Dental Benefit Plan Manager

Systems Companion Guide

April 2017
Version 4

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Section 1

Change Control Table

The Department of Health and Hospitals will provide maintenance of all documentation changes to this Guide using the Change Control Table.

AUTHOR OF CHANGE	SECTIONS CHANGED	DESCRIPTIONS	REASON	DATE
Gustave Lehmann	Appendix J	Dental Data Elements	Added Dental Data Elements	6/26/2014
Gustave Lehmann	Appendix F	MMIS Error Code with Short and Long Description	Added the list of edits	6/26/2014
Darlene White	Section 3	Claim Received Date, Claim Paid date, Interest Paid Amount	Corrected language	6/27/2014
Gustave Lehmann	Section 2	Supplementation of CMS-1500	Removed	6/30/2014
Gustave Lehmann	Appendix G	Provider Registry Edit Report (sample)	Updated	7/2/2014
Gustave Lehmann	Appendix G	Provider Registry Edit File Layout	Updated	7/2/2014
Gustave Lehmann	Appendix G	Provider Registry Site File	Removed	7/2/2014
Gustave Lehmann	Appendix G	Site File Format	Removed	7/2/2014
Gustave Lehmann	Appendix G	Error Messages	Removed	7/2/2014
Gustave Lehmann	Appendix K	Electronic File Layout for TPL	Added example of the layout	7/2/2014
Gustave Lehmann	Appendix K	Molina TPL File Layout to plans	Added example of the layout	7/2/2014
Gustave Lehmann	Claims ICD-10 Extract Change. Appendix Q	Offset Layouts	Add	9/23/2014
Gustave Lehmann	Recipient ICD-10 Extract Change. Appendix R	Offset Layouts	Add	9/23/2014
Gustave Lehmann	Carrier File Layout	Columns, Item, Notes, Length, Format	Add	9/23/2014
Gustave Lehmann	MCNA File Transfer Schedule. Appendix N	File Transfer Schedule	Add	9/23/2014
Gustave Lehmann	Appendix K	Provider IRSNO Change	Add	11/25/2014

AUTHOR OF CHANGE	SECTIONS CHANGED	DESCRIPTIONS	REASON	DATE
Cordelia Clay	Section 3	Plan Internal Control Number (ICN) Billing Provider's Patient Control Number Encounters for Paper Claims Submissions	Update Add Add	2/2/2015
Cordelia Clay	Appendix G	Provider Supplemental Record Layout Standard Provider Extract and Layout	Add Add	2/2/2015
Cordelia Clay	Frequently Asked Questions (FAQ)	Encounter Data definition	Updated RFP location	2/2/2015
Cordelia Clay	Appendix K	TPL Carrier Code Layout Louisiana Medicaid Recipient Aid Category Codes Louisiana Medicaid Recipient Type Case Codes	Add Remove Remove	2/2/2015
Cordelia Clay	Appendix N	Prior Authorization Request Data Elements	Add	2/2/2015
Cordelia Clay	Appendix R	Removed Recipient ICD-10 Extract Change and added to Appendix G Louisiana Medicaid Recipient Aid Category Codes Louisiana Medicaid Recipient Type Case Codes	Removed Add Add	2/2/2015
Cordelia Clay	Appendix F	Repairable Edit Codes Non-Repairable Edit Codes	Add Add	2/2/2015
Cordelia Clay	Appendix D	Updated columns 159-205 of Prior Authorization File Denied Encounter Error Analysis – E-CP-O-90 D Encounter EOB Analysis – E-CP-0-90-E Introduction to 820 File Recipient Extract File	Update Add Add Add Add	2/2/2015
Cordelia Clay	Section 4	Referenced Appendix D to encounter reports	Add	2/2/2015
Cordelia Clay	Section 6	Added the 5010 companion Guide Link,	Add	2/2/2015
Cordelia Clay	Section 2	Added Sub-Headers to section	Add	2/2/2015

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Cordelia Clay	Section 8	Transformed Medicaid Statistical Information System (T-MSIS)	Add	2/2/2015
Cordelia Clay		Added Header and Footer to entire document	Add	2/2/15
Krystal Berthelot	Section 9	Replaced Date of Death section with the Medicare Recovery Process	Add	3/24/2015
Krystal Berthelot	Appendix M Appendix F Appendix D	File Transfer Schedule Encounter Edit Codes - change edit disposition of edit codes 201 and 410 Standard Recipient Files - Addition of email address and current parish fields to recipient header extract	Add Add Add	6/04/2015
Cordelia Clay	Appendix D Section 9 Appendix F	Standard Recipient Files - Removed notification description and highlight of hospice data extract 820 File (FI to DBP) - Updated section to include Medicare Recoveries and correct typo. Medicaid Administrative Retroactive Enrollment Correction Process - Replaced the term "Maximus" with "Molina" Updated Edit Disposition – Deny Repairable table to include edit 410	No longer an update Add Dental Plan does not utilize Maximus as an enrollment broker Add	6/5/2015
Andrea Hollins	Section 3	Batch File Limitations – Updated number of files that may be sent to 20,000 per record total 40,000 per day	Update	4/28/2016
Andrea Hollins	Appendix D	System Generated Reports - 820 File – updated section to include new PMPM Recovery Payment PMPM Recovery Payments 2nd Occurrence – REF*ZZ*001~ - Current Recipient ID of the correct record	Update	4/28/2016
Andrea Hollins	Section 10	PMPM Payment Recovery for Duplicate Recipient Medicaid IDs – New recovery process for duplicate Medicaid recipient IDs	Add	4/28/2016
Andrea Hollins	Appendix S	Valid-Invalid Crosswalk File Layout	Add	4/28/2016

AUTHOR OF CHANGE	SECTIONS CHANGED	DESCRIPTIONS	REASON	DATE
Andrea Hollins	Appendix G	Provider Registry File Layout – Language Indicators 580, 582, 584, 586, and 588 6 = American Sign Language	Add	4/28/2016
Andrea Hollins	Appendix H	File Exchange Schedule – New duplicate ID file Recipient Voided IDs.txt	Add	4/28/2016
Andrea Hollins	Section 10	PMPM Payment Recovery Duplicate Recipient Medicaid IDs – change language	Update	5/24/2016
Andrea Hollins	Cover Page	Department name changed to Louisiana Department of Health and Hospitals Version 3 July 2016	Update	07/11/16
Andrea Hollins	Appendix K	TPL Batch Electronic File Layout Version 4.1 includes initiator code 2	Update	07/11/16
Andrea Hollins	Section 2	EDI Transmission Research Request Form To simplify handling requests for "missing" claims and/or 835 research	Add	07/11/16
Andrea Hollins	Cover Page Footer	Version 4 April 2017	Update	04/05/17
Andrea Hollins	Section 3	Update Plan Internal Control Number MR for Administrative Management Review CR for Clinical Review	Add	04/05/17

Section 2

Overview

Introduction

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) 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 and denied 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 compliance
- Rate Setting
- Quality Management and Improvement

Contract Responsibilities

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 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).

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 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.

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

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.

Encounter Submissions

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). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

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.

File Exchanges

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.

EDI Transmission Research Request Form

INSTRUCTIONS

PURPOSE

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

INSTRUCTIONS

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

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

Date – Enter the date you complete the form.

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

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

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

Transmission Acknowledgement Information

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

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

EDI Transmission Research Request Form

Date: _____

Plan Name: _____
Trading Partner ID: _____

Problem Description:

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

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

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

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

Section 3
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 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 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 up to 99 batch encounter files per day. Each file can include up to 20,000 encounter records, but a limit of 5,000 records per file is recommended. Up to a total of 40,000 encounters can be sent per day. The daily cutoff is at 12:00 (noon) Central; so the EDI daily limits are calculated from 12:01 PM to 12:00 PM. The combined total for Saturday and Sunday should not exceed 40,000. If more than the 40,000 per day limit is needed, then the Plan shall establish a submission schedule with the Molina EDI department.

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

Plan Internal Control Number (ICN)

The Plan ICN is to be populated in Line Patient Control Number, Loop 2400 REF*6R segment. 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 length can be up to 30 characters. DHH requires the Plan to modify the ICN to contain a 4-digit prefix as follows:

Character 1: Standard claim submission media types are:

- **"P"** to indicate submission of claim via paper form
- **"E"** to indicate submission of claim via electronic submission
- **"W"** to indicate the submission of claim via web portal

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

Character 2: Claim paid/denied status

The Plan or their Delegated Vendor must indicate the status of the claim for this character position as follows:

- **"P"** for paid encounters
- **"D"** for denied encounters
- If any other characters are submitted, the Plan must provide a data dictionary.

Character 3-4: Vendor information

- **"MR"** for (Administrative) Management Review
- **"CR"** for Clinical Review

Encounter Reporting of Financial Fields

DHH requires the Plan to report the following financial fields:

Header and Line Item Submitted Charge Amount — The Plan shall report the provider's charge or billed amount. The value may be "$0.00" if the Plan contract with the provider is capitated and the 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 fee-for-service (FFS) basis. The maximum charge or billed amount that can be submitted is 999999.99.

