# Dental Benefit Plan Manager

## Systems Companion Guide

November 2013
Version 1.1

# Dental Benefits Plan System Companion Guide

The Department of Health and Hospitals 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 | Descriptions | Reason | Date |
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# Overview

DHH will require the Dental Benefit Plan Manager, herein referred to in this Guide as the Plan, to report complete and accurate encounter data  for all Medicaid eligible enrollees. Encounters include all paid services provided to Medicaid enrollees. The   Plan will be required to submit complete and accurate encounters to the Fiscal Intermediary (FI) using HIPAA v5010 compliant Provider-to-Payer-to-Payer  COB  837D  (Dental)  and  837P  (Professional  and  NEMT) transactions.

## Definition of an Encounter

Encounters are records of medically related services rendered by a Plan provider to Medicaid recipients enrolled in the Plan on the date of service. It includes all services for which the Plan has any financial liability to a provider. An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. The Plan must report all paid services covered under the Contract. Encounter services include core benefits and services to Medicaid members based on their eligibility groups as specified by DHH in Section 5 of the RFP for the eligibility groups.

## Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

## Contract Requirements

For encounter data submissions, the Plan shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the Plan has a capitation arrangement with a provider

## Rate Setting

The Balanced Budget Act of 1997 (BBA) requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are actuarially sound if they are appropriate for the covered Medicaid population and the services are provided under the Contract. In addition, CMS requires basing rates upon at least one year of recent data that is not more than five years old.

In full consideration of the Contract services rendered by the Plan, DHH agrees to pay the Plan monthly payments based on the number of enrolled Members and other relevant cohort distinctions (age, gender, geographic location, Medicaid category of assistance, etc.).

## Quality Management and Improvement

The DBP is a Medicaid Program partially funded by CMS. The Plan is required to collect and report performance measures (PM) data that demonstrates adherence to clinical practice and/or improvement in patient outcomes. Measures as defined by DHH, include Health Care

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Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality (AHRQ) measures and/or other measures as determined by DHH as outlined in the contract. DHH will use encounter data to evaluate the performance of the Plan and to audit the validity and accuracy of the reported measures.

## Continuous Quality Improvement Plan for Oversight and Assessment of Medicaid Coordinated Care

According to the 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 DHH 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 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 DHH. Data from the Plan will continue to undergo data quality checks beyond the minimum criteria used in the edit process. The results of both the encounter edit codes and ongoing data quality monitoring are combined to develop plan-specific Quality Strategic Opportunity Plans (encounter quality improvement plans).

## Implementation Date

Within sixty (60) days of operation, the Plan's Systems shall be ready to submit encounter data to DHH's FI in a HIPAA compliant provider-to-payer-to-payer COB format. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (D – Dental and P - Professional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

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## DHH Responsibilities

DHH is responsible for administering the Dental Benefit Program. Administration includes data analysis, production of feedback and comparative reports, data confidentiality, and the contents of this Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Mary Johnson
Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
Phone: (225) 342-1304
Fax:   (225) 342-9508
Email:  mary.johnson@la.gov

DHH is responsible for the oversight of the Contract and Plan activities. DHH's claim responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with the Plan, and Plan training. DHH will update the Systems Companion Guide on a periodic basis.

## Fiscal Intermediary (FI) Responsibilities

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

The Plan will receive daily incremental recipient Member File updates, a weekly full Member File, and a weekly full provider extract.  During the Design, Development and Implementation phase (DDI), the Plan will receive an initial file of claims and encounters representing two (2) years of historical data, and then on a weekly basis, the Plan will receive a weekly incremental file of claims and encounters data.  The Plan will also receive a capitation payment each month for each Medicaid eligible as defined in the RFP, and a monthly ANSI ASC X12N v5010 820 file representing the detail payments by member.

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## 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 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

After claim adjudication, an ANSI ASC X12N v5010 835 Remittance Advice (835) will be delivered to the Plan, if requested. The Plan must prearrange for receipt of 835 transactions.

## Proprietary Reports

The FI will also provide the Plan with proprietary MMIS encounter adjudication edit reports following the weekly encounter processing cycle. In addition, a monthly financial reconciliation report (820) will coincide with payment of the PMPM. The file layout can be found in Appendix D of this Guide.

## Dental Benefit Program (Plan) Responsibilities

The Plan shall be able to transmit, receive and process data in HIPAA compliant or DHH 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. Plan generated reports are described in Appendix E of this Guide.

It is, also, the Plan's responsibility to ensure accurate and complete encounter reporting from their providers.

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

The Plan 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 discussed, the Plan must incorporate corrective action steps into the encounter quality improvement plan. Any issues that are not fully addressed on a timely basis may be escalated into a corrective action plan (CAP). The CAP will include a listing of issues, responsible parties, and projected resolution dates

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# 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 (presently v5010). 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). 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 DHH are the 837D Dental and 837P Professional Provider-to-Payer-to-Payer Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

This Guide will not provide detailed instructions on how to map encounters from the Plans systems to the 837 transactions. The 837 IGs contain most of the information needed by the Plan to complete this mapping.

The Plan shall create their 837 transactions for DHH using the HIPAA IG for Version 5010. On January 16, 2009, HHS published final rules to adopt updated HIPAA standards; these rules are available at the Federal Register. Should HHS update the HIPAA IG to a new version, the Plan will be responsible for migrating applications to that new version, according to the timelines issued by HHS.
In one rule, HHS is adopting X12 Version 5010 for HIPAA transactions. For Version 5010, the compliance date for all covered entities is January 1, 2012.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional, and Dental) 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.

## Molina Companion Guides and Billing Instructions

Molina, as DHH'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 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

## DHH Supplemental Instructions

DHH requires the Plan to submit the Provider-to-Payer-to-Payer 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), 2430 (Service Line Adjudication Information) and 2330B (Other Payer information). In the first COB

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loop, the Plan will be required to include information about the Plan provider claim adjudication, including the claim amount paid and payment date as recognized by the Plan. In the first loop, the Plan shall place their unique DHH carrier code in loop 2300B, NM109. Molina will assign the unique carrier code to the Plan. In subsequent loops, the Plan shall provide DHH with any third-party payments. In these loops, the Plan must include the DHH carrier code of the other payer. There can be only one single subsequent loop per unique payer

## Health Plan Carrier Code Assignment

Plan Name: Dental Benefit Plan                    Assigned Carrier Code: 999997.

## Batch Submissions

The Plan may submit batch encounters, up to 99 files per day.    Each batch encounter file is restricted to 20,000 CLM records.

## Plan Internal Control Number (ICN)

The Plan ICN is to be populated in Patient Control Number, Loop 2300, CLM01. The number that the Plan transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the Plan to use the value in this field as a key in the Plan's system to match the encounter to the information returned in the 835 transaction.
The Plan ICN shall be modified to contain a 4-character prefix as follows:

Character 1:  Claim submission media type.  Standard types would be 'P' to indicate a paper, 'E' to indicate an electronic claim, and 'W' to indicate a claim submitted over a web portal.  If other types are submitted, the Plan must provide a data dictionary.

Character 2:  Claim paid\denied status.  If the claim was paid by the Plan or delegated vendor, this character position should have a 'P'.  If claim was denied by the Plan or delegated vendor, this character position should have a 'D'.

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

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## Financial Fields

The financial fields that DHH requests the Plan to report include:

- Header and Line Item Submitted Charge Amount
- Header and Line Item Approved (Allowed) Amount
- Header and Line Item Health Plan Paid Amount
- Header and Line Item Adjustment Amount

**Header and Line Item Submitted Charge Amount** — The Health Plan shall report the provider's charge or billed amount. The value may be "$0.00" if the Health Plan contract with the provider is capitated and the Health Plan 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 DHH 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.   The maximum charge or billed amount that can be submitted is 999999.99.

**Header and Line Item HEALTH PLAN Paid Amount** — If the Health Plan paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the Health Plan or was covered under a sub-capitation arrangement, "$0.00" is the appropriate Paid Amount. This amount is stored in the encounter as a Third Party Liability (TPL) amount.

**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 Health Plan is required to report both the Adjustment Amount and the adjustment reason code. The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

## Claim Received Date

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

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

## Claim Paid Date

The Plan is required to submit the Plan's Claim Paid Date in 837-P and 837-D 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.

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## Interest Paid Amount

When the MCO pays Claim Interest, the Plan is required to submit the MCO's Claim Interest Amount and Paid Date in 837-P and 837-D encounter data. The Claim Interest data will be sent in a distinct set of COB Loops, separate from the set of COB Loops that the Plans use to send their claim adjudication data.

In the Claim Interest set of COB Loops, instead of using the Plan's unique DHH Carrier Code (99999x), a value in INT99x format will be used; where the last digit is the same last digit from the Plan's unique DHH Carrier Code value.For Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2320 using CAS02 value 225. The Interest Paid Amount will also be sent in AMT02 of the Loop 2320 AMT*D Segment. The Interest Paid Date will be sent in the DTP*573 Segment of Loop 2330B.

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

## Professional Identifiers

The Plan is required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter.

## Supplementation of CMS-1500

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

## Category II CPT Codes

DHH 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;

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- Submitted charge ($0.00 shall be entered for PQRI codes);
- Rendering provider number (NPI).

The submitted charge field cannot be left blank. The amount of $0.00 shall be entered on the claim as the charge.

## BHT06

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

## Transaction Type

Appendix J of this Guide contains tables to provide guidance on the use of 837s.  This guidance is subject to change

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# Repairable Denial Edit Codes and Descriptions

## Introduction

DHH is in the process of modifying edits for dental encounter processing. A list of these edits will be incorporated into this Guide in a subsequent version.

## Encounter Correction Process

DHH's FI will send edit code reports to the Plan the day after they are produced by the MMIS adjudication cycle via the web. The Plan is required to submit corrections in accordance with an approved quality assurance plan.

## Resubmissions

The Plan 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 Plan may resubmit the encounter once it has been corrected.

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# Transaction Testing and EDI Certification

## Introduction

The intake of encounter data from the Plan is treated as HIPAA 5010 837 format compliant transactions by DHH and its FI. As such, the Plan 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 Health Plan is requested to send real transmission data. The FI does not define the number of encounters in the transmission; however, DHH will require a minimum set of encounters for each transaction type based on testing needs.

If a Plan rendering contracted provider has a valid NPI and taxonomy code, the Health Plan will submit those values in the 837. If the provider is an atypical provider, the Plan must follow 837 atypical provider guidelines and consult with the FI regarding the appropriate provider identifier.

Prior to testing, the Health Plan must supply DHH 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, DHH will provide the Plan with a list of provider types and specialties (see Appendix J). The Plan 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.lamedicaid.com/provweb1/billing_information/medicaid_billing_index.htm or
www.lmmis.com/provweb1/default.htm and choosing Electronic Claims Submission (EMC).
Below are the required steps of the testing process.

## Electronic Data Interchange (EDI)

Enrollment as an EDI submitter is achieved through the completion of the DHH/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 Health Plan, 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 Health Plan 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 Health Plan 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

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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. **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 Plan 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 Plan will submit to DHH 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 H.

## Timing

The Plan may initiate EDIFECS testing at any time. DHH'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

A flow chart depicting an incoming ANSI ASC X12N 837 transaction validation for syntax of the FI Electronic Data Interchange ( EDI) is located in Appendix N.

## Data Certification

The BBA requires that when State payments to the Plan are based on data that is submitted by the Plan, 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

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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 Plan, which are used to create payments and/or capitated rates, must be certified by a completed signed Data Certification form, which is required to be faxed concurrently with each encounter submission. The data must be certified by one of the following individuals:

1.  DBP's Chief Executive Officer (CEO); or
2.  DBPs Chief Financial Officer (CFO); or
3.  An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

Certification shall be submitted concurrently with the certified data. (**Appendix O**)

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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. DHH will require the Health Plan 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 v5010 999.

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## 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 full listing of encounter edits will be contained in **Appendix F** in a later version of this Guide. After processing, an 835 Remittance Advice is returned to the sender.[1]

## Error Correction Process

The Plan is required to correct and resubmit any transactions or encounters that are rejected in their entirety. For service line rejections, the Plan is required to correct and resubmit errors that are known to be "repairable". A list of repairable denials will be contained in  a later version of this Guide..

## Entire File

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

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[1] If requested by the Plan and prearranged with DHH

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## Claim/Encounter

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

## Service Line

The Plan 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 Health Plan is presented with an edit code report to assist them in identifying repairable errors. The Health Plan 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 Plan may present the outstanding issue(s) to DHH and/or its FI for clarification or resolution. DHH and/or its FI will review the issue(s) and triage the issue(s) to the appropriate entity for resolution, and respond to the Health Plan with their findings. If the outcome is not agreeable to the Plan, then the Plan may re-submit the outstanding issue(s) with supporting documentation to DHH for reconsideration. The outcome as determined by DHH will prevail.

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## Dispute Resolution

The Plan 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 Plan 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 Plan must notify DHH in writing within thirty (30) calendar days if it believes that the resolution of a rejected encounter rests on the FI rather than the Plan. The FI, on behalf of DHH, will respond in writing within thirty (30) days of receipt of such notification. DHH encourages the Plan 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 Plan may use the Edit Reports provided by the FI. The Plan shall highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

The FI will review the Plan's notification and may ask the Plan to research the issue and provide additional substantiating documentation, or the FI may disagree with the Plan claim of an FI error. If a rejected encounter being researched by the FI is later determined not to be caused by the FI, the Plan will be required to make corrections to the encounter, if appropriate, and resubmit during the next billing cycle.

