NM103	Name Last	Individual Last Name	
	2100B	NM104	Name First	Individual First Name	
	2100B	NM105	Name Middle	Individual Middle Initial	
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Insurer's Unique ID number	
	2100B	NM109	Identification Code	Recipient ID	

2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*AZ*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	
	2300B	RMR02	Reference Identification	Claim ICN	
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	

REF=Reference Information (1ˢᵗ occurrence)					
Sample: REF*ZZ*001~					

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	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[t] occurrence – used only for duplicate recipient recoveries)

Sample: REF*ZZ*001~

Loop	Segment	Field	Description	Valuation	
	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~

Loop	Segment	Field	Description	Valuation
	2300B	DTM01	Date/Time Qualifier	"582" - Report Period
	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
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD

Transaction Set Trailer

Sample: SE*39*0001~

Loop	Segment	Field	Description
	SE	SE01	Transaction Segment Count
		SE02	Transaction Set Control Number

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Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (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.

Appendix D

PIHP 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-OBH is interested in analyzing claims that are denied for the following reasons:

1. Lack of documentation to support Medical Necessity

2. Prior Authorization was not on file

3. Member has other insurance that must be billed first

4. Claim was submitted after the filing deadline

5. Service was not covered by the   PIHP

In the future, LDH may elect to obtain additional denied claims information.

The   PIHP is to submit to LDH-OBH an electronic report monthly on the number and type of denied claims referenced above **or the number and type of denied claims with a high occurrence (upward trend)**. The report shall include:

- Denial reason code including long description
- Claim type
- Missing documentation to support medical necessity
- Missing documentation of prior authorization (PA); e.g. no PA on file
- Date of service
- Date of receipt by   PIHP
- Primary diagnosis
- Secondary diagnosis (if applicable)
- Procedure/HCPCS code(s)
- Surgical procedure code(s) (if applicable)
- Revenue code(s) (if applicable)
- Primary insurance carrier (if applicable)
- Primary insurance coverage begin date (if applicable)

FQHC and RHC Quarterly Report

The PIHP shall submit on a quarterly basis by date of service, a report of encounter/claim data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. The report shall include the following information:

- Name and NPI of Rendering Provider
- Name and NPI of Billing Provider
- Medicaid ID of recipient
- Date of Service
- Paid Date
- Billed Amount
- Paid Amount

Appendix E

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 MMIS are subject to edits. Edits may post at the line or at the header. If an encounter denies at the header the encounter must be corrected and resubmitted. Instructions for correcting line level denials are found in Section 7 of this Guide.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS and priced, per LDH guidelines (Pay),
- Encounter contains a fatal error that results in its rejection (Denial).

Below are tables for encounters set to information only (pay) and non-repairable denials. Please see Section 3 of this Guide for the edit codes that are repairable denials and instructions for correction and resubmission by the PIHP.

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO PIHP (PIHP)

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
141	REFILL NOT FILLED WITHIN 12 MONTHS
149	DESI INEFFECTIVE-NOT PAYABLE_____
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
255	DIAG SEX RESTRICTION
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
349	RECIPIENT NOT COVERED FOR THIS SERVICE
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
807	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
852	SUSPCT DUPLICATE ERROR: HOSPITAL AND TITLE 18
860	INVALID COB-1 ID COB-1 PAYER ID MUST BE PLAN ID
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.

Appendix F

Provider Directory/Network Provider and Sub Registry

The PIHP will be required to provide LDH-OBH with a list of contracted providers including various data elements that are publicly available from NPPES through the Freedom of Information Act (FOIA). LDH-OBH shall be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any providers no longer taking patients must be clearly identified. Under the FOIA, CMS allowed disclosure of NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry became operational on September 4th and CMS posted the downloadable file on September 12th, 2007.

At the onset of the PIHP Contract and weekly thereafter, the PIHP should submit to Molina an updated provider directory/registry.

The following file layout describes the data characteristics and structure of the Provider Registry File as it should be submitted by the PIHP to Molina. This file layout is followed by the MMIS allowed Provider Types and Provider Specialties.

Provider Registry File 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 750 bytes. If a field is listed as Optional (O), and the PIHP elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
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 zeroes, be sure to include them.	R
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	1=Individual, 2=Organization	1		R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the Legal Business Name for Organizations. If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-27th characters=last name, 28-30th positions=suffix. If names do not fit in these positions, please truncate the end of the item so that it fits in the positions.		30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or 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, please use a 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)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (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 U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	

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Column(s)	Item	Notes	Length	Format	R=Required O=Optional
334-343	Provider Business Location Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	
345-354	Provider Business Location Address (Fax Number)	Do not enter dashes or 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 we require at least 1 taxonomy per NPI. For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… 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	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 the 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	1st 2 characters are provider type; last 2 characters (3-4) are provider specialty. See PIHP Companion Guide 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
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave 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

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Column(s)	Item	Notes	Length	Format	R=Required O=Optional
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave 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; leave 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-justified, right-fill with spaces.	R
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-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, 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 or 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 (this is the primary language indicator)	1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			
583	Delimiter		1	Character, use the ^ character value	
584	Language Indicator 3 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			
587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	0=no age restrictions 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	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				number of patients that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with PIHP	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of PIHP enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not PIHP) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character value	
610	PIHP Enrollment Indicator	N=New enrollment C=Change to existing enrollment D=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
612-619	PIHP 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		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 PIHP Companion Guide	2		R for PCPs; otherwise optional
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by LDH and is available in PIHP 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 PIHP Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	PIHP Contract Name or Number	This should represent the contract name/number that is established between the	30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		PIHP and the Provider			
662	Delimiter		1	Character, use the ^ character value	
663-670	PIHP Contract Begin Date	Date that the contract between the PIHP and the provider started	8	Numeric date value in the form YYYYMMDD	R
671	Delimiter		1	Character, use the ^ character value	
672-679	PIHP Contract Term Date	Date that the contract between the PIHP and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the PIHP Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	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 the PIHP Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that	2	2-digit parish code value. See the PIHP Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the provider serves. Use only if necessary; otherwise enter 00.			
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	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 the PIHP Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	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 the PIHP Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	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 the PIHP Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	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 the PIHP Companion Guide.	O
701	Delimiter		1	Character, use the ^ character value	
702-703	Provider Parish served – 8th	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 the PIHP Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	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 the PIHP Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that	2	2-digit parish code value. See the PIHP Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the provider serves. Use only if necessary; otherwise enter 00.			
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	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 the PIHP Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	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 the PIHP Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	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 the PIHP Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	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 the PIHP Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
723-724	Provider Parish served – 15th	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 the PIHP Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726	Prescriber Indicator	Used for prescriber types: medical psychologists, physicians, psychiatrists, etc. Valid values are: **blank**=not applicable or no prescriptive authority. **0** = Full Rx Authority. **1** = Resident with Rx authority. **2** = Limited Rx authority (PA,	1	Character	R for prescriber types; otherwise leave blank.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		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.**			
727	Delimiter		1	Character, use the ^ character value	
728-749	Spaces	End of record filler	22	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

LDH Valid Provider Types

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

Provider Type and Description

Provider Type Code	Description
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)

Provider Type Code	Description
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
27	DENTIST (IND & GP)
Provider Type Code	**Description**
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
48	CASE MGMT - PREGNANT WOMEN
49	CASE MGMT - DEVELOP DISABLED
50	PACE (ALL-INCLUSIVE CARE-ELD)
51	AMBULANCE TRANSPORTATION
52	CO-ORDIN CARE NETWORK-SHARED
53	SELF DIRECTED/DIRECT SUPPORT

Provider Type Code	Description
54	AMBULATORY SURGI CTR (IN-ST)
55	EMERG ACCESS HOSPITAL (IN-ST)
56	PRESCRIBER ONLY FOR MCO
57	OPH REGISTERED NURSE (IN-ST)
58	NOT ASSIGNED
59	NEURO REHAB HOSPITAL (IN-ST)
60	HOSPITAL
61	VENERIAL DISEASE CL (IN-ST)
62	TUBERCULOSIS CLINIC
63	TUBERCULOSIS INPT HOSPITAL
64	MENTAL HLTH HOSP (FREE-STAND)
65	REHABILITATION CENTER (IN-ST)
66	KIDMED SCREENING CLINIC
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)
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)
75	OPTICAL SUPPLIER
76	HEMODIALYSIS CENTER (IN-ST)
77	MENTAL REHAB AGENCY (IN-ST)
78	NURSE PRACTITIONER (IND & GP)
79	RURAL HLTH CL(PROV-BSE)(IN-ST)
80	NURSING FACILITY (IN-ST)

Provider Type Code	Description
81	CASE MGMT - VENT ASSTD CARE
82	PERS CARE ATTEND (WVR) (IN-ST)
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
87	RURAL HLTH CL(INDEPEND)(IN-ST)
88	ICF/DD - GROUP HOME (IN-ST)
89	SPRVISE INDEP LIV (WVR)(IN-ST)
90	CERTIFIED NURSE MIDWIFE
91	CERT REG NURS ANEST (IND & GP)
92	PRIVATE DUTY NURSE
93	CLINICAL NURSE SPECIALIST
94	PHYSICIAN ASSISTANT
95	AMERICAN INDIAN/638 FACILITY
96	PSYCH RESID TREAT FACILITY
97	ADULT RESIDENTIAL CARE FAC
98	SUPPORTED EMPLYMENT (IN-ST)

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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	
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 (PSH)	
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	

Provider	Type Code	Description
PO	PRESC ONLY/MCO RELATED	
SP	SUPER PROVIDER/OHCDS	
TS	TRANSPORTATION SUBCONTRACTOR	
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	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
00	All Specialties	1		n/a