Header and Line Item PLAN Paid Amount — If the Plan paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the 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 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-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-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.

Interest Paid Amount

When the Plan pays Claim Interest, the Plan is required to submit the Plan's Claim Interest Amount and Paid Date in 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 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. If the last four (4) digits of the zip code are unknown, then the Plan may substitute "9999".

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.

Billing Provider's Patient Control Number

For all encounters submitted on and after 4/1/2015, including encounters for DOS beginning 7/1/2014, the Billing Provider Patient Control Number (PAT-Ctrl-No) is to be populated in Loop 2300 CLM01.

Encounters for Paper Claims Submissions

The following guidelines apply to encounter records submitted for paper claims.

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

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

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

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

Section 4
Repairable Denial Edit Codes and Descriptions

Introduction

DHH modified edits for dental encounter processing. A list of these edits can be found in **Appendix F** of this Guide.

Encounter Correction Process

On a weekly basis, DHH's FI will send edit code reports (CP-0-90) 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. Encounter edit reports are identified in **Appendix D**.

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.

Section 5
Electronic Data Interchange (EDI) Certification and Testing

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

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/HIPAA/5010v_HIPAA_Index.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 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**)

Section 6
Data Management of File and Encounter Submissions

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. At the FI's Electronic Data Interchange, there are four (4) Front-end levels at which edits are present:

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

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

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

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.

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

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

Claim

999 Level (Entire File)

EDI files 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. EDI file problems reported at the 999 level are reported in ASC X12 999 transaction set format. EDI files that receive a rejected 999 will need to be resubmitted using a new Interchange Control Number (ISA13) value.

Service Line

Pre-Processor Level (Entire File)

Data that passes the FI's edits and receive an accepted 999 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. LA Medicaid data content specifications are listed in Companion Guides located on the LAMedicaid website:
(www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm). Depending upon the level of edit, an individual encounter may deny at the header or at a single detailed line. If there is a problem at the Pre-processor level, the submitter is notified by the FI's EDI Department and the entire EDI file is not processed any further. EDI files that hit Pre-processor level edits will need to be resubmitted using a new Interchange Control Number (ISA13) value.

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

A comprehensive list of encounter edits including the disposition; list of repairable edits and a list of non-repairable edits are located in Appendix F. After processing, an 835 Remittance Advice is returned to the sender.[1]

Correction of File and Encounter Errors

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 Rejection

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

- For EDI File Encryption rejections, the absence of a TA1 is the notification of a problem at this level.
- For TA1 rejections, the TA1 transaction reports the details of the problem.
- For 999 rejections, the 999 transaction reports the details of the problem.
- For Pre-processor rejections, the FI's EDI Department will notify the MCO submitter either by phone or email.
- The Plan is required to work with the FI's Business Support Analysts to determine the cause of the error.

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

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

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

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.

EDI Resolution of 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.

EDI 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:

- the FI acknowledges to be the result of its own error, and
- 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.

Section 7
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.

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.

Section 8

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/HIPAA/5010v_HIPAA_Index.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** To adjust a previously submitted claim, submit a value of "**7**". See also 2300/REF02.
2300	REF01	128	**Reference Identification Qualifier** To adjust a previously submitted claim, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	**Original Reference Number** To adjust a previously submitted claim, 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.

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

Additional Encounter Requirements

Transformed Medicaid Statistical Information System (T-MSIS)

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

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

Additional information and updates will be provided to MCOs via this Guide as approved by DHH.

Section 9

Medicaid Administrative Retroactive Enrollment Correction Process

DHH has determined that in some instances, Administrative Retroactive Corrections to member linkages are necessary to ensure compliance with internal policies and the approved Medicaid state plan. These corrections, also known as retro, may address multiple months, and significantly impact paid claims and PMPMs. In an effort to correct audit trails, the following processes have been implemented:

- On or about the 5th of every month, DHH and Molina will review all changes made by the Plan for the prior month, to identify retro disenrolled excluded populations, identify paid claims, and associated adjustments needed to PMPMs.
- Based on this review, mid-month Molina will void identified Legacy claims paid by an incorrect entity, with denial reason code 999 – Administrative Correction, and providers will receive notice via 835s.
- Providers must check MEVS to obtain correct entity information based on the date of service. Please note that MEVs only returns information for one year from the date of service, but REVs may be used for anything older than one year from the date of service.
- A monthly report of affected members is given to all MCOs and Molina Provider Relations. This report includes detailed information to assist MCOs in anticipating claims which should be billed to them for their retro enrolled members including:
    - Member name, Medicaid ID and voided claim detail;
    - If applicable, original authorization (PA and Pre-cert) numbers;
    - Identification of the entity that paid the original claim; and
    - Identification of the correct entity responsible for prior paid claims due to the retro enrollment.
- The correct entity (MCO or Molina) must accept and honor authorizations (PA or Pre-cert) approved by the prior incorrect entity (unless the original authorization violates state or federal regulations), and payment shall be made whether provider is in-or out-of-network.
- Providers are required to submit **paper/hard copy** claims to the corrected entity (MCO or Molina) no later than 6 months from the date the claim is voided and:
    - Providers will not be required to obtain authorization (PA or Pre-cert) for these claims.
    - Providers must attach documentation supporting the void.

- Claims cannot be denied for failure to meet timely filing, unless the claim is received more
- than 6 months after the date the claim is voided.

MCOs shall, within 30 days of receipt of retro disenrollment notice (via daily, weekly or reconciliation 834s from Molina) perform recoupment processes of inappropriately paid claims.

Medicare Recovery Process

On a monthly basis, the FI runs a query to identify Managed Care members who have retrospectively enrolled in Medicare and do not have Medicaid Coverage in the same month. Once members have been identified, the FI generates and processes voids to recover the PMPM payments made on behalf of these members to a MCNA. The FI will generate an 820 file with detailed information regarding the voids. The 820 file format is located in Appendix D. MCNA will receive a CP-0-12D report which identifies the retrospectively enrolled members for which PMPM payments were made, and the 820 file which is placed on the MCNA's FTP site for retrieval.

Upon receipt of the 820 file, MCNA must notify the provider of the disenrollment prior to recovery of payments made to the provider.

Section 10

PMPM Payment Recovery for Duplicate Recipient Medicaid IDs

DHH identified instances in which Medicaid Members are assigned more than one Medicaid ID. Medicaid performs retrospective reviews to identify and invalidate duplicate member Medicaid ID(s). In some instances, duplicate member IDs have resulted in duplicate PMPM payments.

The Fiscal Intermediary (FI) will effectively begin a monthly PMPM recovery process for duplicate PMPM payments made to Valid (Current) ID and Invalid ID for same date of service.

The FI will modify the 820 to include the Invalid ID from which the recovery is being made and the Valid ID. The Valid ID will be added in the “ref loop” of the 820.

The FI will send MCNA a daily recipient valid-invalid crosswalk file. The File Name is as follows: **Recipient Voided IDs.txt**. The Recip-Multple-ID-Record Layout can be found in **Appendix S**.

MCNA should use recipient valid-invalid daily file **Recipient Voided IDs. Txt** to crosswalk the invalid ID to valid ID. The FI will generate a new report identifying recoveries for MCNA using the same format and using the same data elements as designated in the original file.

MCNA shall not recover provider claim payments for Invalid IDs unless duplicate claim payments are identified (same claim paid to both Invalid and Valid ID).

Appendix A

Definition of Terms

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

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
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 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 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.

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.
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.

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

	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 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 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: • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the Health Plan from the provider and/or switch vendor until the Health Plan hands-off a response to the provider and/or switch vendor.
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.

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.

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 III.19.E.3.e of the DBP 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
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.

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.

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.

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

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	1	Character

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

Column(s)	Item	Notes	Length	Format
121-125	Precert Level of Care (this field should be blank for PA transactions)	GEN ICU NICU REHAB PICU CCU TU=Telemetry LT=LTAC	5	Character
126	Delimiter		1	Uses the ^ character value
127-136	PA Line Occurs	The units approved on the line item, if applicable	10	Numeric
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
149-157	Line Amount Requested	The dollar amount requested on the line item, if applicable.	9	Numeric, with decimal and left-zero fill.
158	Delimiter		1	Uses the ^ character value
159-168	Line Occurs Used	For an approved PA or Precert line item, this field contains any amount used as a result of	10	Numeric, with decimal and left-zero fill.

Column(s)	Item	Notes	Length	Format
		claims processing		
169	Delimiter		1	Uses the ^ character value
170-179	Line Amount Used	The dollar amount paid-out as a result of claim payments on the PA.	10	Numeric, with decimal and left-zero fill.
180	Delimiter		1	Uses the ^ character value
181-190	Line Amount	The dollar amount approved on the line item, if applicable.	10	Numeric, with decimal and left-zero fill.
191	Delimiter		1	Uses the ^ character value
192	Tooth Code	Tooth Code associated with Dental PA requests	2	Character
194	Delimiter		1	Uses the ^ character value
195	Oral Cavity Designator	Oral cavity indicator/code associated with Dental PA requests.	2	Character
197	Delimiter		1	Uses the ^ character value
198	PA Diagnosis ICD 10	Future use. Blank at this time.	8	Character
205	Delimiter		1	Uses the ^ character value

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 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.