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# Continuous Quality Improvement

## Introduction

In accordance with the Balanced Budget Act (BBA), DHH developed a quality strategy plan that serves as the guiding principles for the establishment of quality improvement efforts for the Plan. Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the Plan will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to develop plan-specific encounter quality improvement plans. Interim monitoring and follow-up on identified quality problem areas is an integral component of DHH's encounter process.

The encounter quality improvement plan is designed to provide DHH and the Plan with a comprehensive list of data quality issues present in the data for a given period at the time of the report. DHH will meet with the Plan every three (3) months, or as needed. The encounter quality improvement plans are sent by the Plan to DHH in advance of the meeting. The  Plan meeting attendees are to include claims and EDI experts, and clinical quality assurance staff.

At the site visit, the Plan is expected to have investigated the findings of encounter quality improvement plans and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, the PLAN must incorporate corrective action steps into a quality improvement report. If issues are not resolved in a timely manner, DHH may request a corrective action plan (CAP). The CAP shall include a listing of issues, responsible parties, and projected resolution dates.

## Minimum Standards

There are two components to encounter data quality assessment: Repairable Denials and Data Volume Assessment.

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## Repairable Denials

Repairable denials must be recorded on the encounter quality improvement plan with a corrective action plan for correcting and resubmitting encounters with line level denials or full encounter denials.

## Data Volume Assessment

Data Volume Assessment refers to the evaluation of whether key services meet expected rates of provision, as demonstrated in the data. This is important to decide whether Plans are submitting data and, ultimately, whether the actual level of services are adequate to meet contractual requirements, justify capitation rates, and provide appropriate access to care for the enrolled population. A core audit function includes determining whether DHH has all of the encounter data generated for a specific period.

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# Adjustment Process

## Introduction

In the case of adjustments, the Plan 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 with a line level denial, make the correction(s) to the encounter and resubmit using the instructions below.

## Line Adjustment Process

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

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

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## 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

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## Date of Death Recovery Process

Each quarter in a calendar year the Fiscal Intermediary will run a Date of Death Recovery Process. The basic concept of the process is to identify recipients who are retrospectively deceased including PMPM payments and generates voids to recover payments.

The process takes the Fiscal Intermediary 2 weeks – the first week to identify the recipients who are retrospectively enrolled, and the second week to process the voids. The Plan will receive Report CP-0-12D with impacted providers.

The report contains the following data elements:
☐ Recipient ID
☐ Name
☐ Claim ICN
☐ Procedure Code
☐ Dates of Service
☐ PMPM Payment

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 quarterly 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

Upon receiving the report and/or the 820 file, the Plan is to note that recipients are identified as retrospectively deceased and solicit the FI to send them disenrollment information, and then engage recoveries for claims they have paid.

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## Appendix A

## Definition of Terms

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

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| **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 file format. |
| **999 Functional Acknowledgment** | Transaction set-specific verification is accomplished using a 999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. |
| **Administrative Region** | Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values:<br>1=New Orleans<br>2=Baton Rouge<br>3=Houma/Thibodaux<br>4=Lafayette<br>5=Lake Charles<br>6=Alexandria<br>7=Shreveport<br>8=Monroe<br>9=Covington/Bogalusa |
| **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 do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc). |
| **CAS Segment** | Used to report claims or line level adjustments. |
| **Capitation Payment** | A payment, fixed in advance, the BHSF makes to the DBPM for each member covered under the Contract for the provision of core health benefits and services and assigned to the DBPM. This payment is |

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| | made regardless of whether the member receives core dental benefits and services during the period covered by the payment. |
| **Claim** | Means 1) a bill for services 2) a line item of service or 3) all services for one recipient within a bill. |
| **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 can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. |
| **CMS 1500** | A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-04. |
| **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. |
| **Co-payment** | Any cost sharing payment for which the Health Plan member is responsible, in accordance with 42 CFR 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members. |
| **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 |

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| | and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption. |
| **Covered Services** | Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan and waivers as outlined in the contract's service manual. |
| **Data Certification** | The Balanced Budget Act (BBA) requires that when State payments to a Health Plan are based on data that is submitted by the Health Plan, 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 Health Plan 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 (DHH)** | The Louisiana Department of Health and Hospitals, referred to as DHH. |
| **Dental Benefit Program Manager (DBPM)** | A risk-bearing, Prepaid Ambulatory Health Plan (PAHP) healthcare delivery system responsible for providing specified Medicaid dental Benefits and services included in the Louisiana Medicaid State Plan to eligible Louisiana Medicaid enrollees. |
| **Duplicate claim** | A claim that is either a total or a partial duplicate of services previously paid. |
| **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. |

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| **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 determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act. |
| **Encounter data** | Healthcare encounter data include: (i) All data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter; (ii) The identification of the member receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single encounter. |
| **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** | DHH'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. |

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| **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 healthcare practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other healthcare practitioner includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician. |
| **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. |

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| **ICD-9-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification)** | Codes currently used to identify diagnoses. The Health Plan shall move to ICD-10-CM as it becomes effective. |
| **Information Systems (IS)** | A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction. |
| **Interchange Envelope** | Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B. |
| **Internal Control Number (ICN)** | DHH'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 and Hospitals (DHH)** | 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 DHH, and accepts payment in full for providing benefits, the amounts paid |

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|  | 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 DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles. |
| **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. |
| **NEMT** | Non-Emergency Medical Transportation |
| **Non-Contracting Provider** | A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the Health Plan. |
| **Policies** | The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations. |
| **Prior Authorization** | The process of determining medical necessity for specific services before they are rendered. |
| **Protected Health Information (PHI)** | Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)  45 CFR Part 160 and 164. |
| **Provider** | Either (1) for the FFS program, any individual |

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| | or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Health Plan, any individual or entity that is engaged in the delivery of healthcare 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 the Health Plan 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 Assessment and Performance Improvement Program (QAPI Program)** | Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities. |
| **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 DHH's assessment of the Health Plan's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of Health Plan standards; and review of systems. The review may be done as a desk review, on-site review, or |

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| | combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the Health Plan's ability and readiness to render services. |
| **Reject** | Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported. |
| **Remittance Advice** | An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the Health Plan, 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. |
| **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 Area** | The entire State of Louisiana is the service area. |
| **Service Line** | A single claim line as opposed to the entire claim or the claim header. |
| **Span of Control** | Information systems and telecommunications capabilities that the Health Plan itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the Health Plan. |
| **ST Transaction Set Header** | Indicates the start of a transaction set and to |

|  | assign a control number. |
| --- | --- |
| **Start-Up Date** | The date Health Plan providers begin providing medical care to their Medicaid members. Also referred to as operations start date and "go-live date." |
| **Stratification** | The process of partitioning data into distinct or non-overlapping groups. |
| **Syntactical Error** | Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported. |
| **System Function Response Time** | Based on the specific sub function being performed: <br><br> • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. <br> • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. <br> • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. <br> • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the Health Plan from the provider and/or switch vendor until the Health Plan hands-off a response to the provider and/or switch vendor. |

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| **System Unavailability** | Measured within the Health Plan's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key. |
| **TA1** | The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 999. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B. |
| **Taxonomy codes** | These are national specialty codes used by providers to indicate their specialty at the claim level. |
| **Trading Partners** | Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions. |
| **Validation** | The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis. |

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## Appendix B

Frequently Asked Questions (FAQs)

**What is HIPAA and how does it pertain to the Health Plan?**

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

**What is Molina and what is their role with the Health Plan?**

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

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

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services. The transactions the Health Plan will use will depend upon the type of service being reported. Further instructions can be found in Section 2 of this Guide.

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

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

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

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

**Will DHH provide us with a paper or electronic remittance advice?**

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

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

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

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

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

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

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

Yes, that is correct. Effective with claims and encounter submissions after May 23, 2008, all providers are required to have an NPI and taxonomy. DHH will also require that a 9-digit zip code be placed on the encounter.

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

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

**What is a Trading Partner ID?**

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

**Why must the Health Plan submit encounter data?**

The reasons why the Health Plan is required to submit encounter data are as follows:

1. Encounter Data: Section 17.5.4 of the HEALTH PLAN RFP details the requirements for encounter submission.

2. Rate Setting: The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the Contract.

3. Utilization Review and Clinical Quality Improvement:  DHH's Health Plan Program is partially funded by CMS. Encounter data is analyzed and used by CMS and DHH to evaluate program effectiveness and monitor quality of care, utilization levels and patterns, access to care, and to evaluate Health Plan performance. The utilization data from encounter data provides DHH with performance data and indicators. DHH will use this information to evaluate the performance of the Health Plan and to audit the validity and accuracy of the reported measures.

## Appendix C

# Dental Benefits Plan System Companion Guide

## 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, DHH requires the Plan to adhere to HIPAA standards governing Medical data code sets. Specifically, the Plan 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  Plan 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.

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

A.  International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9- CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:
- Diseases;
- Injuries;
- Impairments;
- Other health problems and their manifestations; and
- Causes of injury, disease, impairment, or other health problems

B.  ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:
- Prevention;
- Diagnosis;
- Treatment; and
- Management

   DHH is presently engaged with its FI to remediate the Medicaid systems to use the ICD-10-CM and ICD-10-PCS codes sets to comply with DHHS/CMS guidelines for implementation on 10/1/2014.

C.  National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:
- Drugs; and
- Biologics.

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

E.  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 Health Plan 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, DHH requires that the Health Plan 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.

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

- Medical supplies,
- Orthotic and prosthetic devices,
- Durable medical equipment. and
- Other services, as applicable, outlined in the Health Plan contract.

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## Appendix D

## System Generated Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH and the Plan 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.

The following reports are generated by the MMIS system and have been selected specifically to provide the Health Plan 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 Plan 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.

The list of electronic files or reports as indicated in the RFP, are to be submitted by the Plan and/or DHH. The format and/or layout requirements for each file or report are located in either this Guide, the Quality Companion Guide, or at a developmental stage.  As the list may not be all inclusive, it is the Plans responsibility to ensure that all required files or reports, as stated in the RFP, are submitted to DHH in a timely manner.

# Dental Benefits Plan System Companion Guide

## Prior Authorization File (FI to DBP)

This file is a one-time file that contains a 2-year history of prior authorization and Pre-Admission Certification (Pre-cert) authorization transactions performed by the Louisiana Medicaid MMIS.

| Column(s) | Item | Notes | Length | Format |
|---|---|---|---|---|
| 1-7 | Provider ID | LA-MMIS assigned ID number | 7 | Numeric, non-check-digit. |
| 8 | Delimiter | | 1 | Uses the ^ character value |
| 9-15 | Provider Check-Digit ID | LA-MMIS assigned ID number, check-digit | 7 | Numeric |
| 16 | Delimiter | | 1 | Uses the ^ character value |
| 17-29 | Recipient ID (Original) | | 13 | Numeric |
| 30 | Delimiter | | 1 | Uses the ^ character value |
| 31-43 | Recipient ID (Current) | | 13 | Numeric |
| 44 | Delimiter | | 1 | Uses the ^ character value |
| 45-54 | NPI | | 10 | Character |
| 55 | Delimiter | | 1 | Uses the ^ character value |
| 56 | Taxonomy | | 10 | Character |
| 66 | Delimiter | | 1 | Uses the ^ character value |
| 67-71 | Procedure Code | | 5 | Character, CPT or HCPCS value |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format |
|---|---|---|---|---|
| 72 | Delimiter | | 1 | Uses the ^ character value |
| 73 | Authorized Units/Amount | | 10 | Numeric, with decimal and left-zero fill |
| 83 | Delimiter | | 1 | Uses the ^ character value |
| 84-91 | Effective Begin Date | | 8 | Numeric, date value in the format YYYYMMDD |
| 92 | Delimiter | | 1 | Uses the ^ character value |
| 93-100 | Effective End Date | | 8 | Numeric, date value in the format YYYYMMDD |
| 101 | Delimiter | | 1 | Uses the ^ character value |
| 102-106 | Admitting Diagnosis Code (for Inpatient Pre-Admission Certification) or Diagnosis code if required on the PA | | 5 | ICD-9-CM |
| 107 | Delimiter | | 1 | Uses the ^ character value |
| 108-111 | Length of Stay in Days (for Inpatient Pre-Admission Certification) | | 4 | Numeric, left zero-fill |
| 112 | Delimiter | | 1 | Uses the ^ character value |
| 113 | PA or Precert Type | 1=PA 2=Precert | 1 | Character |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format |
|---|---|---|---|---|
| 114 | Delimiter | | 1 | Uses the ^ character value |
| 115-116 | PA Type<br><br>Or<br><br>Precert Type | **Precert**:<br><br>03=Inpatient Acute<br><br>**PA**:<br><br>04=Waiver<br><br>05=Rehab<br><br>06=HH<br><br>07=Air EMT<br><br>09=DME<br><br>10=Dental<br><br>11=Dental<br><br>14=EPSDT-PCS<br><br>16=PDHC<br><br>35=ROW<br><br>40=RUM<br><br>50=LT-PCS<br><br>60=Early Steps CM<br><br>88=Hospice<br><br>99=Misc. | 2 | |
| 117 | Delimiter | | 1 | Uses the ^ character value |
| 118-119 | PA or Precert Status | 02=Approved<br><br>03=Denied | 2 | Character |
| 120 | Delimiter | | 1 | Uses the ^ character value |
| 121-125 | Precert Level of | GEN | 5 | Character |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format |
|---|---|---|---|---|
| | Care<br><br>(this field should be blank for PA transactions) | ICU<br><br>NICU<br><br>REHAB<br><br>PICU<br><br>CCU<br><br>TU=Telemetry<br><br>LT=LTAC | | |
| 126 | Delimiter | | 1 | Uses the ^ character value |
| 127-136 | PA Line Amount Used | For an approved PA or Precert line item, this field contains any amount used as a result of claims processing | 10 | Numeric, with decimal and left-zero fill. |
| 137 | Delimiter | | 1 | Uses the ^ character value |
| 138-147 | PA or Precert Number assigned by Molina | | 10 | 9- or 10-digit number |
| 148 | Delimiter | | 1 | Uses the ^ character value |
| 149 | End of Record | | 1 | Value is spaces. |