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
01	General Practice	1		19,20
02	General Surgery	1		19, 20, 93
03	Allergy	1		19,20
04	Otology, Laryngology, Rhinology	1		19,20
05	Anesthesiology	1		19, 20, 91
06	Cardiovascular Disease	1		19,20
07	Dermatology	1		19,20
08	Family Practice	1		19, 20, 78
09	Gynecology (DO only)	1		19
10	Gastroenterology	1		19,20
11	Not in Use	n/a		n/a
12	Manipulative Therapy (DO only)	1		19
13	Neurology	1		19,20
14	Neurological Surgery	1		19,20
15	Obstetrics (DO only)	1		19
16	OB/GYN	1		19, 20, 78, 90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1		19
18	Ophthalmology	1		20
19	Orthodontist	1		19,20
20	Orthopedic Surgery	1		19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	1		19
22	Pathology	1		20
23	Peripheral Vascular Disease or Surgery (DO only)	1		19
24	Plastic Surgery	1		19,20
25	Physical Medicine Rehabilitation	1		19,20
26	Psychiatry	1		19, 20, 93
27	Psychiatry; Neurology (DO only)	1		19
28	Proctology	1		19,20
29	Pulmonary Diseases	1		19,20
30	Radiology	1		19,20
31	Roentgenology, Radiology (DO only)	1		19
32	Radiation Therapy (DO only)	1		19
33	Thoracic Surgery	1		19,20
Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
34	Urology	1		19,20
35	Chiropractor	1		30,35
36	Pre-Vocational Habilitation	1		13
37	Pediatrics	1		19, 20, 78
38	Geriatrics	1		19,20
39	Nephrology	1		19,20
40	Hand Surgery	1		19,20
41	Internal Medicine	1		19,20
42	Federally Qualified Health Centers	1		72

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
43	Not in Use	n/a		n/a
44	Public Health	1		66,70
45	NEMT - Non-profit	1		42
46	NEMT - Profit	1		42
47	NEMT - F+F	1		42
48	Podiatry - Surgical Chiropody	1		20, 32
49	Miscellaneous (Admin. Medicine)	1		20
50	Day Habilitation	1		14
51	Med Supply / Certified Orthotist	1		40
52	Med Supply / Certified Prosthetist	1		40
53	Med Supply CO w/CRTD Prosth OR	1		40
54	Med Supply / Not Included in 51, 52, 53	1		40
55	Indiv Certified Orthotist	1		40
56	Indiv Certified Prosthetist	1		40
57	Indiv Certified Prosthetist - Orthotist	1		40
58	Indiv Not Included in 55, 56, 57	1		40
59	Ambulance Service Supplier, Private	1		51
60	Public Health or Welfare Agencies & Clinics	1		61, 62, 66, 67
61	Voluntary Health or Charitable Agencies	1		unknown
62	Psychologist Crossovers only	1		29, 31
63	Portable X-Ray Supplier (Billing Independently)	1		25
64	Audiologist (Billing Independently)	1		29,34
65	Indiv Physical Therapist	1		29,35
66	General Dentistry (DDS/DMS)	1		27
67	Oral and Maxillofacial Surgery	1		27
68	Pediatric Dentistry	1		27
69	Independent Laboratory (Billing Independently)	1		23
70	Clinic or Other Group Practice	1		19, 20, 68, 74, 76, 91
71	Speech Therapy	1		29
72	Diagnostic Laboratory	1		23
73	Social Worker Enrollment	1		73
74	Occupational Therapy	1		29,37
75	Other Medical Care	1		65
76	Adult Day Care	1		85
77	Habilitation	1		85
78	Mental Health Rehab	1		77
79	Nurse Practitioner	1		78
80	Environmental Accessibility Adaptations	1		15
Specialty Code	**Description**	**Type: 1=Specialty, 2=Subspecialty**	**Related Specialty (if Subspecialty)**	**Related Provider Types**
81	Case Management	1		07, 08, 43, 46, 81
82	Personal Care Attendant	1		82
83	Respite Care	1		83
84	Substitute Family Care	1		84

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
85	Extended Care Hospital	1		60
86	Hospitals and Nursing Homes	1		55, 59, 60, 64, 69, 80, 88
87	All Other	1		26,40,44, 60
88	Optician / Optometrist	1		28,75
89	Supervised Independent Living	1		89
90	Personal Emergency Response Sys (Waiver)	1		16
91	Assistive Devices	1		17
92	Prescribing Only Providers/Providers Not Authorized to Bill Medicaid	1		33, 56, PO
93	Hospice Service for Dual Elig.	1		09
94	Rural Health Clinic	1		79,87
95	Psychologist (PBS Program Only)	1		31
96	Psychologist (PBS Program and X-Overs)	1		31
97	Family Planning Clinic	1		71
98	Supported Employment	1		98
99	Provider Pending Enrollment	1		n/a
1A	Adolescent Medicine	2	37	19,20
1B	Diagnostic Lab Immunology	2	37	19,20
1C	Neonatal Perinatal Medicine	2	37	19,20
1D	Pediatric Cardiology	2	37	19,20
1E	Pediatric Critical Care Medicine	2	37	19,20
1F	Pediatric Emergency Medicine	2	37	19,20
1G	Pediatric Endocrinology	2	37	19,20
1H	Pediatric Gastroenterology	2	37	19,20
1I	Pediatric Hematology - Oncology	2	37	19,20
1J	Pediatric Infectious Disease	2	37	19,20
1K	Pediatric Nephrology	2	37	19,20
1L	Pediatric Pulmonology	2	37	19,20
1M	Pediatric Rheumatology	2	37	19,20
1N	Pediatric Sports Medicine	2	37	19,20
1P	Pediatric Surgery	2	37	19,20
1Q	Pediatric Neurology	2	37	19,20
1R	Pediatric Genetics	2	37	19,20
1S	BRG - Med School	2		19,20
1T	Emergency Medicine	1		19,20
1U	Pediatric Developmental Behavioral Health	2	37	19,20
1Z	Pediatric Day Health Care	1		04
2A	Cardiac Electrophysiology	2	41	19,20
2B	Cardiovascular Disease	2	41	19,20
2C	Critical Care Medicine	2	41	19,20
2D	Diagnostic Laboratory Immunology	2	41	19,20
2E	Endocrinology & Metabolism	2	41	19,20
Specialty Code	**Description**	**Type: 1=Specialty, 2=Subspecialty**	**Related Specialty (if Subspecialty)**	**Related Provider Types**
2F	Gastroenterology	2	41	19,20

2G	Geriatric Medicine	2	41	19,20
2H	Hematology	2	41	19,20
2I	Infectious Disease	2	41	19,20
2J	Medical Oncology	2	41	19,20
2K	Nephrology	2	41	19,20
2L	Pulmonary Disease	2	41	19,20
2M	Rheumatology	2	41	19,20
2N	Surgery - Critical Care	2	41	19,20
2P	Surgery - General Vascular	2	41	19,20
2Q	Nuclear Medicine	1		19,20
2R	Physician Assistant	1		94
2S	LSU Medical Center New Orleans	2		19,20
2T	American Indian / Native Alaskan	2		95
2Y	OPH Genetic Disease Program	1		40
3A	Critical Care Medicine	2	16	19,20
3B	Gynecologic oncology	2	16	19,20
3C	Maternal & Fetal Medicine	2	16	19,20
3D	Community Choices Waiver - Respiratory Therapy	2	87, 75	44, 65
3E	Community Choices Waiver - PT and OT	2	87, 75	44, 66
3F	Community Choices Waiver - PT and S/L T	2	87, 75	44, 67
3G	Community Choices Waiver - PT and RT	2	87, 75	44, 68
3H	Community Choices Waiver - OT and S/L T	2	87, 75	44, 69
3J	Community Choices Waiver - OT and RT	2	87, 75	44, 70
3K	Community Choices Waiver - S/L T and RT	2	87, 75	44, 71
3L	Community Choices Waiver - PT, OT & S/L T	2	87, 75	44, 72
3M	Community Choices Waiver - PT, OT & RT	2	87, 75	44, 73
3N	Community Choices Waiver - PT, S/L T & RT	2	87, 75	44, 74
3P	Organized Health Care Delivery System (OHCDS)	1		
3Q	Community Choices Waiver - OT, S/L T & RT	2	87, 75	44, 75
3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2	87, 75	44, 76
3S	LSU Medical Center Shreveport	2		19,20
3T	DBPP - Dental Benefit Plan Prescriber	1		AY
3U	Community Choices Waiver – Assistive Devices – Home Health	2		
3W	Supportive Housing Agency	1		AW
3X	Extended Duty Dental Assistant	1		AV
3Y	DBPM - Dental Benefit Plan Management	1		AY
3Z	Transportation Subcontractor	1		TS
4A	Developmentally Disabled (DD)	1		01,02
4B	NOW RN	1		06
4C	NOW LPN	1		06
4D	NOW Psychologist	1		06
4E	NOW Social Worker	1		06
4G	New, Provider Domain	1		
4H	Conversion, Participant Domain	1		
4J	Conversion, Provider Domain	1		

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Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
4K	Home and Community-Based Services (HCBS)	1		
4L	New, Participant Domain	1		
4M	EHR Managed Care (Behavior Health)	2		IP
4P	OAAS	1		
4R	Registered Dietician	1		41
4S	Ochsner Med School	2		19,20
4U	OPH Registered Dietitian	1		AU
4W	Waiver Services	1		42
4X	Waiver-Only Transportation	1		42
4Y	EHR Managed Care (Medical)	2		IP
5A	PCS-LTC	1		24
5B	PCS-EPSDT	1		24
5C	PAS	1		24
5D	PCS-LTC, PCS-EPSDT	1		24
5E	PCS-LTC, PAS	1		24
5F	PCS-EPSDT, PAS	1		24
5G	PCS-LTC, PCS-EPSDT, PAS	1		24
5H	Community Mental Health Center			18
5I	Statewide Management Organization (SMO)	1		AB
5J	Youth Support	1		AC
5K	Family Support	1		AC
5L	Both Youth and Family Support	1		AC
5M	Multi-Systemic Therapy			12
5N	Substance Abuse and Alcohol Abuse Center	1		68
5P	PACE	1		50
5Q	CCN-P (Coordinated Care Network, Pre-paid)	1		05
5R	CCN-S (Coordinated Care Network, Shared Savings)	1		52
5S	Tulane Med School	2		19,20
5T	Community Choices Waiver (CCW)	1		
5U	Individual	1		AD
5V	Agency/Business	1		AD
5W	Community Choices Waiver - Personal Assistance Service	2	87	44
5X	Therapeutic Group Homes	1		AT
5Y	PRCS Addiction Disorder	1		
5Z	Therapeutic Group Home Disorder	1		
6A	Psychologist -Clinical	1		31
6B	Psychologist-Counseling	1		31
6C	Psychologist - School	1		31
6D	Psychologist - Developmental	1		31
6E	Psychologist - Non-Declared	1		31
6F	Psychologist - All Other	1		31
6G	Medical Psychologist	1		31