820 File (FI to DBP)

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

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

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

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

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
BPR=Financial Information					
Sample: BPR*I*12345678.90*C*NON******1234567890******20150315~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON=Non-payment 820	S
		BPR05	Payment Format Code	NOT USED	
		BPR06	(DFI) ID Number Qualifier	NOT USED	
		BPR07	(DFI) Identification Number	NOT USED	
		BPR08	Account Number Qualifier	NOT USED	
		BPR09	Account Number	NOT USED	
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	NOT USED	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		BPR13	(DFI) Identification Number	NOT USED	
		BRP14	Account Number Qualifier	NOT USED	
		BPR15	Account Number	NOT USED	
		BPR16	EFT Effective Date	Expressed CCYYMMDD	D
TRN=Re-association Trace Number					
Sample: TRN*3*1123456789*1234567890*~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver's Identification Key					
Sample: REF*18*123456789*CCN Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	D
		REF03	Description	'CCN Fee Payment' or	S
				'CCN Kick Payment'	
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	D
DTM=Delivery Date					
Sample: DTM*035*20120103~					

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	D
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*CCN-S of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	S
	1000A	N102	Name	Information Receiver Last or Organization Name	D
	1000A	N103	Identification Code Qualifier	"FI" – Federal	S
	1000A	N104	Identification Code	Receiver Identifier	D
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*LA-DHH-MEDICAID*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	S
	1000B	N102	Name	Premium Payer Name	S
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	S

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

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	2100B	NM104	Name First	Individual First Name	D
	2100B	NM105	Name Middle	Individual Middle Initial	D
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Individual Identifier	S
	2100B	NM109	Identification Code	Individual Identifier – Recipient ID number	D
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*11*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	S
	2300B	RMR02	Reference Identification	Claim ICN (Molina internal claims number).	D
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	D

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
REF=Reference Information (1st occurrence)					
Sample: REF*ZZ*001~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Capitation Code	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (2nd occurrence) – used only for duplicate recipient recoveries					
Sample: REF*ZZ*001~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Current Recipient ID of the correct record (used only for duplicate recipient recoveries)	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" - Report Period	S
	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	"RD8" – Range of Dates	S
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	D
Transaction Set Trailer					
Sample: SE*39*0001~					
	SE	SE01	Transaction Segment Count		D
		SE02	Transaction Set Control Number		D
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					

An adjustment of a previous original administrative fee payment will be shown as two 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

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

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

An example of the E-CP-O-90-D can be found below.

LAM2D070 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: E-CP-0-90-D
RUN: 07/01/14 20:41:23 DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF) PAGE: 1
CYCLE: 07/01/14 DENIED ENCOUNTER ERROR ANALYSIS
45XXXXX MCO

ERROR CODE	ERROR DESCRIPTION	HOSP 01	LTC 02	OPAT 03	PHY 04	RHAB 05	HH 06	AMBL 07	NAMB 08	DME 09	DNTLE 10	DNTL 11	RX 12	EPSDT 13	18-I 14	18-P 15	ADC 16	HAB 17	HMKR 18	TOTAL
103	INV TOOTH/CAVITY CDE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
130	DENY PROV. 9999999	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
134	ENC DENIED BY PLAN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201	PROVIDER NOT ELIG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
202	PROV CLAIM TYP CONFL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
216	RECIPIENT NOT ELIG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
304	RECIP NOT IN DBP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
313	SUBMIT TO FI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
349	INVALID TYPE CASE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
544	CT NOT COV FP _____	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
613	INV TOOTH/CAVITY CDE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
719	EMERG_COMB_XRAY_ONLY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
775	PAY CUT SAME TOOTH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
840	EXACT DUPE 10 TO 10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
842	EXACT DUPE 11 TO 11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	***** TOTAL *****	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Encounter EOB Analysis – E-CP-O-90-E

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

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

LAM2D070 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: E-CP-0-90-E
RUN: 07/01/14 20:41:23 DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF) PAGE: 1
CYCLE: 07/01/14 ENCOUNTER EOB ANALYSIS
45XXXXX MCO

ERROR CODE	ERROR DESCRIPTION	HOSP 01	LTC 02	OPAT 03	PHY 04	RHAB 05	HH 06	AMBL 07	NAMB 08	DME 09	DNTLE 10	DNTL 11	RX 12	EPSDT 13	18-I 14	18-P 15	ADC 16	HAB 17	HMKR 18	TOTAL
022	INVALID BILLED CHRGS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
136	NO ELIG SERVICE PAID	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
232	PROCEDURE CODE NOF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
233	P/F DATE RESTRICTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
234	P/F AGE RESTRICTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
299	PROC/DRUG NOTCOVERED	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
602	SURFACE CODE CONF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
603	TOOTH/CAVITY CDE REQ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	***** TOTAL *****	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Standard Recipient Files

Overview of Recipient Files

Daily and weekly recipient extracts use the same file layout. For each recipient included in the extracts, there will always be a single Header record for that Recipient. There is a 0 to 1 to many possibility for the other recipient record types. For instance, if a recipient does not have a LTC record in the master files, the extract will not have a LTC record for that Recipient. Also, if a recipient has multiple eligibility records, the extract will have multiple records for that Recipient. All file layouts are based on a fixed length field fixed length file. Daily extracts will be delivered Monday – Thursday nights, and either Saturday or Sunday. Full weekly extracts are delivered either Saturday or Sunday.

Recipient Header

01	EB-RECIPIENT-HEADER.	
05	RECIP-ID-CURRENT	PIC X(13).
05	RECIP-ID-ORIGINAL	PIC X(13).
05	RECIP-HIC	PIC X(12).
05	RECIP-SSN	PIC X(09).
05	RECIP-LAST-NAME	PIC X(12).
05	RECIP-FIRST-NAME	PIC X(12).
05	RECIP-MID-INITIAL	PIC X(01).
05	RECIP-RECIP-TITLE	PIC X(03).
05	RECIP-RECIP-SUFFIX	PIC X(03).
05	RECIP-PREVIOUS-LAST-NAME	PIC X(12).
05	RECIP-PREVIOUS-FIRST-NAME	PIC X(12).
05	RECIP-PREVIOUS-MID-INITIAL	PIC X(01).
05	RECIP-ADDR-LN1	PIC X(25).
05	RECIP-ADDR-LN2	PIC X(25).
05	RECIP-CITY	PIC X(18).
05	RECIP-STATE	PIC X(02).
05	RECIP-ZIP-CODE	PIC 9(09).
05	RECIP-BIRTH-DATE	PIC 9(08).
05	RECIP-SEX	PIC X(01).
05	RECIP-RACE	PIC X(01).
05	RECIP-DATE-OF-DEATH	PIC 9(08).
05	RECIP-DATE-OF-CERTIF	PIC 9(08).
05	RECIP-DATE-OF-APPLIC	PIC 9(08).
05	RECIP-DATE-OF-LAST-ACTIVITY	PIC 9(08).
05	RECIP-GROSS-INCOME	PIC 9(05).
05	RECIP-FAMILY-SIZE	PIC 9(03).
05	RECIP-SEX-OVERRIDE-IND	PIC X(01).
05	RECIP-EPSDT-TRACKING-INDIC	PIC 9(01).
05	RECIP-EPSDT-SIGNATURE-DATE	PIC 9(08).
05	RECIP-DX-DISCHRG-DATE	PIC 9(08).

```
05  RECIP-LTC-REVIEW-DATE                  PIC 9(08).
05  RECIP-RECIP-EXCP-IND                   PIC X(01).
05  RECIP-SOURCE-OF-INPUT                  PIC X(01).
05  RECIP-TEL-NO                           PIC 9(10).
05  RECIP-PBS-BEG-DATE                     PIC 9(08).
05  RECIP-PBS-END-DATE                     PIC 9(08).
05  RECIP-CASE-MANAGER                     PIC X(07).
05  RECIP-PID-CARD-NO                      PIC 9(16).
05  RECIP-MOTHER-PERSON-ID                 PIC X(13).
05  RECIP-HEAD-OF-HOUSEHOLD-NAME.
    10  RECIP-HOH-LAST-NAME                PIC X(12).
    10  RECIP-HOH-FIRST-NAME               PIC X(12).
    10  RECIP-HOH-MIDDLE-INIT              PIC X(1).
05  RECIP-HEAD-OF-HOUSEHOLD-SSN            PIC X(9).
05  RECIP-PREFERRED-LANGUAGE-IND           PIC X(2).
05  RECIP-EXP-ADDR-LN1                     PIC X(35).
05  RECIP-EXP-ADDR-LN2                     PIC X(35).
05  RECIP-EXP-ADDR-LN3                     PIC X(35).
05  RECIP-EXP-CITY                         PIC X(20).
05  RECIP-EXP-STATE                        PIC X(02).
05  RECIP-EXP-ZIP-CODE                     PIC 9(09).
05  RECIP-EXP-LAST-NAME                    PIC X(25).
05  RECIP-EXP-FIRST-NAME                   PIC X(20).
05  RECIP-EXP-MID-INITIAL                  PIC X(01).
05  RECIP-EXP-RECIP-TITLE                  PIC X(03).
05  RECIP-EXP-RECIP-SUFFIX                 PIC X(03).
05  RECIP-EXTRA-PHONE1                     PIC 9(10).
05  RECIP-EXTRA-PHONE2                     PIC 9(10).
05  RECIP-PHY-ADDRESS-1                    PIC X(35).
05  RECIP-PHY-ADDRESS-2                    PIC X(35).
05  RECIP-PHY-ADDRESS-3                    PIC X(35).
05  RECIP-PHY-CITY-REC2                    PIC X(20).
05  RECIP-PHY-STATE-REC2                   PIC X(02).
05 RECIP-PHY-ZIP-REC2                     PIC X(09).
05 RECIP-EMAIL-ADDRESS                    PIC X(50)
05 RECIP-CURR-PARISH                      PIC X(02)
```