# Dental Benefits Plan System Companion Guide

## Diagnosis File for Pre-Admission Certification (FI to DBP)

This file shows all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Pre-cert) operation with Louisiana Medicaid MMIS.

| Column(s) | Item | Notes | Length | Format |
|-----------|------|-------|--------|--------|
| 1-5 | Diagnosis Code | | 5 | Character, does not include the period |
| 6 | Delimiter | | 1 | Uses the ^ character value |
| 7 | Pre-Cert Status | 1=Applicable<br><br>2=Not applicable | 1 | Numeric |
| 8 | Delimiter | | 1 | Uses the ^ character value |
| 9-16 | Effective Begin Date | | 8 | Numeric in date format YYYYMMDD |
| 17 | Delimiter | | 1 | Uses the ^ character value |
| 18-25 | Effective End Date | | 8 | Numeric in date format YYYYMMDD |
| 26 | Delimiter | | 1 | Uses the ^ character value |
| 27 | End of Record | | 1 | Value is spaces. |

# Dental Benefits Plan System Companion Guide

820 File (FI to DBP)

| 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 SG08 at this level will ensure that the appropriate application mapping is utilized at transaction time. | | |

# Dental Benefits Plan System Companion Guide

| BPR=Financial Information | | | | | |
|---|---|---|---|---|---|
| Sample: BPR*I*1234567.89*C*ACH*CCP*01*123456789*DA*123456*1123456789**01*987654321*DA*654321*20120103~ | | | | | |
| | 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 | ACH=Automated Clearinghouse | S |
| | | BPR05 | Payment Format Code | CCP=CCD+ Format | S |
| | | BPR06 | (DFI) ID Number Qualifier | Depository Financial Institution (DFI) Identification Number Qualifier 01 – ABA Transit Routing Number Including Check Digits (9 digits) | S |
| Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.<br><br>SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction.<br><br>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 | ID number of originating Depository (DHH) | S |
| | | BPR08 | Account Number Qualifier | Code indicating type of account          "DA" | S |

| | | | | - Demand Deposit | |
|---|---|---|---|---|---|
| | | BPR09 | Account Number | Premium payer's bank account | 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 | Depository Financial Institution (DFI) Identification Number Qualifier "01" – ABA Transit Routing Number Including Check Digits | S |
| | | BPR13 | (DFI) Identification Number | This is the identifying number of the Receiving Depository Financial Institution receiving the transaction into the ACH network.  (CCN) | S |
| | | BRP14 | Account Number Qualifier | Code indicating type of account              "DA" - Demand Deposit "SG" - Savings | S |
| | | BPR15 | Account Number | CCN bank account number | |
| | | BPR16 | EFT Effective Date | Expressed CCYYMMDD | |
| | | | | | |

# Dental Benefits Plan System Companion Guide

| | | | | | | |
|---|---|---|---|---|---|---|
| TRN=Re-association 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 |
| | | TRN02 | Reference Identification | | EFT Trace Number Used to reassociate payment with remittance information. | S |
| | | TRN03 | Originating Company Identifier | | Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10 | S |
| REF=Premium Receiver's Identification Key | | | | | | |
| Sample: REF*18*123456789*CCN Fee Payment~ | | | | | | |
| | | REF01 | Reference Identification Qualifier | | '18'=Plan Number | S |
| | | REF02 | Reference Identification | | Premium Receiver Reference Identifier | |
| | | REF03 | Description | | 'CCN Fee Payment' | S |

# Dental Benefits Plan System Companion Guide

| 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 |
| | | DTM06 | Date Time Period | Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD | D |

# Dental Benefits Plan System Companion Guide

<table>
<tr><td colspan="6">1000A PREMIUM RECEIVER'S NAME</td></tr>
<tr><td colspan="6">N1=Premium Receiver's Name</td></tr>
<tr><td colspan="6">Sample: N1*PE*CCN-S of Louisiana*FI*1123456789~</td></tr>
<tr><td></td><td>1000A</td><td>N101</td><td>Entity ID Code</td><td>"PE" – Payee</td><td></td></tr>
<tr><td></td><td>1000A</td><td>N102</td><td>Name</td><td>Information Receiver Last or Organization Name</td><td></td></tr>
<tr><td></td><td>1000A</td><td>N103</td><td>Identification Code Qualifier</td><td>"FI" – Federal</td><td></td></tr>
<tr><td></td><td>1000A</td><td>N104</td><td>Identification Code</td><td>Receiver Identifier</td><td></td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">1000B PREMIUM PAYER'S NAME</td></tr>
<tr><td colspan="6">N1=Premium Payer's Name</td></tr>
<tr><td colspan="6">Sample: N1*PR*Louisiana Department of Health and Hospitals*FI*1123456789~</td></tr>
<tr><td></td><td>1000B</td><td>N101</td><td>Entity ID Code</td><td>"PR" – Payer</td><td></td></tr>
<tr><td></td><td>1000B</td><td>N102</td><td>Name</td><td>Premium Payer Name</td><td></td></tr>
<tr><td></td><td>1000B</td><td>N103</td><td>ID Code Qualifier</td><td>"FI" - Federal Taxpayer ID number</td><td></td></tr>
<tr><td></td><td>1000B</td><td>N104</td><td>Identification Code</td><td>Premium Payer ID</td><td></td></tr>
</table>

# Dental Benefits Plan System Companion Guide

| | | | | | |
|---|---|---|---|---|---|
| 2000B INDIVIDUAL REMITTANCE | | | | | |
| ENT=Individual Remittance | | | | | |
| Sample: ENT*1*2J*34*123456789~ | | | | | |
| | 2000B | ENT01 | Assigned Number | Sequential Number assigned for differentiation within a transaction set | |
| | 2000B | ENT02 | Entity Identifier Code | "2J" - Individual | |
| | 2000B | ENT03 | Identification Code Qualifier | "34" - Social Security Number | |
| | 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 | |

# Dental Benefits Plan System Companion Guide

| | 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" – Individual Identifier | |
| | 2100B | NM109 | Identification Code | Individual Identifier – Recipient ID number | |
| | | | | | |

| 2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL | | | | | |
|---|---|---|---|---|---|
| RMR=Organization Summary Remittance Detail | | | | | |
| Sample: RMR*11*1234567890123**400.00~ | | | | | |
| | 2300B | RMR01 | Reference Identification Qualifier | "11" - Account Number | |
| | 2300B | RMR02 | Reference Identification | Claim ICN (Molina internal claims number). | |
| | 2300B | RMR04 | Monetary Amount | Detail Premium Payment Amount | |
| | | | | | |
| | | | | | |
| REF=Reference Information (1st occurrence) | | | | | |
| Sample: REF*ZZ*0101C~ | | | | | |
| | 2300B | REF01 | Reference Identification Qualifier | "ZZ" - Mutually Identified | |

# Dental Benefits Plan System Companion Guide

| | 2300B | REF02 | Reference Identification | Capitation Code | |
|---|---|---|---|---|---|
| | 2300B | REF03 | Not Used | | |
| | 2300B | REF04 | Not Used | | |
| DTM=Individual Coverage Period | | | | | |
| Sample: DTM*582****RD8*20120101-20120131~ | | | | | |
| | 2300B | DTM01 | Date/Time Qualifier | "582" - Report Period | |
| | 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~ | | | | | |
| | SE | SE01 | Transaction Segment Count | | |
| | | SE02 | Transaction Set Control Number | | |
| 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. | | | | | |

# Dental Benefits Plan System Companion Guide

An adjustment of a previous original administrative fee payment will be shown as two 2300B sets: a void of the previous payment and a record showing the new adjusted amount. The void record will have RMR and ADX segments, where the RMR will have the original claim ICN in RMR02 and the original payment amount in RMR05. The ADX will have a negative amount (equal to the original payment) in ADX01 and the value '52' in ADX02. The record showing the new adjusted amount will behave in the same manner as an original payment (RMR). Here is an example of an adjustment set:

***Void sequence (reversal of prior payment):***

ENT*107*2J*ZZ*7787998022222~

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

RMR*AZ*1059610021800***500~

ADX*-500*52~

***Adjusted Amount sequence:***

ENT*107*2J*ZZ*7787998022222~

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

RMR*AZ*1067610041100**600~

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

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

# Dental Benefits Plan System Companion Guide

## Appendix E

## Plan 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, DHH may use encounters as the basis for these reports.

(DHH required version of the Plan generated reports are currently in the developmental stage and will be included in this Guide upon completion)

# Dental Benefits Plan System Companion Guide

## Appendix F

Encounter Edit Codes

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the 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 DHH guidelines (Pay),

- Encounter contains a fatal error that results in its rejection (Denial).

Tables for encounter sets to information only (pay) and non-repairable denials, will be included in a later version of this Guide.

# Dental Benefits Plan System Companion Guide

## Appendix G

### Provider Directory/Network Provider and Subcontractor Registry

The Plan is required to provide an adequate network of providers in sufficient numbers and locations to provide required access to covered services. The plan must provider network must ensure member access to covered services that meets standards of distance, timeliness, amount, duration and scope as defined in the contract with DHH. Plans are required to provide DHH with a listing of all contracted providers. Providers in the Plans' network are not required to be enrolled in Louisiana Medicaid, but all are required to be included in the listing submitted to DHH.

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

The Plan listing of contracted providers is to be submitted electronically through the state's Fiscal Intermediary (FI). Only one unique record per combined NPI and Taxonomy should be submitted in the master Provider Registry. If a provider practices at multiple sites you should submit only the primary site in the Provider Registry. Secondary sites for PCPs and specialist can be submitted through the "Provider Registry Site" file, also described in this Appendix.

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

It is the Plan's responsibility to ensure the completeness and accuracy of the data submitted. Any providers no longer taking patients must be clearly identified. Updates to the registry, must be submitted by the Plans at least monthly, but can be updated weekly. The FI will process all updates submitted by 5:00 p.m. (CDT) each Friday.

# Dental Benefits Plan System Companion Guide

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

### Provider Type

| | Description |
| --- | --- |
| 07 | Case Mgmt - Infants & Toddlers |
| 08 | Case Mgmt - Elderly |
| 09 | Hospice Services |
| 12 | Multi-Systemic Therapy |
| 13 | Pre-Vocational Habilitation |
| 19 | Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group |
| 20 | Physician (MD) and Physician (MD) Group |
| 23 | Independent Lab |
| 24 | Personal Care Services (LTC/PCS/PAS) |
| 25 | Mobile X-Ray/Radiation Therapy Center |
| 26 | Pharmacy |
| 27 | Dentist or Dental Group |
| 28 | Optometrist and Optometrist Group |
| 29 | Title V Part C Agency Services(EarlySteps) |
| 30 | Chiropractor and Chiropractor Group |
| 31 | Psychologist |
| 32 | Podiatrist and Podiatrist Group |
| 34 | Audiologist |
| 35 | Physical Therapist |
| 37 | Occupational Therapist |
| 39 | Speech Therapist |
| 40 | DME Provider |
| 41 | Registered Dietician |
| 42 | Non-Emergency Medical |

# Dental Benefits Plan System Companion Guide

*Provider Type*

| | Description |
|---|---|
| | Transportation |
| *43* | Case Mgmt - Nurse Home Visit - 1st Time Mother |
| *44* | Home Health Agency |
| *46* | Case Mgmt - HIV |
| *51* | Ambulance Transportation |
| *54* | Ambulatory Surgery Center |
| *55* | Emergency Access Hospital |
| *57* | OPH Public Health Registered Nurse |
| *59* | Neurological Rehabilitation Unit (Hospital) |
| *60* | Hospital |
| *61* | Venereal Disease Clinic |
| *62* | Tuberculosis Clinic |
| *64* | Mental Health Hospital Freestanding |
| *65* | Rehabilitation Center |
| *66* | KIDMED Screening Clinic |
| *67* | Prenatal Health Care Clinic |
| *68* | Substance Abuse and Alcohol Abuse Center |
| *69* | Hospital – Distinct Part Psychiatric |
| *69* | Hospital - Distinct Part Psychiatric Unit |
| *70* | EPSDT Health Services |
| *71* | Family Planning Clinic |
| *72* | Federally Qualified Health Center |
| *73* | Social Worker |
| *74* | Mental Health Clinic |
| *75* | Optical Supplier |
| *76* | Hemodialysis Center |
| *77* | Mental Health Rehabilitation |
| *78* | Nurse Practitioner |
| *79* | Rural Health Clinic (Provider Based) |

# Dental Benefits Plan System Companion Guide

*Provider Type*

| | Description |
|---|---|
| *80* | Nursing Facility |
| *81* | Case Mgmt - Ventilator Assisted Care Program |
| *87* | Rural Health Clinic (Independent) |
| *88* | ICF/DD - Group Home |
| *90* | Nurse-Midwife |
| *91* | CRNA or CRNA Group |
| *93* | Clinical Nurse Specialist |
| *94* | Physician Assistant |
| *95* | American Indian / Native Alaskan "638" Facilities |
| *96* | Psychiatric Residential Treatment Facility |
| *97* | Residential Care |
| *AS* | OPH Public Health Clinic |
| *AU* | Public Health Registered Dietitian |