6H	LaPOP	1		01
6N	Endodontist	1		27
6P	Periodontist	1		27
6S	E Jefferson Fam Practice Ctr - Residency Program	2		19,20
6T	Community Choices Waiver - Physical Therapy	2	65, 87, 75	35, 44, 65
6U	Applied Behavioral Analyst	1		AX
6W	Licensed Mid-Wife	1		MW

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
7A	SBHC - NP - Part Time - less than 20 hrs week	1		38
7B	SBHC - NP - Full Time - 20 or more hrs week	1		38
7C	SBHC - MD - Part Time - less than 20 hrs week	1		38
7D	SBHC - MD - Full Time - 20 or more hrs week	1		38
7E	SBHC - NP + MD - Part Time - total = less than 20 hrs week	1		38
7F	SBHC - NP + MD - Full Time - total = 20 or more hrs week	1		38
7G	Community Choices Waiver - Speech/Language Therapy	2	71, 87, 75	39, 44, 65
7H	Community Choices Waiver - Occupational Therapy	2	74, 87, 75	37, 44, 65
7M	Retail Convenience Clinics	2	70	19,20,78
7N	Urgent Care Clinics	2	70	19,20,79
7P	ABA Therapy Psychologist	1		31
7R	Aquatic Therapy	1		31
7T	Art Therapy	1		31
7U	Art and Music	2		31
7V	Music Therapy	1		31
7X	Sensory Integration	1		31
7Y	Therapeutic Horseback Riding	1		31
7Z	Hippotherapy	1		31
7S	Leonard J Chabert Medical Center - Houma	2		19,20
8A	Elderly, Community Choices Waiver, DD	2	82	82
8B	Elderly, Community Choices Waiver	2	82	82
8C	DD services	2	82	82
8D	Community Choices Waiver - Caregiver Temporary Support	1	82, 83	82, 83
8E	CSoC/Behavioral Health	1, 2		AB, AC, AD, AE, AF, AH, AJ, AK, 82, 31, 68, 70, 73, 83, 53
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	2	8D	AN
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	2	8D	AN
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	2	8D	AN

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Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	2	8D	AN
8K	ADHC HCBS	1		AL
8L	Hospital-based PRTF	1		96
8M	Community Choices Waiver - Home-Delivered Meals	1		AM
8N	Community Choices Waiver - Nursing	2		44, 78
8O	IP - Doctor of Osteopathic Medicine	1		IP
8P	IP - Physician - MD	1		IP
8Q	EAA Assesor, Inspector, Approver	2		15
8R	PRTF, other Specialization	1		96
8S	OLOL Med School	2		
8U	Subst Abuse or Addiction	1		96
8V	Methadone Clinic	2	70	68
9A	Community Choices Waiver - Nursing and Personal Assistance Services	2		
9B	Psychiatric Residential Treatment Facility	1		96
9D	Residential Care	1		97
9E	Children's Choice Waiver	1		03
Specialty Code	**Description**	**Type: 1=Specialty, 2=Subspecialty**	**Related Specialty (if Subspecialty)**	**Related Provider Types**
9F	Therapeutic Foster Care (TFC)	1		AR
9G	Non-Medical Group Home (NMGH)	1		AQ
9L	RHC/FQHC OPH Certified SBHC	1		72
9M	Monitored In-Home Caregiving (MIHC)	1		
9P	GNOCHC - Greater New Orleans Community Health Connection	1		99
9Q	PT 21 -Third-Party Biller/Submitter	2		21
9R	Electronic Visit Verification Submitter	2		21
9S	IP - Optical Supplier	1		IP
9T	Exempted from State EVV	2		21
9U	Medicare Advantage Plans	1		21
9V	OCDD - Point of Entry	1		21
9W	OAAS - Point of Entry	1		21
9X	OAD - Point of Entry	1		21
9Y	Juvenile Court/Drug Treatment Center	1		21
9Z	Other Contract with a State Agency	1		21
XX	Error Provider	1		XX

Appendix G

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 plan consists of three (3) tiers of testing, which are outlined in detail below.

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each PIHP must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. The PIHP 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 PIHP 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 Molina Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Molina Electronic Data Interchange (EDI). Certain errors will occur while testing with EDIFECS that shall not be considered when determining whether a PIHP has passed or failed the EDIFECS portion of testing.

EDI must certify each PIHP 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 Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 997 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 4010A (Addenda) 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 997 Acceptance transactions; and
- generate IRL or paired transaction.

Once EDIFECS testing is complete, the PIHP is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the PIHP is identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The PIHP must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item PIHP 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 PIHP's paid amount and not TPL or any other COB amount. For more details, please refer to the Molina Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the LDH.

Testing Tier II

Once the PIHP has successfully passed more than 50% of their encounter data claims through the pre-processors, Molina 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 PIHP via IDEX. Each PIHP 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. Molina will send the new edit code reports to the PIHP 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. Molina is available to answer any questions that any PIHP may have concerning the edit codes.

Testing Tier III

Once satisfactory test results are documented, Molina will move the ASC X12N 837 COB and 835 electronic transaction sets into production. Molina anticipates receiving files from the PIHP in production mode at least once monthly.

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC)
Systems Companion Guide

Appendix H

Websites

The following websites are provided as references for useful information not only for PIHP entities, 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.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**.

Website Address	Website Contents
	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 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

Website Address	Website Contents
	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 I

LTC CSoC PIHP Segment Layout

The file is an ASCII text file.

The file name is: **STOLA_MOLINA_CSOC_YYYYMMDD.TAB** (where YYYYMMDD is the date the file was created).

PART 1: PLAN FILE SUBMISSIONS

File submissions should occur each day, Monday – Friday, by 6:00 pm unless it is a holiday and then you may submit the file on the previous applicable work day.

You may submit only one file per day, so your file should contain all records that you expect to submit during that day.

If you don't have records to submit in a given day, then you should still submit a file, but it should be empty.

File submission instructions, with respect to using Molina's FTP site, will be distributed in the near future.

Plan File submission naming convention: **STOLA_MOLINA_CSOC_YYYYMMDD.TAB**

YYYYMMDD is the date of submission (Monday – Friday).

The submission file has a fixed-length record format. Each record is 117 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 zero(s) is acceptable, unless otherwise noted. Since we do not edit those fields, we will not produce errors based on the data in them. The file does <u>not</u> use delimiters and is formatted as an ASCII text file.

Field Nbr	Column(s)	Field	Format/ Length	R = Required O = Optional	Notes
1	1-1	Record Type	char(1)	R	1 Byte Field, Always equal to '2'
2	2-2	Record_Sub_Type	char(1)	R	1 Byte Field, Always equal to '7'
3	3-11	File_Sequence_No	char(9)	R	File record sequence number: The first record in the file should number 000000001, the second 000000002, etc.

Field Nbr	Column(s)	Field	Format/ Length	R = Required O = Optional	Notes
4	12-24	Recipient_ID	num(13)	R	Medicaid recipient ID
5	25-32	MEDS_Record_Seq_No	char(8)	R	The first record for a recipient should have number 00000001, the second (if present) should have 00000002, etc.
6	33-37	LTC_Waiver-Seq_No	char(5)	0	Populate with '00000'
7	38-45	Segment Start-Date	num(8)	R	YYYYMMDD Must be a date on or after 20151201
8	46-53	Segment_Close_Date	num(8)	R	YYYYMMDD Must be a valid date greater than the start date unless accompanied by closure code 139. **When edit 139 is used, the end date must be ONE day prior to the begin date.**
10	54-60	LTC_Provider_Number	num(7)	R	Must be CSOC Dummy Provider, 0100867, 0101917, or 0101920
11	61-62	LTC_Waiver_Level_of_Care	char(2)	O	Segment Level of Care, populate with zeros
12	63-63	Admission Code	char(1)	O	Segment Admission Code, populate with zeros
13	64-71	Admission Date	num(8)	O	Segment Admission Date, populate with zeros
14	72-79	Discharge Date	num(8)	O	Segment Discharge Date, populate with zeros
15	80-92	PLI_Amount	num(13)	O	Segment PLI Amount, populate with zeros
16	93-95	Secondary_Type_Case	char(3)	R	Must be CSOC Type Case, 200, 202, or 214
17	96-97	Secondary_Level_of_Care	char(2)	O	Segment Secondary Level of Care, populate with zeros
18	98-100	Segment_Cancel/Closure_Code	char(3)	R	Segment Closure Code, Numeric value of 137 or 139
19	101-102	Filler	char(2)	O	Spaces
20	103-109	MEDS_LTC_Facility_Number	char(7)	O	Segment Facility No, populate with zeros
21	110-112	LTC_ Waiver_Type_Case	char(3)	O	Waiver Type Case, populate with zeros
22	113-114	Waiver_Tempstay/Level_of_Care	char(2)	O	Temp Stay Level of Care, populate with zeros
23	115-116	State-Plan_Option	char(2)	O	State Option Plan, populate with zeros
24	117-117	End_of_Record_Marker	char(1)	R	Must be '*'

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End of Record Layout

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, and process it as part of the daily update processing. Molina's update process performs edits and produces a return file that includes the rejected record as sent and a status with error codes tacked onto the end of the record. Molina will also include the accepted records on the return file with a status of '00' and errors equal to '000'.
The return text file will use the naming convention: **CSOC-RETURN-YYYYMMDD.txt**
YYYYMMDD is the date from your submission file, the same date stamp used on the file sent from Magellan.
Below is the format of the return file. Required fields without notes are the fields that were sent to Molina from Magellan.