Recipient SURS LockIn

```
01  EB-SURS-LOCKIN-DETAIL.
    05  SURS-LOCKIN-ID-CURR                PIC X(13).
    05  SURS-LOCKIN-ID-ORIG                PIC X(13).
    05  SURS-LOCKIN-IND                    PIC X(01).
    05  SURS-LOCKIN-PHYSICIAN-1            PIC X(07).
```

```
05  SURS-LOCKIN-PHYSICIAN-2          PIC X(07).
05  SURS-LOCKIN-PHYSICIAN-3          PIC X(07).
05  SURS-LOCKIN-PHYSICIAN-4          PIC X(07).
05  SURS-LOCKIN-PHARMACY-1           PIC X(07).
05  SURS-LOCKIN-PHARMACY-2           PIC X(07).
05  SURS-LOCKIN-BEGIN                PIC 9(08).
05  SURS-LOCKIN-END                  PIC 9(08).
05 SURS-LOCKIN-LAST-ACT               PIC 9(08).
```

Recipient Eligibility

```
01  EB-ELIGIBILITY-DETAIL.
    05  ELIG-ID-CURR                 PIC X(13).
    05  ELIG-ID-ORIG                 PIC X(13).
    05  ELIG-BEGIN-DATE              PIC 9(08).
    05  ELIG-END-DATE                PIC 9(08).
    05  ELIG-AID-CATEGORY            PIC X(02).
    05  ELIG-TYPE-CASE               PIC 9(03).
    05  ELIG-CANCEL-RSN              PIC 9(03).
    05  ELIG-MONEY-CODE              PIC 9(01).
    05  ELIG-MEDS-CASE-ID            PIC 9(13).
    05  ELIG-MEDS-SEQ-ID             PIC 9(05).
    05  ELIG-APPROVAL-CODE           PIC X(03).
    05  ELIG-BUDGET-AID              PIC X(01).
    05  ELIG-SEG-ADD-DATE            PIC 9(08).
    05  ELIG-LAST-ACT-DATE           PIC 9(08).
```

Recipient Other Insurance Detail

```
01  EB-OTHER-INS-DETAIL.
    05  OTHER-INS-RECIP-ID-CURR      PIC X(13).
    05  OTHER-INS-RECIP-ID-ORIG      PIC X(13).
    05  OTHER-INS-TYPE               PIC X(02).
    05  OTHER-INS-COMPANY-NUMBER     PIC X(06).
    05  OTHER-INS-SCOPE-OF-COVERAGE  PIC X(02).
    05  OTHER-INS-MEDICARE-HIC-NO    PIC X(12).
    05  OTHER-INS-BEGIN-DATE         PIC 9(08).
    05  OTHER-INS-END-DATE           PIC 9(08).
    05  OTHER-INS-GROUP-NO           PIC X(15).
    05  OTHER-INS-POLICY-NO          PIC X(13).
    05  OTHER-INS-POLICY-HOLDER-NAME PIC X(20).
    05  OTHER-INS-POLICY-HOLDER-SSN  PIC X(09).
    05  OTHER-INS-AGENT-NAME         PIC X(25).
    05  OTHER-INS-AGENT-PHONE        PIC X(10).
    05  OTHER-INS-AGENT-STREET       PIC X(25).
    05  OTHER-INS-AGENT-CITY         PIC X(20).
```

```
           05  OTHER-INS-AGENT-STATE              PIC X(02).
           05  OTHER-INS-AGENT-ZIP                PIC X(9).
```

Recipient CCN Linkages Data.

```
       01  EB-CCN-PACE-LINKAGE.
           05  CCN-LINKAGE-RECIP-ID-CURR          PIC X(13).
           05  CCN-LINKAGE-RECIP-ID-ORIG          PIC X(13).
           05  CCN-LINKAGE-ENROLL-TYPE            PIC X(01).
           05  CCN-LINKAGE-PLAN-PROV-ID           PIC 9(07).
           05  CCN-LINKAGE-BEGIN-DATE             PIC 9(08).
           05  CCN-LINKAGE-END-DATE               PIC 9(08).
           05  CCN-LINKAGE-LAST-ACT-DATE          PIC 9(08).
           05  CCN-LINKAGE-COV-ACTION-CODE        PIC X(02).
           05  CCN-LINKAGE-DISENROLL-REASON       PIC 9(03).
           05  CCN-LINKAGE-SRC-CHG                PIC X(02).
           05  CCN-LINKAGE-GEO-CODE               PIC X(01).
           05  CCN-LINKAGE-AA-IND                 PIC X(01).
           05  CCN-LINKAGE-EB-ID                  PIC 9(09).
```

Recipient Hospice Data

```
       01  EB-HOSPICE-DATA.
           05  HSP-OUT-RECIP-ID-CURR              PIC X(13).
           05  HSP-OUT-RECIP-ID-ORIG              PIC X(13).
           05  HSP-OUT-ENTITLE-DATE               PIC 9(8).
           05  HSP-OUT-BEGIN-DATE                 PIC 9(8).
           05  HSP-OUT-END-DATE                   PIC 9(8).
           05  HSP-OUT-DIAG1                      PIC X(5).
           05  HSP-OUT-DIAG2                      PIC X(5).
           05  HSP-OUT-CLOSURE-CODE               PIC X(3).
           05  HSP-OUT-PROV                       PIC 9(7).
           05  HSP-OUT-HOSPICE-TYPE               PIC X(2).
           05  HSP-OUT-PERIOD-IND                 PIC X(1).
           05  HSP-OUT-ICD10-1                    PIC X(7).
           05  HSP-OUT-ICD10-2                    PIC X(7).
```

Recipient LTC Data

```
       01  EB-LTC-DATA.
           05  LTC-RECIP-ID-CURR                  PIC X(13).
           05  LTC-RECIP-ID-ORIG                  PIC X(13).
           05  LTC-BEGIN-DATE                     PIC 9(8).
           05  LTC-END-DATE                       PIC 9(8).
           05  LTC-LOC                            PIC X(5).
```

```
05  LTC-PROV                    PIC 9(7).
05  LTC-ADMISSION-DATE          PIC 9(8).
05  LTC-DISCHARGE-DATE          PIC 9(8).
05  LTC-WAIVER-TYPE-CASE        PIC 9(3).
05  LTC-SECONDARY-TC            PIC X(03).
05  LTC-SECONDARY-LOC           PIC X(02).
05 LTC-CANCEL-CODE              PIC X(03).
05  LTC-WAIVER-LOC              PIC X(02).
```

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 may be included in this Guide upon completion)

DENTAL BENEFIT PLAN REPORT GRID

MONTHLY
Post Payment Recoveries (existence of TPL)- M
Member Service Call Center M
Marketing and Member Education Materials Distributed- M
Grievance, Appeal and Fair Hearing Log- M
Claims Payment Accuracy Report- M
Denied Claims Report- M
Provider Call Center- M
Provider Complaint & Appeal Summary Report- M
QAPI Early Warning System Performance Measures- M
Claims Payment Summary – M
QUARTERLY
EPSDT Report (CMS 416)- Q/A
UM Committee Meeting Minutes- Q
Utilization Management Medical Record Review Report- Q
QAPI PCP Profile Reports- Q
PCD Linkages- Q
Grievance, Appeal and Fair Hearing Log
Grievance, Appeal and Fair Hearing Log (redacted Q/A)
QAPI Committee (minutes)- Q
Member Advisory Council (minutes)- Q
Fraud and Abuse Activity Report- Q
Claims Processing Interest Payments- Q

PA Summary- Q
Network Adequacy Review- Q
ANNUAL
Key Staff Organizational Listing- A
Functional Organizational Chart-Location Listing and Key Staff Job Description-A
NW Provider Development Management Plan – A
Utilization Management Dental Record Review Strategy- A
Marketing Activities Annual Review- A
QAPI Program Description and Work Plan- A
QAPI Performance Reporting Measures -** Template not provided. Will accept Health Plans' corporate standard.*
QAPI Performance Improvement Projects (descriptions)- A
QAPI Performance Improvement Projects (outcomes)- A
Member Satisfaction Survey Report A
Provider Satisfaction Survey Report- A
Systems Refresh Plan- A
Emergency Management Plan- A
Back-up File List- A
Annual Audited Financial Statement- A
Independent-Subcontractor EDP Audit (SSAE16)- A
QAPI Impact and Effectiveness of QAPI Program Evaluation- A

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.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS per DHH guidelines,
- Encounter contains a fatal error that results in its Denial.