# Dental Benefits Plan System Companion Guide

For providers registered as individual practitioners, DHH will also require the HEALTH PLAN to assign a DHH provider specialty code from the DHH valid list of specialties found below:

| Provider Specialty | Description | Associated Provider Types |
|---|---|---|
| 01 | General Practice | 19,20 |
| 02 | General Surgery | 19,20,93 |
| 03 | Allergy | 19,20 |
| 04 | Otology, Laryngology, Rhinology | 19,20 |
| 05 | Anesthesiology | 19,20,91 |
| 06 | Cardiovascular Disease | 19,20 |
| 07 | Dermatology | 19,20 |
| 08 | Family Practice | 19,20,78 |
| 09 | Gynecology (DO only) | 19 |
| 10 | Gastroenterology | 19,20 |
| 12 | Manipulative Therapy (DO only) | 19 |
| 13 | Neurology | 19,20 |
| 14 | Neurological Surgery | 19,20 |
| 15 | Obstetrics (DO only) | 19 |
| 16 | OB/GYN | 19,20,78,90 |
| 17 | Ophthalmology, Otology, Laryngology, Rhinology (DO only) | 19 |
| 18 | Ophthalmology | 20 |
| 19 | Orthodontist | 19,20 |
| 20 | Orthopedic Surgery | 19,20 |
| 21 | Pathologic Anatomy; Clinical Pathology (DO only) | 19 |
| 22 | Pathology | 20 |
| 23 | Peripheral Vascular Disease or Surgery | 19 |

# Dental Benefits Plan System Companion Guide

| Provider Specialty | Description | Associated Provider Types |
|---|---|---|
| | (DO only) | |
| 24 | Plastic Surgery | 19,20 |
| 25 | Physical Medicine Rehabilitation | 19,20 |
| 26 | Psychiatry | 19,20,93 |
| 27 | Psychiatry; Neurology (DO only) | 19 |
| 28 | Proctology | 19,20 |
| 29 | Pulmonary Diseases | 19,20 |
| 30 | Radiology | 19,20 |
| 31 | Roentgenology, Radiology (DO only) | 19 |
| 32 | Radiation Therapy (DO only) | 19 |
| 33 | Thoracic Surgery | 19,20 |
| 34 | Urology | 19,20 |
| 35 | Chiropractor | 30,35 |
| 36 | Pre-Vocational Habilitation | 13 |
| 37 | Pediatrics | 19,20,93 |
| 38 | Geriatrics | 19,20 |
| 39 | Nephrology | 19,20 |
| 40 | Hand Surgery | 19,20 |
| 41 | Internal Medicine | 19,20 |
| 42 | Federally Qualified Health Centers | 72 |
| 44 | Public Health | 66,70 |
| 45 | NEMT - Non-profit | 42 |
| 46 | NEMT - Profit | 42 |
| 47 | NEMT - F+F | 42 |
| 48 | Podiatry - Surgical Chiropody | 20,32 |
| 49 | Miscellaneous (Admin. | 20 |

# Dental Benefits Plan System Companion Guide

| Provider Specialty | Description | Associated Provider Types |
|---|---|---|
| | Medicine) | |
| 51 | Med Supply / Certified Orthotist | 40 |
| 52 | Med Supply / Certified Prosthetist | 40 |
| 53 | Med Supply / Certified Prosthetist Orthotist | 40 |
| 54 | Med Supply / Not Included in 51, 52, 53 | 40 |
| 55 | Indiv Certified Orthotist | 40 |
| 56 | Indiv Certified Protherist | 40 |
| 57 | Indiv Certified Protherist - Orthotist | 40 |
| 58 | Indiv Not Included in 55, 56, 57 | 40 |
| 59 | Ambulance Service Supplier, Private | 51 |
| 60 | Public Health or Welfare Agencies & Clinics | 57,61,62,66, 67,AU |
| 62 | Psychologist Crossovers only | 29,31 |
| 63 | Portable X-Ray Supplier (Billing Independently) | 25 |
| 64 | Audiologist (Billing Independently) | 29,34 |
| 65 | Indiv Physical Therapist | 29,35 |
| 66 | Dentist, DDS, DMS | 27 |
| 67 | Oral Surgeon - Dental | 27 |
| 68 | Pedodontist | 27 |
| 69 | Independent Laboratory (Billing Independently) | 23 |

# Dental Benefits Plan System Companion Guide

| Provider Specialty | Description | Associated Provider Types |
|---|---|---|
| 70 | Clinic or Other Group Practice | 19,20,68,74,76, AS |
| 71 | Speech Therapy | 29 |
| 72 | Diagnostic Laboratory | 23 |
| 73 | Social Worker Enrollment | 73 |
| 74 | Occupational Therapy | 29,37 |
| 75 | Other Medical Care | 65 |
| 76 | Adult Day Care | 85 |
| 77 | Habilitation | 85 |
| 78 | Mental Health Rehab | 77 |
| 79 | Nurse Practitioner | 78 |
| 81 | Case Management | 07,08,43,46,81 |
| 83 | Respite Care | 83 |
| 85 | Extended Care Hospital | 60 |
| 86 | Hospitals and Nursing Homes | 55,59,60,64,69, 80,88 |
| 87 | All Other | 26,40,44 |
| 88 | Optician / Optometrist | 28,75 |
| 93 | Hospice Service for Dual Elig. | 09 |
| 94 | Rural Health Clinic | 79,87 |
| 95 | Psychologist (PBS Program Only) | 31 |
| 96 | Psychologist (PBS Program and X-Overs) | 31 |
| 97 | Family Planning Clinic | 71 |
| 1T | Emergency Medicine | 19,20 |
| 2R | Physician Assistant | 94 |
| 2T | American Indian/Native Alaskan | 95 |
| 4R | Registered Dietician | 41 |
| 5B | PCS-EPSDT | 24 |
| 5C | PAS | 24 |
| 5F | PCS-EPSDT, PAS | 24 |
| 5H | Community Mental Health Center | 18 |
| 5M | Multi-Systemic Therapy | 12 |
| 6A | Psychologist -Clinical | 31 |

# Dental Benefits Plan System Companion Guide

| Provider Specialty | Description | Associated Provider Types |
|---|---|---|
| 6B | Psychologist-Counseling | 31 |
| 6C | Psychologist - School | 31 |
| 6D | Psychologist - Developmental | 31 |
| 6E | Psychologist - Non-Declared | 31 |
| 6F | Psychologist - All Other | 31 |
| 6N | Endodontist | 27 |
| 6P | Periodontist | 27 |
| 7A | SBHC - NP - Part Time - less than 20 hrs week | 38 |
| 7B | SBHC - NP - Full Time - 20 or more hrs week | 38 |
| 7C | SBHC - MD - Part Time - less than 20 hrs week | 38 |
| 7D | SBHC - MD - Full Time - 20 or more hrs week | 38 |
| 7E | SBHC - NP + MD - Part Time - combined less than 20 hrs week | 38 |
| 7F | SBHC - NP + MD - Full Time - combined less than 20 hrs week | 38 |
| 9B | Psychiatric Residential Treatment Facility | 96 |
| 9D | Residential Care | 97 |

# Dental Benefits Plan System Companion Guide

PLAN must submit this information in the file layout shown below.

| 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 Plan 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 |
| 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 | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| | | | | value | |
| 45-74 | Provider Name OR the Legal Business Name for Organizations. | | 30 | Character 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), 15-30th characters=last name, If names do not fit in these positions, please truncate the end of the item so that it fits in the positions. **DO NOT include suffixes or titles in the last name see columns 761-765 Provider Suffix and 767-776 Provider Title** | R |
| 75 | Delimiter | | 1 | Character, use the ^ character value | |
| 76-105 | Provider | | 30 | Character | R |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| | Business Mailing Address (First line address) | | | | |
| 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 | |

# Dental Benefits Plan System Companion Guide

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

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| 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 | |
| 334-343 | Provider Business Location Address | Do not enter dashes or parentheses. | 10 | Numeric | R |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|-----------|------|-------|--------|--------|------------------------|
| | (Telephone Number) | | | | |
| 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 | Use if necessary; otherwise leave blank. | 10 | Character | O |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| | 2 | | | | |
| 377 | Delimiter | | 1 | Character, use the ^ character value | |
| 378-387 | Healthcare Provider Taxonomy Code 3 | Use if necessary; otherwise leave blank. | 10 | Character | O |
| 388 | Delimiter | | 1 | Character, use the ^ character value | |
| 389-395 | Other Provider Identifier | If available, enter 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 | $1^{st}$ 2 characters are provider type; last 2 characters (3-4) are provider specialty. See 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 | O |
| 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 |
| 440 | Delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| 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 | |
| 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 | Do not enter dashes or parentheses. | 10 | Numeric | R |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|-----------|------|-------|--------|--------|------------------------|
| | Number) | | | | |
| 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 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients | 1 | Character | O |
| 583 | Delimiter | | 1 | Character, use the ^ character value | |
| 584 | Language | 0=no other language | 1 | Character | O |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| | Indicator 3 (this is a secondary language indicator) | 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 | | | |
| 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 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients | 1 | Character | O |
| 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- | 1 | Character | O |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| | | speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients | | | |
| 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 number** of patients that can be linked to the PCP within **this plan.** It should be left all zeroes if the provider is not a PCP/specialist. | R for PCPs; otherwise optional. |
| 597 | Delimiter | | 1 | Character, use the ^ character value | |
| 598-602 | PCP Actual Linkages with Plan | Numeric | 5 | Numeric, left fill with zeroes. This number represents the actual number of plan enrollees that are currently linked to the PCP. It should be left all zeroes if the provider is not a PCP | R for PCPs; otherwise optional. |
| 603 | Delimiter | | 1 | Character, use the ^ character value | |
| 604-608 | PCP Linkages with HEALTH Plan | Numeric | 5 | Numeric, left fill with zeroes. **Leave this field** | R |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|-----------|------|-------|--------|--------|-----------------------|
| | | | | **all zeroes.** | |
| 609 | Delimiter | | 1 | Character, use the ^ character value | |
| 610 | CCN Enrollment Indicator | **N**=New enrollment **C**=Change to existing enrollment **D**=Disenrollment **X**=Remove | 1 | Use this field to identify new providers, changes to existing providers, disenrolled providers and remove records from the registry | R |
| 611 | Delimiter | | 1 | Character, use the ^ character value | |
| 612-619 | CCN 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 DHH and is available in 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 DHH and is available in the 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 DHH and is available in the Companion Guide | 2 | | O |
| 631 | Delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| 632-661 | Contract Name or Number | This should represent the contract name/number that is established between the CCN and the Provider | 30 | Character | R, but you may enter 0s or spaces to indicator a non-contracted network provider. |
| 662 | Delimiter | | 1 | Character, use the ^ character value | |
| 663-670 | Plan Contract Begin Date | Date that the contract between the CCN and the provider started | 8 | Numeric date value in the form YYYYMMDD | R, but you may enter 0s. |
| 671 | Delimiter | | 1 | Character, use the ^ character value | |
| 672-679 | Plan Contract Term Date | Date that the contract between the Plan and the provider was terminated. | 8 | Numeric date value in the form YYYYMMDD | O, you may enter 0s.  If Contract Begin Date is not 0, then Contract End date must be greater than or equal to Contract Begin Date.  Open End Date=20991231 |
| 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 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 Companion Guide. | O |
| 686 | Delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| 687-688 | Provider Parish served – 3rd | 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 Companion Guide. | O |
| 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 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 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 Companion Guide. | O |
| 698 | Delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|-----------|------|-------|--------|--------|----------------------|
| 699-700 | Provider Parish served – 7$^{th}$ | 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 Companion Guide. | O |
| 701 | Delimiter | | 1 | Character, use the ^ character value | |
| 702-703 | Provider Parish served – 8$^{th}$ | 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 Companion Guide. | O |
| 704 | Delimiter | | 1 | Character, use the ^ character value | |
| 705-706 | Provider Parish served – 9$^{th}$ | 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 Companion Guide. | O |
| 707 | Delimiter | | 1 | Character, use the ^ character value | |
| 708-709 | Provider Parish served – 10$^{th}$ | 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 Companion Guide. | O |
| 710 | Delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|-----------|------|-------|--------|--------|-----------------------|
| 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 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 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 Companion Guide. | O |
| 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 Companion Guide. | O |
| 722 | Delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| 723-724 | Provider Parish served – 15<sup>th</sup> | Parish code value that represents a secondary or other parish that the provider serves.<br><br>Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value.  See the Companion Guide. | O |
| 725 | Delimiter | | 1 | Character, use the ^ character value | |
| 726 | PCP Indicator | 0=Not a PCP.<br><br>1=Regularly serves as a PCP for a general population group (i.e. can have age or gender limits, but not other specialized limitations on populations served)  This would include appropriate provider types and have agreed to fulfill PCP responsibilities for general populations.<br><br>2=PCP Extenders – must be linked to a supervising PCP<br><br>3=PCP Specialized – for designated individuals only (would not show up as a PCP in any registry or directory. | 1 | Numeric, value 0,1,2 or 3. | R |
| 727 | Delimiter | | 1 | Character, use the ^ character | |
| 728 | Display Online indicator | 0=don't display on EB website | | Numeric, value 0 or 1 | R |