Field Nbr	Column(s)	Field	Format/ Length	R = Required O = Optional	Notes
1	1-1	Record Type	char(1)	R	
2	2-2	Record_Sub_Type	char(1)	R	
3	3-11	File_Sequence_No	char(9)	R	
4	12-24	Recipient_ID	num(13)	R	
5	25-32	MEDS_Record_Seq_No	char(8)	R	
6	33-37	LTC_Waiver-Seq_No	char(5)	R	
7	38-45	Segment_Start-Date	num(8)	R	
8	46-53	Segment_Close_Date	num(8)	R	
10	54-60	LTC_Provider_Number	num(7)	R	
11	61-62	LTC_Waiver_Level_of_Care	char(2)	R	
12	63-63	Admission_Code	char(1)	R	
13	64-71	Admission_Date	num(8)	R	
14	72-79	Discharge_Date	num(8)	R	
15	80-92	PLI_Amount	num(13)	R	
16	93-95	Secondary_Type_Case	char(3)	R	
17	96-97	Secondary_Level_of_Care	char(2)	R	
18	98-100	Segment_Cancel/Closure_Code	char(3)	R	
19	101-102	Filler	char(2)	R	
20	103-109	MEDS_LTC_Facility_Number	char(7)	R	
21	110-112	LTC_ Waiver_Type_Case	char(3)	R	
22	113-114	Waiver_Tempstay/Level_of_Care	char(2)	R	
23	115-116	State-Plan_Option	char(2)	R	
24	117-117	End_of_Record_Marker	char(1)	R	
25	118-119	Record Status	char(2)	R	'00' Accepted, '01' Rejected
26	120-123	Error-Code_1	char(3)	R	See Error Messages below.
27	124-127	Error-Code_2	char(3)	R	See Error Messages below.
28	128-131	Error-Code_3	char(3)	R	See Error Messages below.

End of Record Layout

Molina will perform edits that will produce the following errors.

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ERROR CODES	Error Message	Error Criteria
000	No Error	No Error
001	Invalid Record Type	Set error if Record Type not = '2'
002	Invalid Sub Type	Set error of Sub-Type not = '7'
010	Recipient ID Must be Numeric	Set if Field is not numeric
011	Recipient ID Must be > 0000000000000	Set if Field = '0000000000000'
012	Recipient ID not found on LMMIS	Set if ID is not found on LMMIS Recipient File
014	Invalid Cancel Code	Cancel code must be 3 byte Numeric Field values of 137 or 139 only.
020	Begin Date Must be Numeric	Set if Field is not numeric
021	Begin Date Must be a Valid Date	Set if Begin Date is not a valid date (LMMIS uses standard logarithm to validate dates) or if date is prior to 12/01/2015
022	End Date Must be Numeric	Set if Field is not numeric
023	End Date Must be a Valid Date	Set if End Date is not a valid date (LMMIS uses standard logarithm to validate dates)
024	Begin Date Must be >= End Date unless segment has cancel code 139.	Set if Begin Date < End Date and cancel code is not 139.
030	Provider number not Valid CSOC Provider	Set if Provider number is not a valid CSOC Provider id. 0100867, 0101917, or 0101920
031	Invalid Provider ID /Type Case	Set if the Provider ID/Type Case are not a valid CSOC pair. 0100867 - 200; 0101917 - 202; 0101920 - 214
032	CSOC Eligibility cannot overlay existing Waiver	Set if the begin date matches a segment on Molina file, but that segment is not a CSOC segment. (The CSOC Provider/Type case should match when the begin date matches). These updates need to be sent to LDH who in turn will update the data manually. **No action needed by Magellan.**
033	**CSOC Eligibility cannot change existing CSOC or overlap an existing CSOC only segment**	**Set if the begin date matches an existing CSOC segment but the type case and/or dummy provider do not match. Also set if the begin date overlaps with another CSOC only segment.**
040	Secondary Type Case not a Valid CSOC Type Case	Set if Secondary Type Case is not a Valid CSOC Type Case. 200, 202, or 214
060	ME CSOC Overlap	Set if the CSOC begin period and/or end period overlap an existing Medicaid Expansion (ME) recipient type case.

Anytime you receive a record in the edit text file with a status of '01', it indicates that the associated record in your submission file failed to update the LMMIS Recipient File. If you receive a status of '00', that record updated successfully.

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Edits are applicable to required fields, we are not editing optional fields at this time. If you receive a rejected record, you may correct the issue and resubmit the record in a future submission.

Cancel code values: 137 - Behavioral Health Open/Close Segment
139 - LBHP Segments End Date - Start Date

END OF SECTION

APPENDIX J

Prior Authorization File

The Magellan Prior Authorization File will be sent to Molina prior to noon on the following schedule:

The file name: File Name: MGLN-PA-nnnnnnn-20151001.TXT
Where nnnnnnn is Magellan's plan's ID.

- 9-30-15: Magellan will submit a Full (all PA authorizations from 2/1/15 and forward (to-date).

- 10-25-15 : Supplemental File (any authorizations not already sent)

- 11-13-15: Supplemental File (any authorizations not already sent)

- Daily PA file from November 30 through December 14: Supplemental File (any authorizations not already sent)

- Final transfer: Medicaid requested a final PA file on December 14: Supplemental File (any authorizations not already sent)

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

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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
Facility Name	FACIL_NAME			CHAR	50	114-163
Field Common Name	**Field File Name**	**Field Description**	**Notes**	**Type**	**Data Length**	**Columns**
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
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

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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
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
Field Common Name	**Field File Name**	**Field Description**	**Notes**	**Type**	**Data Length**	**Columns**

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
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 K

Supplemental Claims History Record Layout

Column(s)	Item	Notes	Length	Format	Join Keys	Other Information
is N NOTE: This record format describes a fixed-format layout.						A record will be created for all approved claims/encounters
1-8	PLN-CHECKWRITE-DATE	RA Date from Molina	8	Numeric	X	This day will be the effective RA date and part of the key to join to other tables
9-16	PLN-CLAIMID	Sequence number of record processed	8	Numeric	X	This number is generated at the time the extract is executed to create a unique id for each claim/encounter
17-23	PLN-Plan-Submitter-ID	7 digit submitter ID used to identify MCO	7	Numeric		The 7-digit submitter ID associated with each plan, but will be zeroes for FFS claims. 4508073=ACLA 4508063=AMG 4508067=LHCC 4508090=UHC Shared 4508062=CHS Shared 4508989=UHC MCO 4508985=Aetna

						4508178=Magellan 4508846=MCNA Dental Plan.
24-53	PLN-PLAN-ICN	ICN supplied by the plan	30	Character		The ICN supplied by the plans in the LINE-CTRL-NO field. The field is blank for FFS claims.
54-61	PLN-PAY-DATE	The date the provider received payment	8	Numeric YYYYMMDD		The date the plan identified as the date the provider received payment Will be the plan's payment date on encounters and Molina's payment date on FFS claims.
62-69	PLN-RECIEVE-DATE	The date the claim was received	8	Numeric YYYYMMDD		The date the plan or Molina identified as to when the claim was received for adjudication.
70-79	PLN-PLAN-PAID-AMT	The amount paid to the provider	10	Numeric (7.2)		The amount the plan paid the provider for the encounter Will be zeroes on FFS claims.
80-81	PLN-BILL-PROV-TYPE	The provider type of the entity receiving payment	2	Character		The Molina provider type of the entity receiving payment
82-83	PLN-BILL-PROV-SPEC	The provider specialty of the entity receiving payment	2	Character		The Molina provider specialty of the entity receiving payment
84-85	PLN-SVC-PROV-TYPE	The provider type of the entity that performed the service	2	Character		The Molina provider type of the entity that

						performed the service
86-87	PLN-SVC-PROV-SPEC	The provider specialty of the entity that performed the service	2	Character		The Molina provider specialty of the entity that performed the service
88	PLN-BH-INDICATOR	1=this is a BH service 0=this is not a BH service	1	Numeric		Based on Magellan encounters and the MSP.
89-100	FILLER	Additional Space for expansion	12	Character		Will contain spaces.

Criteria for setting the PLN-BH-INDICATOR (claim types 01, 03, 04, 05, 14, 15). Set on Claims and Encounters:

1. Initialize PLN-BH-INDICATOR = 0.
2. If PLN-PLAN-SUBMITTER-ID=4508178 then PLN-BH-INDICATOR=1.
3. If PLN-PLAN-SUBMITTER-ID not = 4508178 then:
   a. If PLN-BILL-PROV-TYPE in (12,18,31,64,68,69,73,74,77,96,AA,AE,AF,AG,AH,AJ,AK,AT,AZ) then PLN-BH-INDICATOR=1.
   b. If PLN-BILL-PROV-TYPE = '19' and PLN-BILL-PROV-SPEC in (26, 27) then PLN-BH-INDICATOR=1.
   c. If PLN-BILL-PROV-TYPE in (78, 93, 94) and PLN-BILL-PROV-SPEC = '26' then PLN-BH-INDICATOR=1.
   d. If PLN-BILL-PROV-TYPE = '72' and PLN-BILL-PROV-SPEC ='42' and BILL provider has sub-specialty='8E' then PLN-BH-INDICATOR=1.
   e. If PLN-SVC-PROV-TYPE in (12,18,31,64,68,69,73,74,77,96,AA,AE,AF,AG,AH,AJ,AK,AT,AZ) then PLN-BH-INDICATOR=1.
   f. If PLN-SVC-PROV-TYPE = '19' and PLN-SVC-PROV-SPEC in (26, 27) then PLN-BH-INDICATOR=1.
   g. If PLN-SVC-PROV-TYPE in (78, 93, 94) and PLN-SVC-PROV-SPEC = '26' then PLN-BH-INDICATOR=1.