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
1	20140701	D	INVALID CLM TYP MOD	INVALID CLAIM TYPE MODIFIER
2	20140701	D	INVALID PROVIDER NO	PROVIDER NUMBER MISSING OR NOT NUMERIC
3	20140701	D	RECIPIENT # INVALID	RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
5	20140701	D	INVAL SERV FROM DATE	SERVICE FROM DATE MISSING/INVALID
6	20140701	D	INVAL SERV THRU DATE	INVALID OR MISSING THRU DATE
7	20140701	D	SERV THRU LT SERV FM	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
8	20140701	D	SERV FRM GT ENTR DTE	SERVICE FROM DATE LATER THAN DATE PROCESSED
9	20140701	D	SERV THR GT ENTR DTE	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
13	20140701	D	ORG CLM W ADJ/VD ICN	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
15	20140701	D	INVALID ACCIDENT IND	ACCIDENT INDICATOR MUST BE Y,N,SPACE
16	20140701	D	INVALID ACCID IND	ACCIDENT INDICATOR NOT Y, N OR SPACE
17	20140701	D	INVALID EPSDT IND	EPSDT INDICATOR NOT Y, N, OR SPACE

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
20	20140701	D	INVAL/MISS DIAG CODE	INVALID OR MISSING DIAGNOSIS CODE
21	20140701	D	INVALID FORMER REFNO	FORMER REFERENCE NUMBER MISSING OR INVALID
22	20140701	E	INVALID BILLED CHRGS	BILLED CHARGES MISSING OR NOT NUMERIC
23	20140701	D	INV PARTIAL RECIP	RECIPIENT NAME IS MISSING
24	20140701	D	INV BILLING PROV NO	BILLING PROVIDER NUMBER NOT NUMERIC
30	20140701	E	SERV THRU DT TOO OLD	SERV THRU DATE MORE THAN TWO YEARS OLD
35	20140701	D	REBILL CORRECT HCPC_	ASC,OP FAC/PHYS.BILLED DIFF CODE;REBILL CORRECT HCPC
40	20140701	D	INV ADMISSION DATE	ADMISSION DATE MISSING OR INVALID
43	20140701	D	INV ATTENDING PHYS	ATTENDING PHYSICIAN NUMBER NOT NUMERIC
44	20140701	E	INV NATURE OF ADMIT	NATURE OF ADMISSION MISSING OR INVALID
45	20140701	D	INV PATIENT STATUS	PATIENT STATUS CODE INVALID OR MISSING
46	20140701	D	INV PATIENT STAT DTE	PATIENT STATUS DATE MISSING OR INVALID
47	20140701	D	PAT STAT DTE GT THRU	PATIENT STATUS DATE GREATER THAN THRU DATE
48	20140701	D	INVALID/MISS PROC	INVALID OR MISSING PROCEDURE CODE
49	20140701	D	INV/CONFLIC SURG DTE	INVALID/CONFLICT SURGICAL DATE
53	20140701	E	INV ACCOMODATION DAY	ACCOMODATION DAYS MISSING OR INVALID
55	20140701	E	INV ACCOM/ANCILL CHG	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID
60	20140701	E	INVALID COVERED DAYS	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING
63	20140701	E	INVALID TOTAL CHARGE	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
64	20140701	E	INVALID NET AMOUNT	THE NET BILLED AMOUNT IS NOT NUMERIC

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
67	20140701	E	INVALID NON-COVERED	NON COVERED HOSP DAYS NOT NUMERIC OR MISSING
68	20140701	E	INV POINT ORIGIN	INVALID POINT OF ORIGIN
69	20140701	D	INV OCCUR DATE	INVALID OCCURRENCE DATE
71	20140701	D	INV STMT COVERS FROM	STATEMENT COVERS FROM DATE INVALID
72	20140701	D	INV STMT COVER THRU	STATEMENT COVERS THRU DATE INVALID
73	20140701	D	STMT FRM LT SERV FRM	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
74	20140701	D	STMT THRU GT SRV THR	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
81	20140701	D	INVALID STATUS DATE	INVALID OR MISSING PATIENT STATUS DATE
82	20140701	D	INVALID STATUS CODE	INVALID PATIENT STATUS CODE
84	20140701	E	INVALID TREAT PLACE	INVALID OR MISSING PLACE OF TREATMENT
93	20140701	E	REVENUE CODE MISSING	REVENUE CODE MISSING/INVALID
94	20140701	D	MISSING PINTS BLOOD	MISSING PINTS BLOOD
97	20140701	E	NON-COVCHG > BILLCHG	NON-COVERED CHARGES EXCEED BILLED CHARGES
102	20140701	D	INVALID SURFACE	INVALID TOOTH SURFACE CODE
103	20140701	D	INV TOOTH/CAVITY CDE	INVALID TOOTH CODE/ORAL CAVITY DESIGNATOR
108	20140701	E	PRV TYPE AGE RESTRIC	PROV TYPE SERVICES NOT COVERED FOR RECIPIENT THIS AGE
115	20140701	E	HCPC CD NOT ON FILE	HCPC CODE NOT ON FILE
120	20140701	D	QTY INVALID/MISSING	QUANTITY INVALID/MISSING
127	20140701	D	MISSING NDC	NDC CODE MISSING OR INCORRECT.
130	20140701	D	DENY PROV. 9999999	ALL PROVIDERS 9999999 TO BE DENY.
131	20140701	D	PRIMARY DX NOF	PRIMARY DIAGNOSIS NOT ON FILE
132	20140701	E	SECONDARY DX NOF	SECONDARY DIAGNOSIS NOT ON FILE

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
134	20140701	D	ENC DENIED BY PLAN	DENIED ENCOUNTER SUBMITTED BY PLAN
136	20140701	E	NO ELIG SERVICE PAID	NO ELIGIBLE SERVICE PAID - ENCOUNTER DENIED
141	20140701	D	REFILL OVR 12 MONTHS	REFILL NOT FILLED WITHIN 12 MONTHS
180	20140701	D	INVALID ADMIT DATE	THE ADMISSION DATE WAS NOT A VALID DATE
183	20140701	D	SURGERY PROC NOF	SURGICAL PROCEDURE NOT ON FILE
186	20140701	D	USE CORRECT MODIFIER	CRNA'S MUST BILL CORRECT MODIFIER
200	20140701	D	PROV/ATTEND NOF	PROVIDER/ATTENDING PROVIDER NOT ON FILE
201	20140701	E	PROVIDER NOT ELIG	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
202	20140701	D	PROV CLAIM TYP CONFL	PROVIDER CANNOT SUBMIT THIS TYPE CLAIM
203	20140701	E	PROVIDER ON REVIEW	PROVIDER ON REVIEW
206	20140701	D	BILL PROV NOT ON FIL	BILLING PROVIDER NOT ON FILE
210	20140701	E	PROV PROC CONFLICT	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
211	20140701	D	DOS LESS THAN DOB	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	20140701	D	RECIPIENT NOT ON FIL	RECIPIENT NOT ON FILE
216	20140701	D	RECIPIENT NOT ELIG	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
217	20140701	E	RECIP NAME MISMATCH	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD
222	20140701	D	SVC OVERLAPS REC ELI	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
223	20140701	D	RECYC RECIP N/O FILE	RECYCLED RECIPIENT NOT 0N FILE
231	20140701	E	NDC NOT ON P/F FILE	NDC CODE NOT ON FILE
232	20140701	E	PROCEDURE CODE NOF	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
233	20140701	E	P/F DATE RESTRICTION	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
234	20140701	E	P/F AGE RESTRICTION	P/F AGE RESTRICTION
235	20140701	E	P/F SEX RESTRICTION	P/F SEX RESTRICTION
237	20140701	E	P/F PROV SPEC RESTRT	P/F PROVIDER SPECIALTY RESTRICTION
248	20140701	D	DELETED,BILL CURR CD	DELETED,BILL CURRENT CODE
252	20140701	D	DIAGNOSIS NOT ON FIL	DIAGNOSIS NOT ON FILE
254	20140701	E	DIAG AGE RESTRICTION	DIAGNOSIS AGE RESTRICTION
255	20140701	E	DIAG SEX RESTRICTION	DIAG SEX RESTRICTION
258	20140701	D	SPAN DATES/QUANT DIF	DIFFERENCE BETWEEN SERVICE DATES AND QUANT
263	20140701	E	PROCEDURE-AGE-RESTRT	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
266	20140701	D	INVALID AMB SURG REV	REV CODE INVALID FOR AMBULATORY SURG PROC.
267	20140701	D	REQ-ICD9-SURGICAL-CD	REVENUE CODE 490 REQUIRES VALID ICD9 SURGICAL PROCEDURE
272	20140701	E	CLAIM OVER 1 YEAR	CLAIM EXCEEDS 1 YEAR FILING LIMIT
273	20140701	E	TPL/PRIVATE	3RD PARTY CARRIER CODE MISSING-REFER TO CARRIER CD.LIST
275	20140701	E	RECIP MEDICARE ELIG	RECIPIENT IS MEDICARE ELIGIBLE
278	20140701	E	RECIP ELIG MEDICARE	RECIPIENT POSSIBLY ELIGIBLE FOR MEDICARE
279	20140701	E	PROF COMP INVLD POT	INVALID PLACE OF TREATMENT FOR PROF COMP
289	20140701	D	INV DENY FOR PROV NO	INVALID PROVIDER NUMBER WHEN DENY APPLIED
295	20140701	D	RECIP RECYC 3 TIMES.	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
299	20140701	E	PROC/DRUG NOTCOVERED	PROC/DRUG NOT COVERED BY MEDICAID