# Dental Benefits Plan System Companion Guide

| Column(s) | Item | Notes | Length | Format | R=Required O=Optional |
|---|---|---|---|---|---|
| | | 1=display on EB website. | | | |
| 729 | Delimiter | | 1 | Character, use the ^ character | |
| 730-759 | Expanded Age Restriction | To allow free-form entry for provider to expand for their practice | 30 | Character | O |
| 760 | Delimiter | | 1 | Character, use the ^ character | |
| 761-765 | Provider Suffix | Example: JR, SR, etc. | 5 | Character | O |
| 766 | Delimiter | | 1 | Character, use the ^ character | |
| 767-776 | Provider Title | Example: MD, RN, etc. | 10 | Character | O |
| 777 | Delimiter | | 1 | Character, use the ^ character | |
| 778-779 | Spaces | End of record filler | 2 | Enter all spaces | |
| 780 | End of record delimiter | | 1 | Character, use the ^ character value | |

# Dental Benefits Plan System Companion Guide

Provider Registry Edit Report (sample)

```
                              LMMIS                       REPORT NO. MW-W-06
             DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF)    Page No.     1
                 WEEKLY CCN PROVIDER REGISTRY EDTI/UPDATE REPORT     MM/DD/YYYY HH:MM
                         REPORTING PERIOD: Week ending MM/DD/YY


     CCN ID: NNNNNNN - PROVIDER NAME FROM LMMIS PROVIDER FILE


     SUBMISSION SUMMARY:
     Total records submitted:  NNN,NNN
     Total records in error:   NNN,NNN
     Total records accepted:   NNN,NNN


     ERROR RECORDS DETAIL:
     Prov ID   Provider NPI          Taxonomy 1  Edit Codes
     -------   --------------------  ----------  ------------------------------------------------
     XXXXXXX   XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
     XXXXXXX   XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
     XXXXXXX   XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
     XXXXXXX   XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX
     XXXXXXX   XXXXXXXXXXXXXXXXXXXX  XXXXXXXXXX   XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX


     Error Codes (A=Accepted, R=Rejected):

     000=(A) No errors found

     001=(R) Missing/Invalid NPI (not 10 digits)

     002=(R) Missing/Invalid Entity Type (must be 1 or 2)

     003=(R) Provider record must include taxonomy

     004=(R) Missing required information (name, address, contact name, etc.)

     005=(R) Missing/Invalid provider type or specialty
```

# Dental Benefits Plan System Companion Guide

006=(R) Invalid provider sub-specialty (if one is submitted and it is not a valid value)

007=(R) Missing/Invalid enrollment indicator (must be N, C, D or X)

008=(R) Missing/Invalid enrollment effective date

009=(R) Invalid panel open indicator value (must be Y, N)

010=(R) Invalid Language indicator value (must be 0,1,2,3,4,or 5)

011=(R) Invalid Age Restriction indicator value (must be 0,1,2)

012=(R) Invalid PCP Linkage Maximum value (must be numeric or zeros)

013=(R) Invalid PCP Linkage BAYOU HEALTH value (must be numeric or zeros)

014=(R) Invalid PCP Linkage Other value (must be numeric or zeros)

015=(R) Invalid Family-Only indicator value (must be 0,1)

016=(R) Missing BAYOU HEALTH Contract Name or Number (found only spaces)

017=(R) Missing/Invalid BAYOU HEALTH Contract begin date

018=(R) Missing/Invalid BAYOU HEALTH Contract termination date

019=(R) Missing provider parish (at least 1 must be submitted)

020=(R) Invalid provider parish value (for a submitted value)

021=(R) Duplicate NPI records found. Only first one in the file is accepted

022=(R) Medicaid Provider ID (Other Provider Identifier) is not found on MMIS Provider File

023=(R) Missing/Invalid NPPES Enum Date

024=(R) Missing/Invalid Provider License Data

025=(A) NPI not found on LMMIS Provider Enrollment File

026=(R) BAYOU HEALTH provider not found on LMMIS Provider Enrollment File

027=(R) Unable to assign a Medicaid provider... too many collisions

028=(R) Enrollment Ind=N (new), but provider already exists on registry

029=(R) Enrollment Ind=C or D, but provider does not exist on registry

# Dental Benefits Plan System Companion Guide

```
030=(R)  Invalid taxonomy format (Special characters not allowed)

031=(R)  Missing Replacement NPI for an atypical provider

032=(R)  Shared Plan providers must be actively enrolled in LA Medicaid

033=(R)  Shared Plan Fiscal Agent-Waiver, EDI Billing Agent and Prescribing Only providers not allowed

034=(R)  Shared Plan Other Provider Type does not match MMIS enrollment file

035=(A)  Non-Par Contractor

036=(A)  Shared Plan Other Provider Specialty does not match MMIS enrollment file
037=(R)  Invalid PCP Indicator Field (must be 0, 1, 2 or 3)
038=(R)  Invalid display online field (must be 0 or 1)
END OF REPORT
```

# Dental Benefits Plan System Companion Guide

Provider Registry Edit file layout

| Columns | Field Name | Format | Size | Comments |
|---------|-----------|--------|------|----------|
| 1-7 | Plan ID number | Numeric | 7 digits | This is the plan ID. |
| 8 | Delimiter | Character | 1 | Value is ^ character. |
| 9 | Enroll Code | Character | 1 | Submitted by plan: <br><br> N=New <br><br> C=Change <br><br> D=Disenroll <br><br> X=Remove. |
| 10 | Delimiter | Character | 1 | Value is ^ character. |
| 11-17 | Provider ID | Numeric | 7 digits | This is the provider's LA Medicaid ID number |
| 18 | Delimiter | Character | 1 | Value is ^ character. |
| 19-28 | Provider NPI | Character | 10 | |
| 29 | Delimiter | Character | 1 | Value is ^ character. |
| 30-59 | Provider Name | Character | 30 | |
| 60 | Delimiter | Character | 1 | Value is ^ character. |

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| 61-70 | Provider Taxonomy | Character | 10 | |
|---|---|---|---|---|
| 71 | Delimiter | Character | 1 | Value is ^ character. |
| 72-78 | Provider ID | Numeric | 7 digits | |
| 79 | Delimiter | Character | 1 | Value is ^ character. |
| 80 | Molina Accept/Reject Indicator | Character | 1 | A=Accepted R=Rejected |
| 81 | Delimiter | Character | 1 | Value is ^ character. |
| 82-84 | Edit Code 1 | Character | 3 | |
| 85 | Delimiter | Character | 1 | Value is ^ character. |
| 86-88 | Edit Code 2 | Character | 3 | |
| 89 | Delimiter | Character | 1 | Value is ^ character. |
| 90-92 | Edit Code 3 | Character | 3 | |
| 93 | Delimiter | Character | 1 | Value is ^ character. |
| 94-96 | Edit Code 4 | Character | 3 | |
| 97 | Delimiter | Character | 1 | Value is ^ character. |
| 98-100 | Edit Code 5 | Character | 3 | |
| 101 | Delimiter | Character | 1 | Value is ^ character. |
| 102-104 | Edit Code 6 | Character | 3 | |

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

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Provider Registry Site File


We now have a new Site Provider Registry link on the BYU menu web page. The process is similar to the Provider Registry where the plan will upload their site file updates to Molina using the naming schema "YYYYMMDD_NNNNNNN_Site_PR.txt", where YYYYMMDD is the date of the submission (YMD) and NNNNNNN is their assigned Medicaid provider ID.  Molina will use the current site master in place as a starting point thus allowing the plans to send updates only.


With this in place Molina will no longer accept site updates via email.  Also if a Plan makes a change to a provider on the Provider Registry master file, then it is the Plan's responsibility to make the corresponding change to their site file. Molina will no longer manually make this change for them.  If you change the master registry record for a provider, you must also send the provider's site record(s).  The reason for this is because we use a lot of information from the master registry record on the site record when we send them to Maximus.  If you change provider type, specialty, max linkages, etc., then you must submit the site record(s) so that these changes are propagated to Molina.

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## Site File Format

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

| Column ID | Field Position in record | Field | Type | Length | Required or Optional | Valid values | Other notes | Applicable Error Code(s) (see table below). |
|---|---|---|---|---|---|---|---|---|
| 1 | 1-7 | Plan ID | Numeric | 7 | Required | Must be your assigned Plan ID | Use your Plan ID formatted 2162nnn, where nnn is your specific assigned number. Once, assigned It must remain consistent. | 016 |
| 2 | 8 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 3 | 9-18 | Provider NPI | Numeric | 10 | Required | Must be the provider's NPI | | 001, 004, 013, 015 017. |

# Dental Benefits Plan System Companion Guide

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | (015 is not a rejection error for Pre-Paid plans), |
| 4 | 19 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 5 | 20-29 | Provider Taxonomy | Character | 10 | Required | Must be a valid Taxonomy | | 002, 020 |
| 6 | 30 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 7 | 31-37 | LMMIS Medicaid Provider ID | Numeric | 7 | Optional | If not available then place all zeros in this field. | This is the assigned Louisiana Medicaid Provider ID. It is the check-digit number. Check-digit provider numbers begin with 1 or 2, not with 00 or 01. | 014 . (014 is not a rejection error for Pre-Paid plans). |
| 8 | 38 | Delimiter | Character | 1 | Required | ^ | | 023 |

| 9 | 39-41 | Site Number | Numeric | 3 | Required | **Must be a number between 001 and 998. May not be 000 or 999.**<br><br>Be sure to left-fill with zeros, if appropriate.<br><br>**Plan's MUST maintain consistency with this number by NPI and Taxonomy.** | Site Number should be a unique number for each practice site/location by Provider (NPI and Taxonomy). For a specific provider, it should start with 001 for the first site, then 002, etc. | 003, 022 |
|---|---|---|---|---|---|---|---|---|
| 10 | 42 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 11 | 43-92 | Practice/Site Street Address 1 | Character | 50 | Required | | Do not use a PO Box.<br><br>**Do not send multiple site records that share the exact same address, based on** | 003, 013, 021 |

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| | | | | | | | | columns 11, 13, 15, and 17. | |
|---|---|---|---|---|---|---|---|---|---|
| 12 | 93 | Delimiter | Character | 1 | Required | ^ | | | 023 |
| 13 | 94-143 | Practice/Site Street Address 2 | Character | 50 | Optional | If not used, then place spaces in this field. | Do not use a PO Box. | | 003, 013, 021 |
| 14 | 144 | Delimiter | Character | 1 | Required | ^ | | | 023 |
| 15 | 145-194 | City | Character | 50 | Required | Must not be all spaces. | | | 003 |
| 16 | 195 | Delimiter | Character | 1 | Required | ^ | | | 023 |
| 17 | 196-197 | State Abbreviation | Character | 2 | Required | Must use the appropriate USPS State or Territory abbreviation. | | | 003 |
| 18 | 198 | Delimiter | Character | 1 | Required | ^ | | | 023 |
| 19 | 199-207 | Zip Code | Numeric | 9 | Required | Must use the USPS ZIP+4 format.  If the last 4 digits are not available, then code them with 0000. | | | 003 |

# Dental Benefits Plan System Companion Guide

| 20 | 208 | Delimiter | Character | 1 | Required | ^ | | 023 |
|----|-----|-----------|-----------|---|----------|---|---|-----|
| 21 | 209-210 | Parish Code | Numeric | 2 | Required | Must use a valid Louisiana Medicaid parish code value between '01' and '64' if in-state or '99' if out-of-state. | | 011, 012 |
| 22 | 211 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 23 | 212-261 | Contact Name | Character | 50 | Required | Must not be all spaces. | | 003 |
| 24 | 262 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 25 | 263-272 | Contact Phone Number | Numeric | 10 | Required | Must be 10 numeric digits | | 003 |
| 26 | 273 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 27 | 274-283 | Contact Fax Number | Numeric | 10 | Optional | Must be 10 numeric digits.  If not available, then use 0000000000. | | 003 |
| 28 | 284 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 29 | 285 | PCP Indicator | Character | 1 | Required | Y or N.  Blank/space value | | 008 |

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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | will cause an error. | | |
| 30 | 286 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 31 | 287 | Accepting New Patients Indicator | Character | 1 | Optional | Y or N.<br><br>If not known, then use N.<br><br>If you send a blank/space value, it will be interpreted as Y. | | 007 |
| 32 | 288 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 33 | 289-318 | Age Restriction Information | Character | 30 | Optional | If not known, then place all spaces in this field. | This is a text field that may be used by the plan to represent age restrictions at the practice site/location. If there are no age restrictions, you may enter the value NONE. | |
| 34 | 319 | Delimiter | Character | 1 | Required | ^ | | 023 |

| 35 | 320-369 | Group Affiliation Information | Character | 50 | Optional | If not used, then place all spaces in this field. | This is a text field that the plan may use to identify a group or clinic for which the provider site is affiliated. Examples are:<br><br>LSU Healthcare Network<br><br>Ochsner Clinics<br><br>We request that the plan maintain consistency in this field. | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 36 | 370 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 37 | 371 | Submission Type / Enrollment Indicator | Character | 1 | Required | **N**=New Site Record<br><br>**C**=Change to Existing Site Record | For changes and dis-enrollments, this record (identified by **Plan ID, NPI, Taxonomy** | 005, 018, 019 |