END OF SECTION

Appendix L
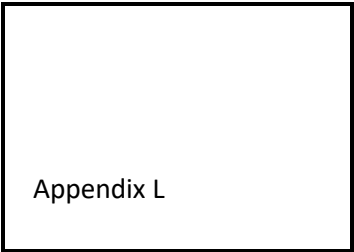
UPDATED Provider Supplemental Record Layout

Document Date:
Subject to Change

Part 1: Plan File Submission

File submissions should occur every Wednesday and Friday by 5:00 pm unless it is a holiday and then you may submit the file on the previous applicable work day.

You may submit only one file per day, so your file should contain all records that you expect to submit during that day. If there is a new provider on the Provider Registry then hold off on sending that provider on the Provider Supplemental until you receive the Medicaid Assigned ID.

Plan file submission naming convention: CCYYMMDD_xxxxxxx_Provider_Suppl.txt

CCYYMMDD is the date of submission.

Xxxxxxxx is the Plan ID.

The submission file has a fixed-length record format. Each record is 1049 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 spaces are acceptable, unless otherwise noted. A PDF error report and an error text file will be generated and sent back via the sFTP.

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 683 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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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
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	2	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		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			
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	O
62-62	Delimiter	Use the ^ character value	1	Character	R
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	O
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
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	**O**
392-392	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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	**O**
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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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	**O**
596-596	Delimiter	Use the ^ character value	1	Character	R
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	**O**
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
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
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
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
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
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
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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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
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

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Appendix M

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 Resources (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 the PIHP 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 <u>not</u> use delimiters and is formatted as an ASCII text file.

Field Nbr	Column(s)	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 the Recipient.
11	102-114	Original Recipient Medical ID	char(13)	Original Recipient ID obtained from Molina file.

END OF RECORD LAYOUT

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Appendix N
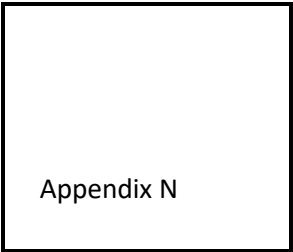
File Exchange Schedule

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 MOLINA							
File Name	**File Description**	**HISTORY OF THE FILE**	**Frequency**	**Send On**		**File From:**	**File To:**
PROVIDER_DAILY_UPDATE_{DAILY8}.ZIP	Daily Provider updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing		MOLINA	MAXIMUS MAGELLAN
RECIPIENT_DAILY_UPDATE_{DAILY8}.ZIP	Daily Recipient updated records extracts	Exclude periods of eligibility the month after a recipient turns 20 years of age.	Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing		MOLINA	MAXIMUS MAGELLAN
Recipient Voided IDs.txt	Daily Duplicate Member		Daily	Each Working Monday		MOLINA	MAGELLAN MCNA

	Recipient Crosswalk File			through Thursday evening and Friday after Weekly Processing		
CSOC-RETURN-YYYYMMDD.txt	CSOC Return File		Daily	Every Work Day	MOLINA	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	MOLINA	MAGELLAN
CCN_PA_Precert_Transactions_CCYYMMDD.zip	Weekly PA Extract for MCO		Weekly	Each Tuesday by COB	MOLINA	MCO MAGELLAN
CCN_Provider_List_CCYYMMDD.zip	List of Medicaid providers enrolled since 2011		Weekly	Each Tuesday by COB	MOLINA	MCO MAGELLAN
PROVIDER_SUPPLEMENTAL_xxxxxxx_ccyymmdd.txt	Twice Weekly Supplemental Edit Response File		Twice Weekly	Every Wednesday and Friday night unless it is a holiday and then you may submit the file on the previous applicable work day	MOLINA	MCO MCNA MAGELLAN
MW-W-50-xxxxxxx-ccyymmdd.PDF	Twice Weekly Supplemental Edit Response File Report			Every Wednesday and Friday night unless it is a holiday and then you may submit the file on the previous applicable work day	Molina	MCO MCNA MAGELLAN

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	MOLINA	MCO MAGELLAN
CLAIMS_WEEKLY_{DAILY8}.ZIP	FFS Weekly claims extracts	Exclude Age 20 and older with DOS 12/01/2015		Weekly	Every Weekend	MOLINA	MAGELLAN
ENCNTRS_WEEKLY_{DAILY8}.ZIP	Encounter Weekly claims extracts	Exclude Age 20 and older with DOS 12/01/2015		Weekly	Every Weekend	MOLINA	MAGELLAN
PHARMACY_WEEKLY_{DAILY8}.ZIP	Pharmacy Weekly FFS/ENC claims extracts	Exclude Age 20 and older with DOS 12/01/2015		Weekly	Every Weekend	MOLINA	MAGELLAN
PROVIDER REGISTRY	Weekly Provider Registry edit reports			Weekly	Every Friday Night	MOLINA	MCO MCNA MAGELLAN
PROVIDER_WEEKLY_COMPLETE_{DAILY8}.ZIP	Weekly full Provider extracts			Weekly	Every Weekend	MOLINA	MAGELLAN
RECIPIENT_WEEKLY_COMPLETE_{DAILY8}.ZIP	Weekly full Recipient extracts	Exclude periods of eligibility the month after a recipient turns 20 years of age.		Weekly	Every Weekend	MOLINA	MAGELLAN
SMO-W-001-PlanID-CCYYMMDD.txt	Weekly summarization of the errors incurred for encounters processing			Weekly	Each Tuesday by COB	MOLINA	MAGELLANMCNA
SMO-W-005-PlanID-CCYYMMDD.txt	Weekly summarization of the edit codes for encounters processing			Weekly	Each Tuesday by COB	MOLINA	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	MOLINA	MAGELLAN MCNA
TPL-ERROR-PlanID-CCYYMMDD.TXT	Weekly edit report of TPL records submitted by MCOs		Weekly	Every Thursday Night	MOLINA	MAGELLAN MCNA
Weekly 837 files (Inpatient, Outpatient, Professional)	Crossover 837 encounters files		Weekly	Weekly on Thursday by 12:00 noon CT	MOLINA	MAGELLAN
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	MOLINA	MCO MAGELLAN MCNA
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
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		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN

	Louisiana Medicaid MMIS.					
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
Monthly 820 DOD recovery files	DOD recoveries 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
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

NOTE: Subject to change by LDH

		INBOUND FILES TO MOLINA				
		Molina is changing its delivery system from a PUSH to PULL. The 3 existing 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	Bayou Health 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 submitted 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 submitted 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 submitted by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCNA	MOLINA
CCYYMMDD_PLANID_Site_PR.txt	Weekly site provider registry records submitted by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCO	MOLINA
CCYYMMDD_xxxxxxx_Provider_Suppl.txt	Twice-Weekly provider supplemental records submitted by MCOs for TMSIS	Twice Weekly	Every Wednesday and Friday by 5:00 pm unless it is a holiday	A PDF error report and an error text file will be generated and sent back via the sFTP.	MCO MAGELLAN MCNA	MOLINA

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				and then you may submit the file on the previous appli-cable work day			
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		Weekly	Every Thursday COB	First working day of following week COB	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 MAGELLA NMCNA	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 Thursday 12:00 noon CT. Note that NCPDP encounters may not be submitted on Thursday	On Check Write Schedule	MCO MAGELLA NMCNA	MOLINA

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SPECLNK_{DAILY8}.CSV	Specially requested and LDH-approved Bayou Health 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	MOLINA
STOLA_MOLINA_CSOC_YYYYMMDD.TAB	LTC CSoC Segment File Layout	*	Every Workday then daily beginning 12/1/15	*Every Work Weeknight until 12/1/15 then nightly (Monday thru Friday)	MAGELLAN	MOLINA

NOTE: Subject to change by LDH

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Appendix O
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PIHP CSoC Batch Electronic File Layout for TPL Information
Document Date: 11/20/2012
Edited: 06/01/2016
This information is subject to change

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.

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 (2177141), and YYYYMMDD is the date of submission.

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 space(s) is acceptable, unless otherwise noted. If you enter a value that is not spaces, the value will be edited appropriately. The file does not use delimiters and is formatted as an ASCII text file. For update records (Field 53 value = 3), fields that you may update/change are highlighted in blue below.