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
304	20140701	D	NOT USED - AVAILABLE	NOT USED - AVAILABLE
307	20140701	D	SURG PROC MISSING	SURGICAL PROCEDURE MISSING
309	20140701	D	SURG DATE MISSING	DATE OF SURGERY MISSING
310	20140701	D	SURG DTE LT SRV FROM	DATE OF SURGERY LESS THAN SERVICE FROM DATE
318	20140701	D	SUSP CON MIS/REQ-RF2	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL 2
319	20140701	D	SUSP CON MIS/REQ-RF3	SUSPECTED CONDITION MISSING REQUIRED FOR REFERRAL 3
329	20140701	E	CLIA NOT CERT DOS	CLIA # DOES NOT COVER DATE OF SERVICE
330	20140701	D	QMB NOT MED. ELIG.	QMB NOT MEDICAID ELIGIBLE
339	20140701	D	OCCUR DATES CONFLICT	OCCUR CODES/DATES CONFLICT
340	20140701	E	SPAN DAYS CONFLICT	SPAN DAYS/NON COVERED DAYS CONFLICT
349	20140701	D	INVALID TYPE CASE	RECIPIENT NOT COVERED FOR THIS SERVICE
364	20140701	D	RECIP INELIG/DECEASE	RECIPIENT INELIGIBLE/DECEASED
386	20140701	E	NOT PAY W/CLIA CERT	NOT PAYABLE WITH CLIA CERT TYPE
387	20140701	E	CLIA # NOT ON FILE	NO CLIA # ON OUR FILE
400	20140701	D	REFER PHYSICIAN REQD	REFERRING/ATTENDING PHYSICIAN REQUIRED
401	20140701	E	CONCURRENT CARE	CONCURRENT CARE IS NOT COVERED BY THE PROGRAM
410	20140701	D	ENC LICN PREFIX ERROR	LICN PREFIX ON ENCOUNTER IS MISSING OR INVALID
414	20140701	E	ENC PLAN PMT DT ERR	PLAN PAYMENT DATE ON ENCOUNTER IS MISSING OR INVALID
416	20140701	E	ENC RCV DT ERROR	PLAN RECEIVE DATE ON ENCOUNTER IS MISSING OR INVALID
417	20140701	E	ENC INT PMT ERROR	INTEREST PAYMENT ON PLAN ENCOUNTER IS INVALID
433	20140701	D	MISSING/INVALID DIAG	MISSING/INVALID DIAGNOSIS CODE

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
444	20140701	D	M/I SERVICE PROVIDER	MISSING/INVALID SERVICE PROVIDER
475	20140701	E	QW MODIFIER NEEDED	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE
506	20140701	D	SUB PROV NON PAR BYU	SUBMIT TO RECIPIENTS SHARED PLAN
513	20140701	D	HCPCS REQ	HCPCS REQUIRED
522	20140701	E	MOTH/NEWBRN BILL SEP	MOTHER/NEWBORN MUST BE BILLED SEPARATE
539	20140701	E	CLAIM REQ DETAIL	CLAIM REQUIRES DETAILED BILLING
544	20140701	D	CT NOT COV FPW	CLAIM TYPE/FORMAT NOT COVERED BY THE FPW PROGRAM
545	20140701	D	REV CODE INVALID NDC	REVENUE CODE INVALID FOR REPORTING NDC INFO
550	20140701	E	NO MULTI - PROVIDERS	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	20140701	E	ATND PRV NOT LNK BYU	ATTENDING/SERVICING PROVIDER NOT LINKED TO BYU PLAN
563	20140701	D	ADJ-ADD-ON-WITH-51	ADJ ADD-ON CODE WITH 51 MOD THEN REBILL PRIMARY PROC
578	20140701	E	INV POS/MOD COMBO	INVALID PLACE OF SERVICE/PROCEDURE MODIFIER COMBINATION
601	20140701	D	ADULT DENTAL-UNDER21	ADULT DENTAL CLAIM FILED FOR RECIP UNDER 21
602	20140701	E	SURFACE CODE CONF	CLAIM DOES NOT INDICATE CORRECT NUMBER OF SURFACES
603	20140701	E	TOOTH/CAVITY CDE REQ	TOOTH CODE/ORAL CAVITY DESIGNATOR REQUIRED
604	20140701	D	EPSDT DENT AGE GR 21	EPSDT DENTAL CLAIM - RECIPIENT AGE GREATER THAN 21
613	20140701	D	INV TOOTH/CAVITY CDE	INVALID TOOTH CODE/ORAL CAVITY DESIGNATOR
618	20140701	E	URINALYSIS NOT BILLE	URINEALYSIS BILLED INCORRECTLY
631	20140701	D	EPSDT AGE ERROR	EPSDT AGE OVER 21

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
644	20140701	D	VISIT CODE PD/DOS	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
663	20140701	E	NO ABORTION DONE	ABORTION NOT DONE-FETUS NOT ALIVE AT TIME OF PROCEDURE
673	20140701	D	EVAL & MGT PD DOS	EVAL AND MGT CODE PAID FOR THIS DOS
675	20140701	D	VACCINE/ADM CONFLICT	VACC & ADM MUST PAY/AGREE;IF ONLY ONE PAYS TOTAL DENIES
676	20140701	D	PRIMARY CODE DENIED	PAYABLE ONLY IF PRIMARY CODE IS PAID
678	20140701	E	GLOBAL CODE PD	GLOBAL CODE PD THIS DOS THIS RECIP
679	20140701	E	COMPONENT CODE PD	COMPONENT CODE PD THIS DOS RECIP
680	20140701	E	ABORT PD MOTHER LIFE	ABORTION PAID MOTHERS LIFE ENDANGERED
695	20140701	D	HOSP DISCHARGE PAID	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
702	20140701	D	NEW PT/EST PT CD CON	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
704	20140701	D	ER VISIT/INP HOS SER	ER VISIT ON DATE OF INP HOS SERVICES
706	20140701	D	SEPARATE NB CARE CHG	FOLLOWUP NB CARE BILLED SEPARATELY
711	20140701	E	SAME SPEC/SUBSP PAID	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
712	20140701	D	INITIAL HOSP INPT PD	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
715	20140701	E	2ND. VISIT SAME DAY	FOUND DUPLICATE VISIT SAME DAY
716	20140701	D	PROC INCLUDED IN OV	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT
720	20140701	D	TO BE BILLED BY PROV	MUST BE BILLED BY PROVIDER OF SERVICE
721	20140701	E	SUR ASST NOT NEEDED	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST
735	20140701	D	PREV PD ANES-SAME RE	PREVIOUSLY PAID ANES.OR SUPERVISING ANES,SAME RECI/DOS