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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | **D**=Disenrollment of Site Record  **X**=Remove | **and Site Number**) must already exist on the site registry. For new records, the record must not already exist on the site registry. | |
| 38 | 372 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 39 | 373-380 | Submission Date | Numeric | 8 | Required | Must be a numeric date value in the format YYYYMMDD. | This is the date that you are submitting the record. | 006 |
| 40 | 381 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 41 | 382-389 | Site Enrollment Effective Begin Date | Numeric | 8 | Required | Must be a numeric date value in the format YYYYMMDD. | This is the effective begin date of the practice/site enrollment. You may not use zeros, and it must represent a | 009 |

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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | valid date. | |
| 42 | 390 | Delimiter | Character | 1 | Required | ^ | | 023 |
| 43 | 391-398 | Site Enrollment Effective End Date | Numeric | 8 | Required | Must be a numeric date value in the format YYYYMMDD. | This is the effective end date of the practice/site enrollment. You may not use zeros, and it must represent a valid date.<br><br>Do not use zeros to indicate open-end; instead, use 20991231 to indicate open-end. The enrollment end date must be greater than or equal to the enrollment | 010 |

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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | begin date. | |
| 44 | 399 | END OF RECORD INDICATOR | Character | 1 | Required | ^ | If not present, the record will be rejected. | 023 |

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**Error Messages**

'000'='No errors found'

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

'002'='Provider record must include taxonomy'

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

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

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

'006'='Missing/Invalid submission date'

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

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

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

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

'011'='Missing provider site parish '

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

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

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

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

'016'='BAYOU HEALTH **Plan** ID not found on LMMIS Provider Enrollment File'

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

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

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

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

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

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

'023'='Record format is not delimited or end-of-record indicator is missing/invalid **Error File Format**

| Column | Name | Size | Type |
|---|---|---|---|
| **1** | BAYOU HEALTH Plan ID | 7 | numeric |
| **8** | Delimiter | 1 | ^ |
| **9** | SUBMISSION TYPE | 1 | alphanumeric |
| **10** | Delimiter | 1 | ^ |
| **11** | PROVIDER NPI | 10 | numeric |
| **21** | Delimiter | 1 | ^ |
| **22** | PROVIDER NAME | 30 | alphanumeric |
| **52** | Delimiter | 1 | ^ |
| **53** | PROVIDER TAXONOMY | 10 | alphanumeric |
| **63** | Delimiter | 1 | ^ |
| **64** | SITE NUMBER | 3 | numeric |
| **67** | Delimiter | 1 | ^ |

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| | | | | |
|---|---|---|---|---|
| **68** | ERROR INDICATOR | 1 | | alphanumeric |
| **69** | Delimiter | 1 | ^ | |
| **70** | ERROR 1 | | 3 | numeric |
| **73** | Delimiter | | 1 | ^ |
| **74** | ERROR 2 | | 3 | numeric |
| **77** | Delimiter | | 1 | ^ |
| **78** | ERROR 3 | | 3 | numeric |
| **81** | Delimiter | | 1 | ^ |
| **82** | error 4 | | 3 | numeric |
| **85** | Delimiter | | 1 | ^ |
| **86** | ERROR 5 | | 3 | numeric |
| **89** | Delimiter | | 1 | ^ |
| **90** | ERROR 6 | | 3 | numeric |
| **93** | Delimiter | | 1 | ^ |
| **94** | ERROR 7 | | 3 | numeric |
| **97** | Delimiter | | 1 | ^ |
| **98** | ERROR 8 | | 3 | numeric |
| **101** | Delimiter | | 1 | ^ |
| **102** | ERROR 9 | | 3 | numeric |

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| | | | |
|---|---|---|---|
| **105** | Delimiter | 1 | ^ |
| **106** | ERROR 10 | 3 | numeric |
| **109** | Delimiter | 1 | ^ |

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## Appendix H

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 Health Plan must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. The Health Plan 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 Health Plan 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). There are certain errors that will occur while testing with EDIFECS that shall not be considered when determining whether the Health Plan has passed or failed the EDIFECS portion of testing.

EDI must certify the Health Plan 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, 999 Acceptance, or return transaction. X12 837 transactions (837D, 837I and 837P) must be in the 5010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;

- validate Trading Partner IDs;

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- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;

- validate the test submission with 999 Acceptance transactions; and

- generate IRL or paired transaction.

Once EDIFECS testing is complete, the Health Plan is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the Health Plan is identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The Health Plan must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item DBP 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 Health Plan'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 DHH.

## Testing Tier II

Once the Health Plan 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 Health Plan via IDEX. The Health Plan 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 Health Plan and DHH 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 the Health Plan may have concerning the edit codes.

## Testing Tier III

Once satisfactory test results are documented, Molina will move the Health Plan into production. Molina anticipates receiving files from the Health Plan in production mode at least once monthly.

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## Appendix I

Websites

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

| **W**ebsite 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** |

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| Website Address | Website Contents |
|---|---|
| | **website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free. |
| http://www.ansi.org | This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process. |
| http://www.x12.org | This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their 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 |

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

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## Appendix J

Common Data Element Values

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The following common data element values are provided as references for useful information for CCN entities.

**Type of Service (TOS)**

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

| 17 | Home Health |
|----|-------------|
| 18 | Expanded Dental Services for Pregnant Women (EDSPW) |
| 19 | Personal Care Services (LTC) |
| 20 | Enhanced Outpatient Rehab Services |
| 21 | EPSDT, EPSDT Dental |
| 22 | Childnet (Early Steps) |
| 23 | Waiver - Children's Choice |
| 24 | Waiver - ADHC |
| 25 | Waiver - EDA |
| 26 | Waiver - PCA |
| 27 | Special Purpose Facility |
| 28 | Center Based Special Purpose Facility |
| 29 | American Indian |
| 30 | Acute Care Outpatient Services |
| 31 | Family Planning Waiver |
| 32 | Supports Waiver |
| 33 | New Opportunity Waiver (NOW) |
| 34 | DME Special Rates |
| 35 | Residential Options Waiver (ROW) |
| 36 | Community Mental Health Center |
| 37 | Small Rural Hospital Outpatient |
| 38 | Adult Residential Care (ARC) |
| 39 | State Hospital Outpatient Services |
| 40 | Sole Community Hospital |
| 41 | Psychiatric Residential Treatment Facility |

| | |
|---|---|
| 42 | Mental Health Rehabilitation |
| 43 | LaPOP, Louisiana Personal Options Program |
| 44 | Pediatric Day Health Care Facility (PDHC) |
| 45 | Coordinated Care Network - Pre-paid (CCN-P) |
| 46 | Coordinated Care Network - Shared Services (CCN-S) |

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Category of Service (COS)

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

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| | |
|---|---|
| 20 | DME (Appliances) |
| 21 | Rural Health Clinics |
| 22 | Family Planning Service |
| 23 | Non-Emergency Medical Transportation |
| 24 | Medical Transportation |
| 25 | Adult Dental Services |
| 26 | EPSDT - Screening Services |
| 27 | EPSDT - Dental |
| 28 | EPSDT - Other |
| 29 | Homemaker Services |
| 30 | Other Medical Services |
| 31 | Default |
| 32 | Administrative Error State Funds Only |
| 33 | Recovery Unidentified Services |
| 34 | EPSDT Health Services Non-School Board |
| 35 | Medical TPL |
| 36 | Title XIX Health Insurance Payment |
| 37 | Case Management |
| 38 | FQHC |
| 39 | PCA |
| 40 | Personal Health Care Clinic Services |
| 41 | HMO Over 65 |
| 42 | Rehab for Chronically Mentally Ill |
| 43 | Childrens' Choice Waiver |

| | |
|----|----|
| 44 | EPSDT - Personal Care Services |
| 45 | Dental Services for Pregnant Women |
| 46 | EPSDT Health Services |
| 47 | VD Clinic |
| 48 | TB Clinic |
| 49 | Title XIX Part-A Premium |
| 50 | Psychology |
| 51 | Audiology |
| 52 | Physical Therapy |
| 53 | Multi-Specialty Clinic Services |
| 54 | Certified Registered Nurse (CRNA) |
| 55 | Private Duty Nurse |
| 56 | Occupational Therapy |
| 57 | CM - HIV |
| 58 | CM - CMI |
| 59 | CM - PW |
| 60 | Rehab - ICF/DD |
| 61 | CM - DD |
| 62 | DD Waiver |
| 63 | CM - Infants & Toddlers |
| 64 | Home Care Elderly Waiver |
| 65 | Head Injury Maintenance Waiver |
| 66 | Hospice / NF |
| 67 | Social Worker Services |

| 68 | Contractors / CM |
| --- | --- |
| 69 | Nurse Home Visits - First Time Mothers Program |
| 70 | NOW Waiver |
| 71 | LTC - Personal Care Services |
| 72 | PAS - Personal Care Services |
| 73 | Early Steps |
| 74 | Behavior Management Services |
| 75 | PACE |
| 76 | American Indian/Native Alaskans |
| 77 | Family Planning Waiver |
| 78 | Support Waiver |
| 79 | Community Mental Health Center |
| 80 | Residential Options Waiver (ROW) |
| 81 | Coordinated Care Network |
| 91 | Coded for internal purposes only |
| 99 | LTC Administrative Cost |

# Dental Benefits Plan System Companion Guide

## Provider Specialty, Sub-specialty

| Specialty Code | Description | Type: 1=Specialty, 2=Subspecialty |
|---|---|---|
| 00 | All Specialties | 1 |
| 01 | General Practice | 1 |
| 02 | General Surgery | 1 |
| 03 | Allergy | 1 |
| 04 | Otology, Laryngology, Rhinology | 1 |
| 05 | Anesthesiology | 1 |
| 06 | Cardiovascular Disease | 1 |
| 07 | Dermatology | 1 |
| 08 | Family Practice | 1 |
| 09 | Gynecology (DO only) | 1 |
| 10 | Gastroenterology | 1 |
| 11 | Not in Use | n/a |
| 12 | Manipulative Therapy (DO only) | 1 |
| 13 | Neurology | 1 |
| 14 | Neurological Surgery | 1 |
| 15 | Obstetrics (DO only) | 1 |
| 16 | OB/GYN | 1 |
| 17 | Ophthalmology, Otology, Laryngology, Rhinology (DO only) | 1 |
| 18 | Ophthalmology | 1 |
| 19 | Orthodontist | 1 |

| 20 | Orthopedic Surgery | 1 |
| 21 | Pathologic Anatomy; Clinical Pathology (DO only) | 1 |
| 22 | Pathology | 1 |
| 23 | Peripheral Vascular Disease or Surgery (DO only) | 1 |
| 24 | Plastic Surgery | 1 |
| 25 | Physical Medicine Rehabilitation | 1 |
| 26 | Psychiatry | 1 |
| 27 | Psychiatry; Neurology (DO only) | 1 |
| 28 | Proctology | 1 |
| 29 | Pulmonary Diseases | 1 |
| 30 | Radiology | 1 |
| 31 | Roentgenology, Radiology (DO only) | 1 |
| 32 | Radiation Therapy (DO only) | 1 |
| 33 | Thoracic Surgery | 1 |
| 34 | Urology | 1 |
| 35 | Chiropractor | 1 |
| 36 | Pre-Vocational Habilitation | 1 |
| 37 | Pediatrics | 1 |
| 38 | Geriatrics | 1 |
| 39 | Nephrology | 1 |
| 40 | Hand Surgery | 1 |
| 41 | Internal Medicine | 1 |
| 42 | Federally Qualified Health Centers | 1 |

# Dental Benefits Plan System Companion Guide

| 43 | Not in Use | n/a |
|----|------------|-----|
| 44 | Public Health | 1 |
| 45 | NEMT - Non-profit | 1 |
| 46 | NEMT - Profit | 1 |
| 47 | NEMT - F+F | 1 |
| 48 | Podiatry - Surgical Chiropody | 1 |
| 49 | Miscellaneous (Admin. Medicine) | 1 |
| 50 | Day Habilitation | 1 |
| 51 | Med Supply / Certified Orthotist | 1 |
| 52 | Med Supply / Certified Prosthetist | 1 |
| 53 | Med Supply / Certified Prosthetist Orthotist | 1 |
| 54 | Med Supply / Not Included in 51, 52, 53 | 1 |
| 55 | Indiv Certified Orthotist | 1 |
| 56 | Indiv Certified Protherist | 1 |
| 57 | Indiv Certified Protherist - Orthotist | 1 |
| 58 | Indiv Not Included in 55, 56, 57 | 1 |
| 59 | Ambulance Service Supplier, Private | 1 |
| 60 | Public Health or Welfare Agencies & Clinics | 1 |
| 61 | Voluntary Health or Charitable Agencies | 1 |
| 62 | Psychologist Crossovers only | 1 |
| 63 | Portable X-Ray Supplier (Billing Independently) | 1 |
| 64 | Audiologist (Billing Independently) | 1 |
| 65 | Indiv Physical Therapist | 1 |
| 66 | Dentist, DDS, DMS | 1 |

# Dental Benefits Plan System Companion Guide

| 67 | Oral Surgeon - Dental | 1 |
|----|----|---|
| 68 | Pedodontist | 1 |
| 69 | Independent Laboratory (Billing Independently) | 1 |
| 70 | Clinic or Other Group Practice | 1 |
| 71 | Speech Therapy | 1 |
| 72 | Diagnostic Laboratory | 1 |
| 73 | Social Worker Enrollment | 1 |
| 74 | Occupational Therapy | 1 |
| 75 | Other Medical Care | 1 |
| 76 | Adult Day Care | 1 |
| 77 | Habilitation | 1 |
| 78 | Mental Health Rehab | 1 |
| 79 | Nurse Practitioner | 1 |
| 80 | Environmental Modifications | 1 |
| 81 | Case Management | 1 |
| 82 | Personal Care Attendant | 1 |
| 83 | Respite Care | 1 |
| 84 | Substitute Family Care | 1 |
| 85 | Extended Care Hospital | 1 |
| 86 | Hospitals and Nursing Homes | 1 |
| 87 | All Other | 1 |
| 88 | Optician / Optometrist | 1 |
| 89 | Supervised Independent Living | 1 |
| 90 | Personal Emergency Response Sys (Waiver) | 1 |