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: **1=general TPL update.**
4	16-27	TPL_PRI_INDIV_NAME_LAST	char(12)	R	Left Justify
5	28-34	TPL_PRI_INDIV_NAME_FIRST	char(7)	R	Left Justify
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
8	49-57	TPL_PRI_INSURED_SSN	char(9)	R	Enter a valid SSN
9	58-59	TPL_INITIATOR_CODE	char(2)	R	Value: **18=Magellan**
10	60-71	TPL_CASE_NAME_LAST	char(12)	O	Left justify

Field Nbr	Column(s)	Field	Format/ Length	R = Required O = Optional	Notes
11	72-78	TPL_CASE_NAME_FIRST	char(7)	O	Left justify
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
16	109-115	TPL_POLICY_HOLDER_NAME_FIRST	char(7)	O	Left justify
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
19	142-161	TPL_POLICY_HOLDER_CITY	char(20)	O	Left Justify
20	162-163	TPL_POLICY_HOLDER_STATE	char(2)	O	USPS abbreviation
21	164-172	TPL_POLICY_HOLDER_ZIP	char(9)	O	Left Justify
22	173-181	TPL_POLICY_HOLDER_SSN	char(9)	O	Use all zeros if not available
23	182-234	TPL_EMPLOYER_GRP_MAINT_COVER	char(53)	O	Left Justify
24	235-259	TPL_EMPLOYER_CLAIM_FIL_STREET	char(25)	O	Left Justify
25	260-279	TPL_EMPLOYER_CLAIM_FIL_CITY	char(20)	O	Left Justify
26	280-281	TPL_EMPLOYER_CLAIM_FIL_STATE	char(2)	O	Left Justify
27	282-290	TPL_EMPLOYER_CLAIM_FIL_ZIP	char(9)	O	Left Justify
28	291-343	TPL_INSURANCE_NAME	char(53)	R	Left Justify
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
35	419-433	TPL_GROUP_NBR	char(15)	O	Left Justify, leave blank if not used.
36	434-435	TPL_SCOPE_OF_COVERAGE_1	char(2)	R	See Scopes of Coverage in SCG.
37	436-437	TPL_SCOPE_OF_COVERAGE_2	char(2)	O	See Scopes of Coverage in SCG, if provided.
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
41	448-455	TPL_END_DATE_YYMMDD	char(8)	R	YYYYMMDD, use 20991231 if the entry is open-ended
42	456-480	TPL_AGENT_NAME	char(25)	O	Left Justify

Field Nbr	Column (s)	Field	Format/ Length	R = Required O = Optional	Notes
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 01-64 or 77. See Parish Code table in SCG**
Field Nbr	Column (s)	Field	Format/ Length	R = Required O = Optional	Notes
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, 3=update an existing entry,**
54	571-577	TPL_SEQUENCE_NUMBER	char(7)	R	File record sequence number: The first record in the file should have number 0000001, the second 0000002, etc.
~~55~~	~~578-585~~	~~TPL_LAHIPP_BEGIN_DATE~~	~~char(8)~~	~~O~~	~~Leave spaces.~~
~~56~~	~~586-593~~	~~TPL_LAHIPP_END_DATE~~	~~char(8)~~	~~O~~	~~Leave spaces.~~
	[Note: the previous 2 items (55 and 56) are removed and are not applicable.]				
57	578-700	TPL_FILLER	char(123)	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 in the update process on the LMMIS TPL Resource File.

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Molina's update process performs extensive edits and produces error reports, and we will also create an error text file and send it back to you via your FTP server (showing only your submitted records, if they hit an edit). If none of your records hit an edit, we will send back an empty error text file.

IMPORTANT NOTE: If you do <u>NOT</u> 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 (**2177141**) 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	1-7	TPL_SEQUENCE_NUMBER	char(7)	File record sequence number from your submission.
2	8-20	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.
Field Nbr	Column(s)	Field	Format/ Length	Notes
8	42	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. So, for example:

Error Code	DESCRIPTION
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 value of the field was a space.
007	Invalid value for Field 7 (TPL_PRI_MED_ID_NO). The field contains spaces, or the field is not numeric, or the field is not 13 digits.
008	Invalid value for Field 8 (TPL_PRI_INSURED_SSN). The field contains spaces, or the field is not numeric, or the field is not 9 digits.
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.

Error Code	DESCRIPTION
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). This field is not edited, so you should not see edit error 022 in the edit response file.

Error Code	DESCRIPTION
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 spaces.
029	Invalid value for Field 29 (TPL_INSURANCE_NUMBER). Value submitted is spaces or value is not found on LMMIS Carrier Code file. If TPL_PROCESS_TYPE=3 then value was not found on Recipient's TPL record.
030	Invalid value for Field 30 (TPL_INSURANCE_CLAIM_FIL_STREET). Value submitted is spaces.
031	Invalid value for Field 31 (TPL_INSURANCE_CLAIM_FIL_CITY). Value submitted is spaces.
032	Invalid value for Field 32 (TPL_INSURANCE_CLAIM_FIL_STATE). Value submitted is spaces.
033	Invalid value for Field 33 (TPL_INSURANCE_CLAIM_FIL_ZIP). Value submitted is spaces.
034	Invalid value for Field 34 (TPL_POL_NBR). Value is spaces or all 0s or all 9s.
035	Invalid value for Field 35 (TPL_GROUP_NBR). Value is spaces or all 0s or all 9s.
036	Invalid value for Field 36 (TPL_SCOPE_OF_COVERAGE_1). Not a valid scope of coverage.
037	Invalid value for Field 37 (TPL_SCOPE_OF_COVERAGE_2). Not a valid scope of coverage.
038	Invalid value for Field 38 (TPL_SCOPE_OF_COVERAGE_CD_1). Value should be a space.
039	Invalid value for Field 39 (TPL_SCOPE_OF_COVERAGE_CD_2). Value should be a space.
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 044 in the edit response file.

046	Invalid value for Field 46 (TPL_AGENT_STATE). A non-blank value was submitted and it does not represent a valid USPS state code.
047	Invalid value for Field 47 (TPL_AGENT_ZIP). A non-blank value was submitted and it is not a 5-digit or 9-digit number.
048	Invalid value for Field 48 (TPL_PARISH). A non-blank value was submitted and it is not a valid LMMIS parish code value.
049	Invalid value for Field 49 (FILLER). This field is not edited, so you should not see edit error 044 in the edit response file.

Error Code	DESCRIPTION
050	Invalid value for Field 50 (TPL_PRIV_INSUR_SUBMIT_ID). This field is not edited, so you should not see edit error 044 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 044 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 044 in the edit response file.
053	Invalid value for Field 53 (TPL_PROCESS_TYPE). Must be 1 or 3. If value is 1, then a record <u>must not exist</u> on the LMMIS TPL Resource File. If value is 3, then a record <u>must exist</u> on the LMMIS TPL Resource File.
054	Invalid value for Field 54 (TPL_SEQUENCE_NUMBER). Must be a number and must be unique in the file.

END OF RECORD LAYOUT

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 TPL Resource File. If you receive no error record for a submitted record (based on the TPL_SEQUENCE_NUMBER), you may assume that the record passed all edits and was applied to the LMMIS 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 may 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 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].

RULES for PROCESSING TPL RECORDS

1. An Existing TPL Record is a record that is on the MMIS system and has not been logically deleted (end date = begin date).

2. If a TPL record exists for an individual on the MMIS System, based on Recipient ID (Field 7) and Policy Number (Field 34), then you should submit an update record (Field 53 value = 3) when you wish to update the record. The rule is that if a record already exists on the MMIS System, and you wish to update that record, then you should submit an update transaction (Field 53 value = 3).

3.   If you submit a New Entry record (Field 53 value = 1) for a record that exists on the MMIS System, then the record will be rejected with error code 053. The rule is that you may not add a new record if a TPL record already exists on the MMIS System.

4.   If you wish to "remove" a record that exists on the MMIS System, you will need to logically delete the record by submitting an update record (Field 53 value = 3) with the end date (Field 041) equal to the begin date (Field 040). This will effectively cancel the record. There is no provision to physically delete a TPL record. Because AMG's system cannot send a record with an end date = begin date. If AMG wishes to "remove" a record that exists on the MMIS System, AMG should send a type 4 record (Field 53 value = 4).

5.   If you attempt to update a TPL record that does not exist on the MMIS System, based on Recipient ID (Field 7) and Policy Number (Field 34), then the record will be rejected with error code 053. Therefore, if a TPL record does not exist for an individual and you wish to add one, then submit a New Entry record (Field 53 value = 1).

6.   For update records (Field 53 value = 3), the fields that you may update are highlighted in **blue** in the record layout of Part 1 of this document.

7.   To change the carrier code (TPL_INSURANCE_NUMBER (Field 29)), on an existing TPL record for an individual, based on Recipient ID (Field 7), and Policy Number (Field 34), complete the follow process:
   a.   Day 1, logically delete the existing record (end date same as begin date) on a type 3 record (Field 53 value = 3).   AMG is the exception to this rule. AMG should delete existing records by sending type 4 record (Field 53 value = 4).
   b.   Day 2, send a new record (Field 53 value =1) for same policy with correct carrier code.

8.   Medicare Advantage Plan Carrier Codes begin with HXXXXX, and SOC is 30.   If you submit a record for a Medicare Advantage Plan, the Carrier Code (Field 29), should be reported as HXXXXX, and the Scope of Coverage (Fields 36-37)) should be reported as 30.
   a.   If you submit a record whose SOC is 30 and the Carrier Code is not HXXXX, the record will reject.
   b.   If you submit a record whose Carrier Code is HXXXXX, and the SOC is not 30, the record will reject.

9.   If you identify a second SOC in addition to the SOC reported on your TPL reconciliation file, report the primary scope of coverage in Field 36 (TPL_SCOPE_OF_COVERAGE_1), and report the secondary SOC in Field 37 (TPL_SCOPE_OF_COVERAGE_2).

10. For new records (Field 53 value = 1), Policy Number (Field 29), **must not contain spaces or special characters or punctuation marks**. For new records (Field 53 value = 1) where the policy number has spaces, special characters or punctuation marks will reject with error code 034 (edit pending-effective date TBD).

11. ~~Molina will convert alpha characters in lower case to upper case; therefore, your TPL reconciliation file will return alpha characters in the policy number in upper case.~~

12. **For new records** (Field 53 value = 1), **alpha characters reported in Policy Number** (Field 29), **must be in UPPER CASE**. New records (Field 53 value = 1), where policy number (Field 29) reports lower case characters will reject with error code 034 (edit pending-effective date TBD).

13. **For update records** (Field 53 value = 3), **policy number must exactly match that of the policy number on file**. For example, Member 123, Carrier Code, 22270, policy number 45a567B-00 on Molina TPL Resource File. The policy number reported in the update record (Field 53 value = 3), for member 123, Carrier Code 22270 must mirror the policy on file which is: 45a567B-00; otherwise, the record will reject with error code 053.

14. How to report records where there exist gaps in coverage. (TBD).

IMPORTANT NOTE: This process applies 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 Plan for its members.)