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
746	20140701	D	SAME ATTD PD IP CONS	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
748	20140701	D	1 DEL.ALLOW. 6MTH.SP	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN
749	20140701	D	DEL HYST/STER CONFLI	DELIVERY BILLED AFTER HYSTERECTOMY/STERLIZ WAS DONE
750	20140701	E	STERILIZATION INDIC_	FOUND PROC. 2 X INDICATES STERILIZATION
753	20140701	D	REBILL-DELIVERY	REBILL DELIVERY (DELIVERY-SURGERY) CODE & OFFICE VISIT
755	20140701	D	BILL AS ADJ/CNT STAY	THIS SHOULD BE BILLED AS ADJUST.FOR CNT STAY
757	20140701	D	ADJ PD LINE 51 MOD	ADJUST PAID LINE WITH 51 MODIFIER THEN RESUBMIT MAJOR
758	20140701	D	FND DUP SERV SM DAY	FOUND DUPLICATE SERVICE SAME DAY
777	20140701	E	ABORTION RAPE-PAID	ABORTION DUE TO RAPE PAID
781	20140701	E	MODIFIER NOT CORRECT	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL
789	20140701	E	ABORTION INCEST-PAID	ABORTION DUE TO INCEST PAID
794	20140701	D	INPT SER PD SAME ATT	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
796	20140701	D	ORIG/ADJ PROV DIFF	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
797	20140701	D	DUP ADJ. RECORD	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	20140701	D	HIST ALREADY ADJSTED	HISTORY RECORD ALREADY ADJUSTED
799	20140701	D	NO ADJ HISTORY	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
800	20140701	D	ON-LINE DUPE DENY	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	20140701	D	EXACT DUPE 01 TO 01	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
805	20140701	D	EXACT DUPE 03 TO 03	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
806	20140701	D	EXACT DUPE 03 TO 05	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
807	20140701	D	EXACT DUPE 03 TO 06	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
808	20140701	D	EXACT DUPE 03 TO 07	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE
810	20140701	D	EXACT DUPE 03 TO 09	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUIPMENT
813	20140701	E	EXACT DUPE 04 TO 04	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
815	20140701	E	EXACT DUPE 05 TO 05	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS
816	20140701	D	EXACT DUPE 05 TO 06	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH
817	20140701	D	EXACT DUPE 05 TO 07	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE
818	20140701	D	EXACT DUPE 05 TO 08	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANCE
819	20140701	D	EXACT DUPE 05 TO 09	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE EQUIP
822	20140701	D	EXACT DUPE 06 TO 06	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS
823	20140701	D	EXACT DUPE 06 TO 07	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
828	20140701	D	EXACT DUPE 07 TO 07	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
830	20140701	D	EXACT DUPE 07 TO 09	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP
833	20140701	D	EXACT DUPE 08 TO 08	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLAIMS
837	20140701	D	EXACT DUPE 09 TO 09	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS
843	20140701	D	EXACT DUPE 12 TO 12	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
849	20140701	D	PD SAME ATTEN/DIF BL	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
851	20140701	E	SUSPCT DUPE 01 TO 01	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	20140701	E	SUSPCT DUPE 03 TO 03	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
857	20140701	E	SUSPCT DUPE 01 TO 06	SUSPCT DUPLICATE ERROR: OUTPATIENT AND HOME-HEALTH
859	20140701	E	SUSPCT DUPE 03 TO 08	SUSPCT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULANCE
860	20140701	E	ENCOUNTER COB ERROR	FIRST COB LOOP ON ENCOUNTERS IS INVALID (NOT PLAN PAYER ID)
863	20140701	E	SUSPCT DUPE 04 TO 04	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
865	20140701	E	SUSPCT DUPE 05 TO 05	SUSPEC DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS
866	20140701	E	SUSPCT DUPE 05 TO 06	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH
867	20140701	E	SUSPCT DUPE 05 TO 07	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE
868	20140701	E	SUSPCT DUPE 05 TO 08	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANC
869	20140701	E	SUSPCT DUPE 05 TO 09	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND DME
872	20140701	E	SUSPCT DUPE 06 TO 06	SUSPCT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS
873	20140701	E	SUSPCT DUPE 06 TO 07	SUSPCT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
874	20140701	E	SUSPCT DUPE 06 TO 08	SUSPCT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULANCE
878	20140701	E	SUSPCT DUPE 07 TO 07	SUSPCT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS

MMIS Error Code	Effective Date (YYYYMMDD)	Default Disposition Status	SHORT DESCRIPTION	LONG DESCRIPTION
879	20140701	E	SUSPCT DUPE 07 TO 08	SUSPCT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANCE
884	20140701	E	SUSPCT DUPE 08 TO 09	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND DME CLAIMS
887	20140701	E	SUSPCT DUPE 09 TO 09	SUSPECT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS
893	20140701	E	SUSPCT DUPE 12 TO 12	SUSPECT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
898	20140701	D	EXACT DUPE SAME ICN	EXACT DUPE SAME ICN - DROPPED
900	20140701	D	LIFETIME LIMITS-ONE	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED
924	20140701	E	EFF 11/5/10 NDC REQU	EFF 11/5/10 PAS FOR THIS HCPC REQUIRES CORRECT NDC CODE
931	20140701	E	DENIED PER TPL EOB	DENIED PER THE TPL EOB INFORMATION
946	20140701	E	SPLIT BILL FOR PART.	SPLIT BILL FOR PARTIAL ELIGIBILITY.
948	20140701	E	INC IN MAJ SUR PROC	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	20140701	E	DISCH DATE NOT COV	DATE OF DISCHARGE NOT COVERED
952	20140701	E	INC IN OV/RELAT PROC	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
957	20140701	E	PROC/DIAG NO MED NEC	PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY
970	20140701	D	INAPPROPRIATE CODE,	INAPPROPRIATE CODE, BILL LAB OR SPECIFIC HANDLING.
973	20140701	E	NO SURGERY MODIFIER	CLAIM DESCRIPT INDICATES PROC CODE SHOULD HAVE MODIFIER
980	20140701	E	INVALID ADJ REASON	INVALID ADJUSTMENT REASON
983	20140701	D	SYS CALC NET TOTAL	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE
991	20140701	E	PROCEDURE IN PANEL	PROCEDURE INCLUDED IN PANEL

Encounter Edit Disposition Summary

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

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

Column(s)	Item	Notes	Length	Format
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-005”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 10=Dental 11=Dental	2	Numeric
25	Delimiter		1	Uses the ^ character value
26-29	Error Code		4	Numeric
30	Delimiter		1	Uses the ^ character value
31-38	Number of claim records having this error code		8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.

Column(s)	Item	Notes	Length	Format
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “SMO-W-005”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-29	Unused		4	Value is spaces
30	Delimiter		1	Uses the ^ character value
31-38	Total Number of Claim records denied	This value should match that of the SMO-W-001 file. It may not equal the total of all detail lines in the SMO-W-005 file because one claim may have several edits.	8	Numeric

Column(s)	Item	Notes	Length	Format
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.

Repairable Edit Codes

Below is a list of repairable encounter edit codes. The MCO is required to correct repairable edits and resubmit the encounter to the FI for processing.

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

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
002	INVALID-PROV-NO
003	INVALID-RECIP-NO
005	INVALID-STMT-FROM-DTE
006	INVALID-STMT-THRU-DTE
007	SERV THRU LT SERV FM
008	SERV FRM GT ENTR DTE
009	SRV-THRU-GT-ENTRY
013	ORG CLM W ADJ/VD ICN
015	INVALID ACCIDENT IND
016	INVALID ACCID IND
017	INVALID EPSDT IND
020	DIAG-MISSING
021	INVALID FORMER REFNO
023	INV PARTIAL RECIP
024	INV BILLING PROV NO
040	INVALID-ADMISSION-DTE-ERR
045	INV PATIENT STATUS
046	INV PATIENT STAT DTE
047	PAT STAT DTE GT THRU
069	INVALID-OCUR-DATE
071	INV STMT COVERS FROM
072	INV STMT COVER THRU
073	STMT FRM LT SERV FRM
074	STMT THRU GT SRV THR
081	INVALID STATUS DATE

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
082	INVALID STATUS CODE
094	MISSING-PTS-BLOOD
120	QTY-INVALID-MISSING
130	DENY-PROV-9999999
180	INVALID ADMIT DATE
186	CRNA-MUST-BILL-CORRECT-MOD
206	BILL PROV NOT ON FIL
211	DOS-LESS-THAN-DOB
215	RECIPIENT-NOT-ON-FILE
266	INVALID-AMB-SURG-REV
267	REQ-ICD9-SURGICAL-CD
289	REJ-DENY-INV-PROV
307	SURG PROC MISSING
309	SURG DATE MISSING
310	SURG DTE LT SRV FROM
318	SUSP-COND-MISS-REF2
319	SUSP-COND-MISS-REF3
400	REFER-PHYS-REQD
410	ENC LICN PREFIX ERROR
444	M/I SERVICE PROVIDER
513	HCPCS-REQUIRED
563	ADJ-ADD-ON-WITH-51
676	PRIMARY CODE DENIED
702	NEW PT/EST PT CD CON
706	FOLLOW-UP-NB-CARE-BILLED
720	TO BE BILLED BY PROV
753	REBILL-DELIVERY
755	BILL AS ADJ/CNT STAY
757	ADJ PD LINE 51 MOD
796	ORIG/ADJ PROV DIFF
799	NO ADJ HISTORY
970	INAPPROPRIATE CODE
983	TOTAL-CHRG-CHANGED
TBD	PROV-NOT-CCN

Non-Repairable Edit Codes

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

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
035	REBILL CORRECT HCPC
222	RECIP-ELIG-DATE-OVERLAP
631	EPSDT-AGE-ERROR
644	VISIT CODE PD/DOS
673	EVAL & MGT PD DOS
695	HOSP DISCHARGE PAID
704	ER VISIT/INP HOS SER
712	INITIAL HOSP INPT PD
716	PROC-INCLUDED-IN-OV
735	PREV PD ANES-SAME RE
746	SAME ATTD PD IP CONS
748	1 DEL.ALLOW. 6MTH.SP
749	DEL HYST/STER CONFLI
758	FND DUP SERV SM DAY
794	INPT SER PD SAME ATT
797	DUP ADJ. RECORD
798	HIST ALREADY ADJSTED
800	ON-LINE DUPE DENY
801	EXACT DUPE 01 TO 01
805	EXACT DUPE 03 TO 03
806	EXACT DUPE 03 TO 05
807	EXACT DUPE 03 TO 06
808	EXACT DUPE 03 TO 07
810	EXACT DUPE 03 TO 09
816	EXACT DUPE 05 TO 06
817	EXACT DUPE 05 TO 07
818	EXACT DUPE 05 TO 08
819	EXACT DUPE 05 TO 09
822	EXACT DUPE 06 TO 06
823	EXACT DUPE 06 TO 07
828	EXACT DUPE 07 TO 07
830	EXACT DUPE 07 TO 09
833	EXACT DUPE 08 TO 08
837	EXACT DUPE 09 TO 09
843	EXACT DUPE 12 TO 12
849	PD SAME ATTEN/DIF BL
898	EXACT DUPE SAME ICN
900	LIFETIME LIMITS-ONE
917	OVER LIFETIME LIMIT

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 make sure that there is adequate provider network access to covered services that meets standards of distance, timeliness, amount, duration and scope as defined in the contract with DHH for the members. 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.