# Dental Benefits Plan System Companion Guide

| | | |
|---|---|---|
| 91 | Assistive Devices | 1 |
| 92 | Prescribing Only Providers | 1 |
| 93 | Hospice Service for Dual Elig. | 1 |
| 94 | Rural Health Clinic | 1 |
| 95 | Psychologist (PBS Program Only) | 1 |
| 96 | Psychologist (PBS Program and X-Overs) | 1 |
| 97 | Family Planning Clinic | 1 |
| 98 | Supported Employment | 1 |
| 99 | Provider Pending Enrollment | 1 |
| 1A | Adolescent Medicine | 2 |
| 1B | Diagnostic Lab Immunology | 2 |
| 1C | Neonatal Perinatal Medicine | 2 |
| 1D | Pediatric Cardiology | 2 |
| 1E | Pediatric Critical Care Medicine | 2 |
| 1F | Pediatric Emergency Medicine | 2 |
| 1G | Pediatric Endocrinology | 2 |
| 1H | Pediatric Gastroenterology | 2 |
| 1I | Pediatric Hematology - Oncology | 2 |
| 1J | Pediatric Infectious Disease | 2 |
| 1K | Pediatric Nephrology | 2 |
| 1L | Pediatric Pulmonology | 2 |
| 1M | Pediatric Rheumatology | 2 |
| 1N | Pediatric Sports Medicine | 2 |
| 1P | Pediatric Surgery | 2 |

# Dental Benefits Plan System Companion Guide

| | | |
|---|---|---|
| 1S | BRG - Med School | 2 |
| 1T | Emergency Medicine | 1 |
| 1Z | Pediatric Day Health Care | 1 |
| 2A | Cardiac Electrophysiology | 2 |
| 2B | Cardiovascular Disease | 2 |
| 2C | Critical Care Medicine | 2 |
| 2D | Diagnostic Laboratory Immunology | 2 |
| 2E | Endocrinology & Metabolism | 2 |
| 2F | Gastroenterology | 2 |
| 2G | Geriatric Medicine | 2 |
| 2H | Hematology | 2 |
| 2I | Infectious Disease | 2 |
| 2J | Medical Oncology | 2 |
| 2K | Nephrology | 2 |
| 2L | Pulmonary Disease | 2 |
| 2M | Rheumatology | 2 |
| 2N | Surgery - Critical Care | 2 |
| 2P | Surgery - General Vascular | 2 |
| 2R | Physician Assistant | 1 |
| 2S | LSU Medical Center New Orleans | 2 |
| 2T | American Indian / Native Alaskan | 2 |
| 2Y | OPH Genetic Disease Program | 1 |
| 3A | Critical Care Medicine | 2 |
| 3B | Gynecologic oncology | 2 |

# Dental Benefits Plan System Companion Guide

| 3C | Maternal & Fetal Medicine | 2 |
|---|---|---|
| 3S | LSU Medical Center Shreveport | 2 |
| 4A | Developmental Disability | 1 |
| 4B | NOW RN | 1 |
| 4C | NOW LPN | 1 |
| 4D | NOW Psychologist | 1 |
| 4E | NOW Social Worker | 1 |
| 4R | Registered Dietician | 1 |
| 4S | Ochsner Med School | 2 |
| 4X | Waiver-Only Transportation | 1 |
| 4W | Waiver Services | 1 |
| 5A | PCS-LTC | 1 |
| 5B | PCS-EPSDT | 1 |
| 5C | PAS | 1 |
| 5D | PCS-LTC, PCS-EPSDT | 1 |
| 5E | PCS-LTC, PAS | 1 |
| 5F | PCS-EPSDT, PAS | 1 |
| 5G | OCS-LTC, PCS-EPSDT, PAS | 1 |
| 5H | Community Mental Health Center | |
| 5M | Multi-Systemic Therapy | |
| 5P | PACE | 1 |
| 5Q | CCN-P (Coordinated Care Network, Prepaid) | 1 |
| 5R | CCN-S (Coordinated Care Network, Shared Savings) | |
| 5S | Tulane Med School | 2 |

# Dental Benefits Plan System Companion Guide

| | | |
|---|---|---|
| 6A | Psychologist -Clinical | 1 |
| 6B | Psychologist-Counseling | 1 |
| 6C | Psychologist - School | 1 |
| 6D | Psychologist - Developmental | 1 |
| 6E | Psychologist - Non-Declared | 1 |
| 6F | Psychologist - All Other | 1 |
| 6H | LaPOP | 1 |
| 6N | Endodontist | 1 |
| 6P | Periodontist | 1 |
| 6S | E Jefferson Fam Practice Ctr - Residency Program | 2 |
| 7A | SBHC - NP - Part Time - less than 20 hrs week | 1 |
| 7B | SBHC - NP - Full Time - 20 or more hrs week | 1 |
| 7C | SBHC - MD - Part Time - less than 20 hrs week | 1 |
| 7D | SBHC - MD - Full Time - 20 or more hrs week | 1 |
| 7E | SBHC - NP + MD - Part Time - combined less than 20 hrs week | 1 |
| 7F | SBHC - NP + MD - Full Time - combined less than 20 hrs week | 1 |
| 7M | Retail Convenience Clinics | 2 |
| 7N | Urgent Care Clinics | 2 |
| 7S | Leonard J Chabert Medical Center - Houma | 2 |
| 8A | EDA & DD services | 2 |
| 8B | EDA services | 2 |
| 8C | DD services | 2 |
| 9B | Psychiatric Residential Treatment Facility | 1 |

# Dental Benefits Plan System Companion Guide

| | | |
|---|---|---|
| 9D | Residential Care | 1 |
| 9E | Children's Choice Waiver | 1 |
| 9L | RHC/FQHC OPH Certified SBHC | 1 |
| 9Q | PT 21 - EDI Independent Billing Company | 2 |
| 9U | Medicare Advantage Plans | 1 |
| 9V | OCDD - Point of Entry | 1 |
| 9W | OASS - Point of Entry | 1 |
| 9X | OAD | 1 |
| 9Z | Other Contract with a State Agency | 1 |

# Dental Benefits Plan System Companion Guide

## Pricing Action Code (PAC)

| PAC | Description |
|-----|-------------|
| **MEDICAL** | |
| 250 | Price at Level III - Anesthesia |
| 260 | Price as for Anesthesia |
| 810 | Price manually, individual consideration (IC) |
| 820 | Deny |
| 830 | Price at Level I (U&C File) |
| 850 | Price at Level III - Louisiana BHSF set price on Procedure/Formulary File |
| 860 | Price at Level I and Level II (U&C File and Prevailing Fee File) |
| 880 | Maximum amount - Pend if billed charge is greater than Procedure/Formulary price |
| 8F0 | Maximum amount - Pay at billed amount |
| | |
| **DENTAL** | |
| 610 | Manage Price |
| 620 | Deny |
| 630 | Price at Level I (U&C File) |
| 650 | Price at Level III - Louisiana BHSF set price on Procedure/Formulary File |
| 660 | Price at Level I and II (U&C File and Prevailing Fee File) |
| 680 | Maximum Amount - Pend if billed charge is greater than Procedure/Formulary File |
| 6F0 | Maximum Amount - Pay at billed amount |

# Dental Benefits Plan System Companion Guide

## Appendix K

TPL Discovery Web Application

The following web page screens depict the web application that is made available to Health Plan organizations to identify and report to DHH the TPL information for Medicaid recipients.

Further clarification regarding the method of receiving TPL information from the Plan will be provided at a later date.

# Dental Benefits Plan System Companion Guide

TPL Entry Screen, Page 1

# Dental Benefits Plan System Companion Guide

# Dental Benefits Plan System Companion Guide

## Scopes of coverage

Below is the list from the MDW DED:

| 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 | Drugs Only |
| 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 | Pharmacy (PBM) |
| 33 | HMO No Maternity |

# Dental Benefits Plan System Companion Guide

## Louisiana Medicaid Recipient Aid Category Codes

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

# Dental Benefits Plan System Companion Guide

## Louisiana Medicaid Recipient Type Case Codes

| LAMMIS Type Case | Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions) | SSI Status (1=SSI, 0=Non-SSI) |
|---|---|---|
| 001 | SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic | 0 |
| 002 | Deemed Eligible | 0 |
| 003 | SSI Conversion | 0 |
| 004 | SSI SNF | 1 |
| 005 | SSI/LTC | 1 |
| 006 | 12 Months Continuous Eligibility | 0 |
| 007 | LACHIP Phase 1 | 0 |
| 008 | PAP - Prohibited AFDC Provisions | 0 |
| 009 | LIFC - Unemployed Parent / CHAMP | 0 |
| 010 | SSI in ICF (II)- Medical | 1 |
| 011 | SSI Villa SNF | 1 |
| 012 | Presumptive Eligibility, Pregnant Woman | 0 |
| 013 | CHAMP Pregnant Woman (to 133% of FPIG) | 0 |
| 014 | CHAMP Child | 0 |
| 015 | LACHIP Phase 2 | 0 |
| 016 | Deceased Recipient - LTC | 0 |
| 017 | Deceased Recipient - LTC (Not Auto) | 0 |
| 018 | ADHC (Adult Day Health Services Waiver) | 0 |
| 019 | SSI/ADHC | 1 |
| 020 | Regular MNP (Medically Needy Program) | 0 |
| 021 | Spend-Down MNP | 0 |
| 022 | LTC Spend-Down MNP (Income > Facility Fee) | 0 |
| 023 | SSI Transfer of Resource(s)/LTC | 1 |

# Dental Benefits Plan System Companion Guide

| | | |
|---|---|---|
| 024 | Transfer of Resource(s)/LTC | 0 |
| 025 | LTC Spend-Down MNP | 0 |
| 026 | SSI/EDA Waiver | 1 |
| 027 | EDA Waiver | 0 |
| 028 | Tuberculosis (TB) | 0 |
| 029 | Foster Care IV-E - Suspended SSI | 0 |
| 030 | Regular Foster Care Child | 0 |
| 031 | IV-E Foster Care | 0 |
| 032 | YAP (Young Adult Program) | 0 |
| 033 | OYD - V Category Child | 0 |
| 034 | MNP - Regular Foster Care | 0 |
| 035 | YAP/OYD | 0 |
| 036 | YAP (Young Adult Program) | 0 |
| 037 | OYD (Office of Youth Development) | 0 |
| 038 | OCS Child Under Age 18 (State Funded) | 0 |
| 039 | State Retirees | 0 |
| 040 | SLMB (Specified Low-Income Medicare Beneficiary) | 0 |
| 041 | OAA, ANB or DA (GERI HP-ICF(I) SSI-No) | 0 |
| 042 | OAA, ANB or DA (GERI HP-ICF(I) SSI Pay) | 1 |
| 043 | New Opportunities Waiver - SSI | 1 |
| 044 | OAA, ANB or DA (GERI HP-ICF(2) SSI-Pay) | 1 |
| 045 | SSI PCA Waiver | 1 |
| 046 | PCA Waiver | 0 |
| 047 | Illegal/Ineligible Aliens Emergency Services | 0 |
| 048 | QI-1 (Qualified Individual - 1) | 0 |
| 049 | QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002) | 0 |
| 050 | PICKLE | 0 |
| 051 | LTC MNP/Transfer of Resources | 0 |

# Dental Benefits Plan System Companion Guide

| 052 | Breast and/or Cervical Cancer | 0 |
|-----|-------------------------------|---|
| 053 | CHAMP Pregnant Woman Expansion (to 185% FPIG) | 0 |
| 054 | Reinstated Section 4913 Children | 0 |
| 055 | LACHIP Phase 3 | 0 |
| 056 | Disabled Widow/Widower (DW/W) | 0 |
| 057 | BPL (Walker vs. Bayer) | 0 |
| 058 | Section 4913 Children | 0 |
| 059 | Disabled Adult Child | 0 |
| 060 | Early Widow/Widowers | 0 |
| 061 | SGA Disabled W/W/DS | 0 |
| 062 | SSI/Public ICF/DD | 1 |
| 063 | LTC Co-Insurance | 0 |
| 064 | SSI/Private ICF/DD | 1 |
| 065 | Private ICF/DD | 0 |
| 066 | AFDC- Private ICF DD - 3 Month Limit | 0 |
| 067 | AFDC or IV-E(1) Private ICF DD | 0 |
| 068 | SSI-M (Determination of disability for Medicaid Eligibility) | 1 |
| 069 | Roll-Down | 0 |
| 070 | New Opportunities Waiver, non-SSI | 0 |
| 071 | Transitional Medicaid | 0 |
| 072 | LAMI Psuedo Income | 0 |
| 073 | Recipient (65 Plus) Eligible SSI/Ven Pay Hospital | 1 |
| 074 | Description not available | 0 |
| 075 | TEFRA | 0 |
| 076 | SSI Children's Waiver - Louisiana Children's Choice | 1 |
| 077 | Children's Waiver - Louisiana Children's Choice | 0 |
| 078 | SSI (Supplemental Security Income) | 1 |
| 079 | Denied SSI Prior Period | 0 |
| 080 | Terminated SSI Prior Period | 1 |