END OF DOCUMENT

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:

Column(s)	Description
01-06	Carrier Code (Payer ID)
07	delimiter, value is ^
08-60	Insurance Company Name
61	delimiter, value is ^
62-86	Street Address 1
87	delimiter, value is ^
88-112	Street Address 2
113	delimiter, value is ^
114-133	City
134	delimiter, value is ^
135-136	State (abbrev)
137	delimiter, value is ^
138-146	Zip+4
147	delimiter, value is ^

TPL Scope of Coverage Codes

Date Revised – 06/03/2016

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 with No Major Medical Coverage Identified
20	Nursing Home Only
21	Cancer Only
22	CHAMPUS/CHAMPVA
23	Veterans Administration
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

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Appendix P

ELIG Recon File Layout

Document Date: 01/25/2016
Subject to Change

PART 1: Magellan Submission

File submissions should occur weekly each Monday by COB unless it is a holiday and then you may submit the file on the previous applicable work day.
File submission will be retrieved from the Magellan ftp server in the following folder:
/Home/MolinaHCProd/Outbound

Magellan File submission naming convention: STOLA_MOLINA_RECON_YYYYMMDD.TAB
The submission file has a fixed-length record format. Each record is 62 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 is tab delimited and is formatted as an ASCII text file.

The error text file will have this layout:

Field Nbr	Column(s)	Field	Format/ Length	R=Required O=Optional	Notes
1	1-13	Recipient ID	num(13)	R	Medicaid Recipient ID
2	14-14	delimiter	char(1)	R	Constant value of tab
3	15-26	Recipient Last Name	char(12)	R	First 12 chars of the Recipient Last name.
4	27-27	delimiter	char(1)	R	Constant value of tab
5	28-34	Recipient First Name	char(7)	R	First 7 chars of the Recipient First name.
6	35-35	delimiter	char(1)	R	Constant value of tab
7	36-43	Recipient Birth Date	num(8)	R	Recipient Birth Date
8	44-44	delimiter	char(1)	R	Constant value of tab
9	45-52	Eligibility Begin Date	num(8)	R	Begin date of the eligibility segment to be matched.
10	53-53	delimiter	char(1)	R	Constant value of tab
11	54-61	Eligibility End Date	num(8)	R	End date of the eligibility segment to be matched.
12	62-62	delimiter	char(1)	R	Constant value of tab

END OF RECORD LAYOUT

Version 22 – December 2023

PART 2: Molina Processing and forwarding of files to Magellan

Molina will capture the file from Magellan. Molina will run the information against the Recipient master file and attempt to match the recipient based on Recipient ID, Last name, First name, and Birth date. If there is a mismatch of these fields, a message will be generated. If the Recipient ID does not exist, a message will be generated. If the Begin and End dates do not match an existing Eligibility segment, a message will be generated.

File submission by Molina will be to the Magellan FTP site in the following folder:
/Home/MolinaHCProd/Inbound
The three return text files will use the naming convention:
WEEKLY_RECIP_RECON_RESP_{DAILY8}.TXT – Response file
WEEKLY_RECIP_RECON_REPT_{DAILY8}.TXT – MM-O-310 report
WEEKLY_RECIP_RECON_REPT_FILE_{DAILY8}.TXT – Unformatted (tab delimited) version of MM-O-310 report

Below is the format of the response file. The file has a fixed-length record format, and contains only recipient information sent by Magellan, where the recipient does not exist in the Master Recipient file. Each record is 44 characters in length, and uses the following record layout.

Field Nbr	Column(s)	Field	Format/ Length	R=Required O=Optional	Notes
1	1-13	Recipient ID	num(13)	R	Medicaid Recipient ID
2	14-14	delimiter	char(1)	R	Constant value of tab
3	15-26	Recipient Last Name	char(12)	R	First 12 chars of the Recipient Last name.
4	27-27	delimiter	char(1)	R	Constant value of tab
5	28-34	Recipient First Name	char(7)	R	First 7 chars of the Recipient First name.
6	35-35	delimiter	char(1)	R	Constant value of tab
7	36-43	Date of Birth	num(8)	R	Date of Birth
8	44-44	delimiter	char(1)	R	Constant value of tab

END OF RECORD LAYOUT

Below is the format of the Recon Report file. The file has a fixed-length record format, and contains a tab delimited, no header version of the MM-O-310 repot. Each record is 112 characters in length, and uses the following record layout.

Field Nbr	Column(s)	Field	Format/ Length	R=Required O=Optional	Notes
1	1-13	Recipient ID	num(13)	R	Medicaid Recipient ID
2	14-14	delimiter	char(1)	R	Constant value of tab
3	15-26	Recipient Last Name	char(12)	R	First 12 chars of the Recipient Last name.
4	27-27	delimiter	char(1)	R	Constant value of tab

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Field Nbr	Column(s)	Field	Format/ Length	R=Required O=Optional	Notes
5	28-34	Recipient First Name	char(7)	R	First 7 chars of the Recipient First name.
6	35-35	delimiter	char(1)	R	Constant value of tab
7	36-43	Recipient Birth Date	num(8)	R	Recipient Birth Date
8	44-44	delimiter	char(1)	R	Constant value of tab
9	45-52	Eligibility Begin Date	num(8)	R	Begin date of the eligibility segment to be matched.
10	53-53	delimiter	char(1)	R	Constant value of tab
11	54-61	Eligibility End Date	num(8)	R	End date of the eligibility segment to be matched.
12	62-62	delimiter	char(1)	R	Constant value of tab
13	63-111	Message	char(49)	R	Text field containing any messages created.
14	112-112	delimiter	char(1)	R	Constant value of tab

END OF RECORD LAYOUT

Appendix Q

RECIP-MULTIPLE-ID-RECORD FILE LAYOUT

| LEVEL	FIELD NAME	PICTURE	FIELD NUMBER	START	END	LENGTH	Format	Description
	RECIP-MULTIPLE-ID-RECORD							
1	RECIP-MULTIPLE-ID-RECORD			1	86	86		
5	RMIR-OBSOLETE-ID	9(13)	1	1	13	13	13-digits	CURRENT-ID that is no longer valid
5	RMIR-OBSOLETE-ORIGINAL	9(13)	2	14	26	13	13-digits	ORIGINAL-ID no longer to be associated with preceding ID, but can be associated with following VALID-ID
5	RMIR-VALID-ID	9(13)	3	27	39	13	13-digits	CURRENT-ID associated with Medicaid Recipient
5	RMIR-VALID-ORIGINAL	9(13)	4	40	52	13	13-digits	ORIGINAL-ID associated with preceding VALID-ID
5	RMIR-OBSOLETE-SSN	9(9)	5	53	61	9	9-digits	INVALID or PSEUDO SSN previously associated with Medicaid Recipient
5	RMIR-VALID-SSN	9(9)	6	62	70	9	9-digits	Valid SSN to be used for identifying Medicaid Recipient
5	RMIR-ADD-DATE	9(8)	7	71	78	8	yyymmdd	Date upon which information was supplied to Molina
5	RMIR-ACTIVITY-DATE	9(8)	8	79	86	8	yyymmdd	Date of last activity associated with the current record

End of Record Layout

Appendix R

THIRD PARTY LIABILITY (TPL) BATCH FULL RECONCILIATION FILE LAYOUT

FIELD NBR	COLUMN(s)	FIELD IDENTIFICATION	FORMAT/ LENGTH	NOTES
1	01 - 13	Member Medicaid ID (Current)	char 13	
2	14 - 26	Member Medicaid ID (Original)	char 13	
3	27 - 28	Insurance Type Indicator	char 2	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 Scope of Coverage; **Note the 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	
19	213-214	Initiator Code	char 2	

20	215-225	MBI	char 11	Will be spaces on PR and LH records.

Appendix S

THIRD PARTY LIABILITY (TPL) FILE LAYOUT to MAGELLAN

(Incremental and full reconciliation files)

DataBase Name:	EB-RECIPIENT-HEADER				
Location:	File Extract				
Column Name or Field name	Columns	Length	Data Type	Accepted Values	Description
RECIP-ID-CURRENT	1-13	13	Numeric	13-digit Medicaid Recipient ID number	The recipient's current Medicaid ID number
RECIP-ID-ORIGINAL	14-26	13	Numeric	13-digit Medicaid Recipient ID number	The recipient's original Medicaid ID number
RECIP-HIC	27-38	12	CHAR		SSOC CLAIM BENEFITS(HIC) NUMBER
RECIP-SSN	39-47	9	Numeric		
RECIP-LAST-NAME	48-59	12	CHAR		
RECIP-FIRST-NAME	60-71	12	CHAR		
RECIP-MID-INITIAL	72-72	1	CHAR		
RECIP-RECIP-TITLE	73-75	3	CHAR		
RECIP-RECIP-SUFFIX	76-78	3	CHAR		
RECIP-PREVIOUS-LAST-NAME	79-90	12	CHAR		
RECIP-PREVIOUS-FIRST-NAME	91-102	12	CHAR		
RECIP-PREVIOUS-MID-INITIAL	103-103	1	CHAR		
RECIP-ADDR-LN1	104-128	25	CHAR		Street Address
RECIP-ADDR-LN2	129-153	25	CHAR		Street Address, additional if necessary
RECIP-CITY	154-171	18	CHAR		
RECIP-STATE	172-173	2	CHAR	Uses USPS Standard State Abbreviation	
RECIP-ZIP-CODE	174-182	9	Numeric	9-digit USPS ZIP code	
RECIP-BIRTH-DATE	183-190	8	Numeric	Format YYYYMMDD	The recipient's DOB
RECIP-SEX	191-191	1	CHAR	1=Male, 2=Female, 9=Unknown.	