# Dental Benefits Plan System Companion Guide

| 081 | Former SSI | 1 |
|---|---|---|
| 082 | SSI DD Waiver | 1 |
| 083 | Acute Care Hospitals (LOS > 30 days) | 0 |
| 084 | LaCHIP Pregnant Woman Expansion (185-200%) | 0 |
| 085 | Grant Review | 0 |
| 086 | Forced Benefits | 0 |
| 087 | CHAMP Parents | 0 |
| 088 | Medicaid Buy-In Working Disabled (Medicaid Purchase Plan) | 0 |
| 089 | Recipient Eligible for Pay-Habitation and Other | 0 |
| 090 | LTC (Long Term Care) | 0 |
| 091 | A, B, D Recipient in Geriatric SNF; No SSI Pay | 0 |
| 092 | AFCD, GA, A, B, D in SNF; No AFDC Pay | 0 |
| 093 | DD Waiver | 0 |
| 094 | QDWI (Qualified Disabled/Working Individual) | 0 |
| 095 | QMB (Qualified Medicare Beneficiary) | 0 |
| 097 | Qualified Child Psychiatric | 0 |
| 098 | AFDC, GA, A, B, D ICF(2) No AFDC/Other Pay | 0 |
| 099 | Public ICF/DD | 0 |
| 100 | PACE SSI | 1 |
| 101 | PACE SSI-related | 0 |
| 102 | GNOCHC Adult Parent | 0 |
| 103 | GNOCHC Childless Adult | 0 |
| 104 | Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL | 0 |
| 109 | LaChoice, Childless Adults | 0 |
| 110 | LaChoice, Parents with Children | 0 |
| 111 | LHP, Childless Adults | 0 |
| 112 | LHP, Parents with Children | 0 |
| 113 | LHP, Children | 0 |

| 115 | Family Planning, Previous LAMOMS eligibility | 0 |
|---|---|---|
| 116 | Family Planning, New eligibility / Non LaMOM | 0 |
| 117 | Supports Waiver SSI | 1 |
| 118 | Supports Waiver | 0 |
| 119 | Residential Options Waiver - SSI | 1 |
| 120 | Residential Options Waiver - NON-SSI | 0 |
| 121 | SSI/LTC Excess Equity | 1 |
| 122 | LTC Excess Equity | 0 |
| 123 | LTC Spend Down MNP Excess Equity | 0 |
| 124 | LTC Spend Down MNP Excess Equity(Income over facility fee) | 0 |
| 125 | Disability Medicaid | 0 |
| 127 | LaChip Phase IV: Non-Citizen Pregnant Women Expansion | 0 |
| 130 | LTC Payment Denial/Late Admission Packet | 0 |
| 131 | SSI Payment Denial/Late Admission | 1 |
| 132 | Spendown Denial of Payment/Late Packet | 0 |
| 133 | Family Opportunity Program | 0 |
| 134 | LaCHIP Affordable Plan | 0 |
| 136 | Private ICF/DD Spendown Medically Needy Program | 0 |
| 137 | Public ICF/DD Spendown Medically Needy Program | 0 |
| 138 | Private ICF/DD Spendown MNP/Income Over Facility Fee | 0 |
| 139 | Public ICF/DD Spendown MNP/Income Over Facility Fee | 0 |
| 140 | SSI Private ICF/DD Transfer of Resources | 1 |
| 141 | Private ICF/DD Transfer of Resources | 0 |
| 142 | SSI Public ICF/DD Transfer of Resources | 1 |
| 143 | Public ICF/DD Transfer of Resources | 0 |
| 144 | Public ICF/DD MNP Transfer of Resources | 0 |
| 145 | Private ICF/DD MNP Transfer of Resources | 0 |
| 146 | Adult Residential Care/SSI | 1 |
| 147 | Adult Residential Care | 0 |

| | | |
|---|---|---|
| 148 | Youth Aging Out of Foster Care (Chaffee Option) | 0 |
| 149 | New Opportunities Waiver Fund | 0 |
| 150 | SSI New Opportunities Waiver Fund | 1 |
| 151 | ELE - Food Stamps (Express Lane Eligibility-Food Stamps) | 0 |
| 152 | ELE School Lunch (Express Lane Eligibility -School Lunch) | 0 |
| 153 | SSI - Community Choices Waiver | 1 |
| 154 | Community Choices Waiver | 0 |
| 155 | HCBS MNP Spend down | 0 |
| 178 | Disabled Adults authorized for special hurricane Katrina assistance | 0 |
| 200 | CsoC-SED MEDICAID CHILD -MEDS TC and sgmt TC<br><br>CSoC Waiver Children - 1915(c) waiver.<br>Children under age 22, meeting a hospital and nursing facility LOC of CSoC will be eligibile up to 300% of FBR, using institutional eligibility criteria.<br>LOC 60=hospital, 61=NF. | 0 |
| 201 | LBHP1915(i) NON MEDICAID ADULT 19 &OLDER<br><br>CSoC Waiver Adults - 1915(i) only; non-Medicaid.<br>Adults over the age of 18, not otherwise eligible for Medicaid, meeting the 1915(i) LON criteria up to 150% of FPL. | 0 |
| 202 | CSoC 1915(i)-LIKE MEDICAID CHILD sgmt<br><br>1915(i)-like Children (aka 1915(b)(3) children): temp type case on LTC segment if recipient is in LTC/NH/ICF.<br>Otherwise Medicaid eligible children under age 22, meeting a LON of CSoC and eligible for additional services under 1915(b)(3) savings. | 0 |
| 203 | LBHP1915(i) MEDICAID ADULT 19 &OLDER sgmt<br><br>CSoC Waiver Adults - 1915(i): temp type case on LTC segment if recipient is in LTC/NH/ICF.<br>Adults over the age of 21, otherwise eligible for Medicaid, meeting the 1915(i) LON criteria. | 0 |
| 204 | LBHP1115-NON-MEDICAID ADULTS 19 & OLDER<br><br>1115 waiver for 1915(i) persons whose income is below 150% of FTPL and meeting the LON criteria.  These individuals do not have to meet a category of assistance.  The new aid cat/type case combination will be 40/204 and the segment temp type case will be 204. | 0 |

# Dental Benefits Plan System Companion Guide

| 205 | LBHP Spend down (Adult) | |
|-----|-------------------------|---|

# Dental Benefits Plan System Companion Guide

## Appendix L

DHH Medicaid FI Transmission of Medicaid Enrollment/Eligibility Data to the Plan

- The FI utilizes a proprietary format to send all Louisiana Medicaid enrollment/eligibility data to the Plan.

- The FI sends an initial, comprehensive enrollment/eligibility file to the Plan at the initiation of production  processes associated with the project.

- The FI sends work-day incremental enrollment/eligibility files to the Plan. The file is generated after the existing work-day MEDS-to-MMIS Recipient Update process.

- On a weekly basis the FI generates a comprehensive reconciliation file and sends it to the Plan. The Plan utilizes the "recon" file to ensure that their enrollment information is accurate. The SMO reports discrepancies to the DHH MEDS unit for disposition/resolution, which may require the Plan to correct their records.

# Dental Benefits Plan System Companion Guide

## Appendix M

File Transfer Schedule

Weekly (each Sunday):
        Full Recipient information, including TPL data,
        Full Provider information.

Weekly (each Tuesday):
        Claims and Encounter History for the previous week's processing,
        835 response file (from encounters submitted by Magellan in the previous week).

Weekly (each Thursday evening):
        TPL response data (from TPL data submitted by Magellan).

Weekly (each Friday evening):
        Provider registry response data (from provider registry data submitted by
Magellan).

Daily (each work-day evening):
        Incremental Recipient information, including TPL data,
        Incremental Provider information.

Monthly (first work-day evening of the Month):
        TPL Carrier Code information (third-party insurance company information).

Monthly (as scheduled by DHH):
        820 file showing detail of PMPM payments.
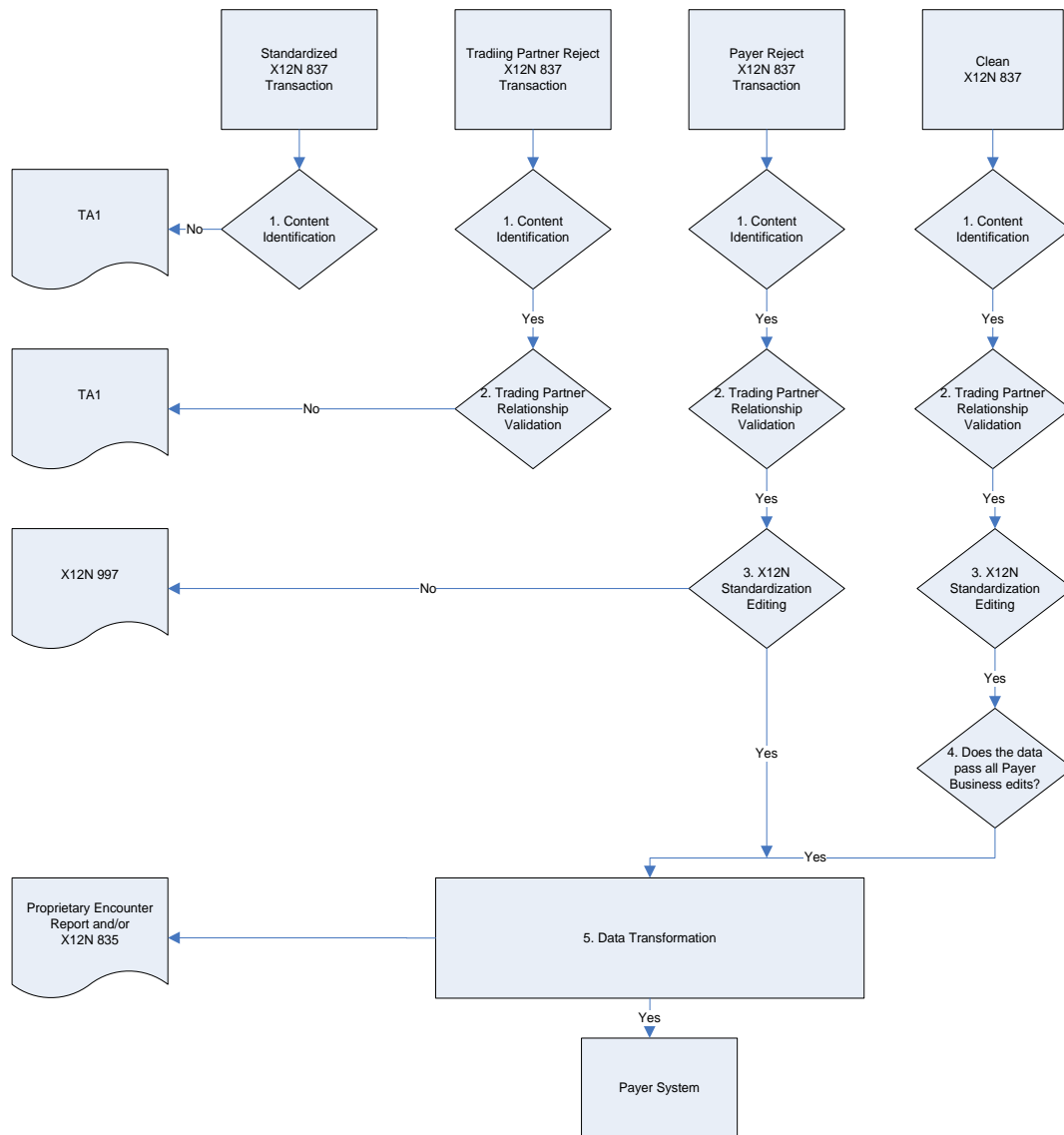
# Dental Benefits Plan System Companion Guide

## Appendix N

Process Flow Chart

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

# Dental Benefits Plan System Companion Guide

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

| Standardized X12N 837 Transaction | Tradiing Partner Reject X12N 837 Transaction | Payer Reject X12N 837 Transaction | Clean X12N 837 |
| --- | --- | --- | --- |

TA1 ←No— 1. Content Identification

1. Content Identification — Yes

1. Content Identification — Yes

1. Content Identification — Yes

TA1 ←No— 2. Trading Partner Relationship Validation

2. Trading Partner Relationship Validation — Yes

2. Trading Partner Relationship Validation — Yes

X12N 997 ←No— 3. X12N Standardization Editing

3. X12N Standardization Editing — Yes

3. X12N Standardization Editing — Yes

4. Does the data pass all Payer Business edits? — Yes

Proprietary Encounter Report and/or X12N 835 ← 5. Data Transformation — Yes

Payer System

# Dental Benefits Plan System Companion Guide

## Appendix O

DHH – LA Department of Health and Hospitals
  Encounter Data Certification Form

# Dental Benefits Plan System Companion Guide

*Please Type or Print Clearly*

| Dental Benefit Plan | Name of Preparer/Title |
|---|---|
| **For The Period Ending** <br><br> _____, 20____ | **Contact Phone Number/Email Address** |

**BAYOU Health DATA Certification Statement**

On behalf of the above-named Bayou Health Plan, I attest, based on best knowledge, information and belief, that all data submitted to the DHH - LA Department of Health and Hospitals is accurate, complete, and true. This statement applies to all documents and files submitted to DHH.

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 Bayou Health Plan contract.

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

Date Form Submitted:_____

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

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

| Date | MCO Chief Executive Officer/Delegate Name & Title | Signature |
|---|---|---|
| Date | MCO Financial Officer/Delegate Name & Title Officer/Delegate Name & Title | Signature |