Prepaid Inpatient Health Plan (PIHP) Coordinated System of Care (CSoC) Systems Companion Guide

Column Name or Field Name	Columns	Length	Data Type	Accepted Values	Description
RECIP-RACE	192-192	1	CHAR	0=Not declared 1=White 2=Black or African American 3=American Indian or Alaskan Native 4=Asian 5=Hispanic or Latino (no other race info) 6=Native Hawaiian or Other Pacific Islander 7=Hispanic or Latino and one or more other races 8=More than one race indicated (and not Hispanic or Latino) 9=Unknown	
RECIP-DATE-OF-DEATH	193-200	8	Numeric	Format YYYYMMDD	
RECIP-DATE-OF-CERTIF	201-208	8	Numeric	Format YYYYMMDD	
RECIP-DATE-OF-APPLIC	209-216	8	Numeric	Format YYYYMMDD	
RECIP-DATE-OF-LAST-ACTIVITY	217-224	8	Numeric	Format YYYYMMDD	
RECIP-GROSS-INCOME	225-229	5	Numeric	GROSS INCOME IN WHOLE DOLLARS	
RECIP-FAMILY-SIZE	230-232	3	Numeric	The number of persons in the family of which a recipient is a member. FAMILY SIZE NOT > 255	
RECIP-SEX-OVERRIDE-IND	233-233	1	CHAR	BLANK=NO RESTRICTION Y = SEX RESTRICTION A = AGE RESTRICTION B = SEX AND AGE RESTRICTION	Used in MMIS claims processing to override specific age or sex restricted procedures due to special circumstances and/or conditions associated with the recipient.
RECIP-EPSDT-TRACKING-IND	234-234	1	Numeric	1=Requested medical & dental screening 2=Requested only medical screening 3=Requested only dental screening 6=Non-participant 7=Non-participant 8=Currently participates in program.	A code that Indicates the recipient's response to an offer of EPSDT services.

RECIP-EPSDT-SIGNATURE-DATE	235-242	8	Numeric	Format YYYYMMDD	
RECIP-DX-DISCHARGE-DATE	243-250	8	Numeric	Format YYYYMMDD	
RECIP-LTC-REVIEW-DATE	251-258	8	Numeric	Format YYYYMMDD	
RECIP-RECIP-EXCP-IND	259-259	1	CHAR	N or space=Not exempt Y=Eligible is exempt from CommunityCARE	
RECIP-SOURCE-OF-INPUT	260-260	1	CHAR	W Weekly BHSF update tape O On-line (RC-1 Form) L On-line (Lock-in) Community Care D Daily MEDS update P On-line (DX Discharge or CPE Date Modified)	
RECIP-TEL-NO	261-270	10	Numeric	May be 0.	
RECIP-PBS-BEG-DATE	271-278	8	Numeric	Format YYYYMMDD	
RECIP-PBS-END-DATE	279-286	8	Numeric	Format YYYYMMDD	
RECIP-CASE-MANAGER	287-293	7	CHAR	Medicaid Provider ID number	This is the case manager for Chisholm recipients, but it is optional. Not all Chisholm-class recipients will be assigned a case manager, and so this value may be 0.

Column Name or Field Name	Columns	Length	Data Type	Accepted Values	Description
RECIP-PID-CARD-NO	294-309	16	Numeric	16-digit number in the format 777nnnnnnnnnnnss where nnnnnnnnnnn is a unique number and ss is the card sequence number, starting at 01. Each replacement card has the same first 14 digits, but the card sequence number is incremented by 1. Only the last card number assigned is valid.	Recipient's current plastic ID card number, sometimes called a CCN=card control number.
RECIP-MOTHER-PERSON-ID	310-322	13	Numeric	Recipient ID of the Mother of a newborn	May or may not be available.
RECIP-HEAD-OF-HOUSEHOLD-LAST-NAME	323-334	12	CHAR	Last name of Head of Household or SDX payee	May or may not be available.
RECIP-HEAD-OF-HOUSEHOLD-FIRST-NAME	335-346	12	CHAR	First name of Head of Household or SDX payee	May or may not be available.

Column Name or Field Name	Columns	Length	Data Type	Accepted Values	Description
RECIP-HEAD-OF-HOUSEHOLD-MIDDLE-INIT	347-347	1	CHAR	Middle initial of Head of Household or SDX payee	May or may not be available.
RECIP-HEAD-OF-HOUSEHOLD-SSN	348-356	9	Numeric	Social security number of Head of Household or SDX payee	May be zeroes if not available.
RECIP-PREFERRED-LANGUAGE-IND	357-358	2	CHAR	See ' PREFERRED-LANGUAGE' tab	
RECIP-EXP-ADDR-LN1	359-393	35	CHAR		Expanded Address field – line1
RECIP-EXP-ADDR-LN2	394-428	35	CHAR		Expanded Address field – line2
RECIP-EXP-ADDR-LN3	429-463	35	CHAR		Expanded Address field – line3
RECIP-EXP-CITY	464-483	20	CHAR		
RECIP-EXP-STATE	484-485	2	CHAR		
RECIP-EXP-ZIP-CODE	486-494	9	Numeric		
RECIP-EXP-LAST-NAME	495-519	25	CHAR		
RECIP-EXP-FIRST-NAME	520-539	20	CHAR		
RECIP-EXP-MID-INITIAL	540-540	1	CHAR		
RECIP-EXP-RECIP-TITLE	541-543	3	CHAR		
RECIP-EXP-RECIP-SUFFIX	544-546	3	CHAR		
RECIP-EXTRA-PHONE1	547-556	10	Numeric		
RECIP-EXTRA-PHONE2	557-566	10	Numeric		
RECIP-PHY-ADDRESS-1	567-601	35	CHAR		Recipient's Physical address 1
RECIP-PHY-ADDRESS-2	602-636	35	CHAR		Recipient's Physical Address 2
RECIP-PHY-ADDRESS-3	637-671	35	CHAR		Recipient's Physical Address 3
RECIP-PHY-CITY-REC2	672-691	20	CHAR		Recipient's Physical City of Residence
RECIP-PHY-STATE-REC2	692-693	2	CHAR		Recipient's Physical State of Residence
RECIP-PHY-ZIP-REC2	694-702	9	CHAR		Recipient's Physical Zip Code
RECIP-EMAIL-ADDRESS	703-752	50	CHAR		Email of the recipient as provided.
RECIP-CURR-PARISH	753-754	2	CHAR		Current Parish of the recipient
RECIP-RENEWAL-DATE	755-762	8	CHAR	Format YYYYMMDD	Recipient's Renewal Date
Column Name or Field Name	**Columns**	**Length**	**Data Type**	**Accepted Values**	**Description**

RECIP-RENEWAL-CODE	763-764	2	CHAR	01 - Renewal Form 02 - Adv./Incomplete 04 - Adv/Pnd Closure 05 - Adv./DHH Appeal 06 - LAMI Closure 07 - SDX Closure 08 - Elig Evaluation 09 - Adv./SSA Appeal 10 - SDX Mcaid Elg Q 11 - Ex Parte 12 - 12 Mo Cont Elig 13 - OCS Closure 14 - Telephone 16 - Cit/Id Ver Pend 17 - Admin Renewal 18 - Online 19 - Remain In Coins 20 - ELE Renewal 21 - SNAP Closure 22 - Flood and Snap Renewal	Renewal Code Value
RECIP-MULT-BIRTH-IND	765-765	1	CHAR	Y = Yes N = None Blank = None	A code that indicates if the recipient has had multiple births or not.
RECIP-MEDICARE-MBI	766-776	11	CHAR	MBI ALGORITHM: Position 1 = numeric 1-9 Position 2 = alpha (A-Z)* Position 3 = alpha/numeric 0-9 and A-Z* Position 4 = numeric 0 - 9 Position 5 = alpha (A-Z)* Position 6 = alpha/numeric0 – 9, A – Z* Position 7 = numeric 0 - 9 Position 8 = alpha (A-Z)* Position 9 = alpha (A-Z)* Position 10 = numeric 0 - 9 Position 11 = numeric 0 – 9 (*) – alpha is Upper case only and excludes S, L, O, I, B, Z	Medicare Beneficiary Identifier

END OF RECORD LAYOUT

A new 2 character predetermined (assigned) field that denotes the initiator of the private insurance segments has been added to the TPL file layout sent to the Plans (Magellan, MCNA, MCOs).

TPL File Layout To Magellan	
TPL01	***EB-OTHER-INS-DETAIL.***
05	OTHER-INS-RECIP-ID-CURR PIC X(13).
05	OTHER-INS-RECIP-ID-ORIG PIC X(13).
05	OTHER-INS-TYPE PIC X(02).
88	PRIVATE-TPL VALUE 'PR'.
88	MEDICARE-PART-A VALUE 'MA'.
88	MEDICARE-PART-B VALUE 'MB'.
88	LAHIPP VALUE 'LH'.
05	OTHER-INS-COMPANY-NUMBER PIC X(06)
05	OTHER-INS-SCOPE OF COVERAGE PIC X(02)
05	OTHER-INS-MEDICARE-HIC-NO PIC X(12)
05	OTHER-INS-BEGIN-DATE PIC 9(08).
05	OTHER-INS-END-DATE PIC 9(08).
05	OTHER-INS-GROUP-NO PIC X(15).
05	OTHER-INS-POLICY-NO PIC X(13).
05	OTHER-INS-POLICY-HOLDER-NAME PIC X(20).
05	OTHER-INS-POLICY-HOLDER-SSN PIC X(09).
05	OTHER-INS-AGENT-NAME PIC X(25).
05	OTHER-INS-AGENT-PHONE PIC X(10).
05	OTHER-INS-AGENT-STREET PIC X(25).
05	OTHER-INS-AGENT-CITY PIC X(20).
05	OTHER-INS-AGENT-STATE PIC X(02).
05	OTHER-INS-AGENT-ZIP PIC X(09).
05	OTHER-INS-INITIATOR-CODE PIC x(02)

TPL Initiator Codes	
Code	**Description**
01	State Office
02	IV-D-SES
03	CCN-P (Pre-Paid)
04	CNN-S (Shared)
07	TPL Contractor - HMS
15	Amerigroup
16	LaCare
17	LHC
18	Magellan
19	MCNA
20	Aetna
21	UHC Pre-Paid
22	LDH RPA
23	Provider Submitted
24	LDH Other

END OF RECORD LAYOUT