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.

Provider Types

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
01	*Fiscal Agent (WVR)*
02	*Transitional Support (WVR)*
03	*Children's Choice (WVR)(In- ST)*
04	*Pediatric Day Health Care*
05	*Managed Care Organization – Prepaid*
06	*NOW Professional Services*
07	*Case Mgmt - Infants & Toddlers*
08	*Case Mgmt - Elderly*
09	*Hospice Services*
10	*Comprehensive Community Support Services*
11	*Shared Living – Waiver*
12	*Multi-Systemic Therapy*
13	*Pre-Vocational Habilitation*
14	*Day Habilitation - Waiver*
15	*Environmental Acc Adap – Waiver*
16	*Personal Emergency Response System – Waiver*
17	*Assistive Devices – Waiver*
18	*Comm Mental Health Center/Part Hospital*
19	*Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group*
20	*Physician (MD) and Physician (MD) Group*
21	*Third Party Billing Agent/Submitter*
22	*Personal Care Attendant – Waiver*
23	*Independent Lab*
24	*Personal Care Services (LTC/PCS/PAS)*

Provider Type	Description
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*
33	*Prescribing Only Provider*
34	*Audiologist*
35	*Physical Therapist*
36	*Not Assigned*
37	*Occupational Therapist*
38	*School Based Health Center*
39	*Speech Therapist*
40	*DME Provider*
41	*Registered Dietician*
42	*Non-Emergency Medical Transportation*
43	*Case Mgmt - Nurse Home Visit - 1st Time Mother*
44	*Home Health Agency*
45	*Case Management*
46	*Case Mgmt - HIV*
47	*Case Management – CMI*
48	*Case Management – Pregnant Women*
49	*Case Management – Develop Disabled*
50	*PACE (All-Inclusive Care – Elderly)*
51	*Ambulance Transportation*
52	*Co-ordin Care Network – Shared*
53	*Self Direct/Direct Support*

Provider Type	Description
54	*Ambulatory Surgery Center*
55	*Emergency Access Hospital*
56	*Prescriber Only for MCO*
57	*OPH Public Health Registered Nurse*
58	*Not Assigned*
59	*Neurological Rehabilitation Unit (Hospital)*
60	*Hospital*
61	*Venereal Disease Clinic*
62	*Tuberculosis Clinic*
63	*Tuberculosis Inpatient Hospital*
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 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)*
80	*Nursing Facility*
81	*Case Mgmt - Ventilator Assisted Care Program*
82	*Personal Care Attendant – Waiver*
83	*Center-Based Respite Care*
84	*Substitute Family Care – Waiver*

Provider Type	Description
85	*Adult Day Health Care – Waiver*
86	*ICF/DD Rehabilitation*
87	*Rural Health Clinic (Independent)*
88	*ICF/DD - Group Home*
89	*Supervise Independent Living – Waiver*
90	*Nurse-Midwife*
91	*CRNA or CRNA Group*
92	*Private Duty Nurse*
93	*Clinical Nurse Specialist*
94	*Physician Assistant*
95	*American Indian / Native Alaskan "638" Facilities*
96	*Psychiatric Residential Treatment Facility*
97	*Residential Care*
98	*Supported Employment*
99	*Greater New Orleans Community Health Connection*
AA	*Assertive Community Treatment Team*
AB	*Prepaid Inpatient Health Plan*
AC	*Family Support Organization*
AD	*Transition Coordination*
AE	*Respite Care Service Agency*
AF	*Crisis Receiving Center*
AG	*Behavioral Health Rehab Agency*
AH	*Licensed Marriage & Family Therapy*
AJ	*Licensed Addiction Counselor*
AK	*Licensed Professional Counselor*
AL	*Community Choice Waiver – Nurs*
AM	*Home Delivered Meals*
AN	*Caregiver Temporary Support*
AQ	*Non-Medical Group Home*
AR	*Therapeutic Foster Care*

Provider Type	Description
AS	*Office of Public Health Clinic*
AT	*Therapeutic Group Home*
AU	*Public Health Registered Dietitian*
AW	*Permanent Support Housing Agent*
AX	*Certified Behavior Analyst*
AY	*Dental Benefit Plan Manager*
AZ	*Substance Use Residential Treatment Facility*
BC	*Birth Center – Free Standing*
BI	*Behavior Intervention*
IP	*HER Incentive Program*
MI	*Monitored In-Home Caregiving*
MW	*Licensed Mid-Wife*
SP	*Super Provider/OHCDS*
XX	*Error Provider*

Provider Specialty Types

For providers registered as individual practitioners, DHH will also require the 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 (DO only)	19

Provider Specialty	Description	Associated Provider Types
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. Medicine)	20
50	Day Habilitation	1
51	Med Supply / Certified Orthotist	40

Provider Specialty	Description	Associated Provider Types
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
70	Clinic or Other Group Practice	19,20,68,74,76,AS
71	Speech Therapy	29
72	Diagnostic Laboratory	23

Provider Specialty	Description	Associated Provider Types
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
80	Environmental Accessibility Adaptations	1
81	Case Management	07,08,43,46,81
82	Personal Care Attendant	1
83	Respite Care	83
84	Substitute Family Care	1
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
89	Supervised Independent Living	1
90	Personal Emergency Response System – Waiver	1
91	Assistive Device	1
92	Prescribing Only Providers/Providers Not Authorized to Bill Medicaid	1
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31

Provider Specialty	Description	Associated Provider Types
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
98	Supported Employment	1
99	Provider Pending Environment	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
1Q	Pediatric Neurology	2
1R	Pediatric Genetics	2
1S	BRG – Med School	2
1T	Emergency Medicine	19,20

Provider Specialty	Description	Associated Provider Types
1U	Pediatric Developmental Behavior	2
1Z	Pediatric Day Health Care	2
2A	Cardiac Electrophysiology	2
2B	Cardiovascular Disease	2
2C	Critical Care Medicine	2
2D	Diagnostic Laboratory Immunology	2
2E	Endocrinology & Metabolism	2
2F	Gastroenrology	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
2Q	Nuclear Medicine	1
2R	Physician Assistant	94
2S	LSU Medical Center New Orleans	2
2T	American Indian/Native Alaskan	95
2Y	OPH Genetic Disease Program	1
3A	Critical Care Medicine	2
3B	Gynecologic Oncology	2

Provider Specialty	Description	Associated Provider Types
3C	Maternal & Fetal Medicine	2
3D	Community Choices Waiver – Respiratory Therapy	2
3E	Community Choices Waiver – PT and OT	2
3F	Community Choices Waiver – PT and S/L T	2
3G	Community Choices Waiver – PT and RT	2
3H	Community Choices Waiver – OT and S/L T	2
3J	Community Choices Waiver – OT and RT	2
3K	Community Choices Waiver - /L T and RT	2
3L	Community Choices Waiver – PT, OT & S/L T	2
3M	Community Choices Waiver – PT, OT &RT	2
3N	Community Choices Waiver – PT, S/L T & RT	2
3P	Organized Health Care Delivery System (OHCDS)	2
3Q	Community Choices Waiver – OT, S/L T & RT	2
3R	Community Choices Waiver – All Skilled Maintenance Therapies (PT, OT, S/L, T, RT)	2
3S	LSU Medical Center Shreveport	2

Provider Specialty	Description	Associated Provider Types
3T	DBPP – Dental Benefit Plan Prescriber	1
3U	Community Choices Waiver – Assistive Devices – Home Health	2
3W	Supportive Housing Agency	1
3X	Extended Duty Dental Assistant	1
3Y	DBPM – Dental Benefit Plan Management	1
4A	Developmentally Disabled (DD)	1
4B	NOW RN	1
4C	NOW LPN	1
4D	NOW Psychologist	1
4E	NOW Social Worker	1
4G	New, Provider Domain	1
4H	Conversion, Participant Domain	1
4J	Conversion, Provider Domain	1
4K	Home and Community- Based Services	1
4L	New, Participant Domain	1
4M	EHR Managed Care (Behavior Health)	2
4P	OAAS	1
4R	Registered Dietician	1
4S	Ochsner Med School	2
4U	OPH Registered Dietician	1
4W	Waiver Services	1

Provider Specialty	Description	Associated Provider Types
4X	Waiver – Only Transportation	1
4Y	EHR Managed Care (Medical)	2
5A	PCS-LTC	1
5B	PCS-EPSDT	24
5C	PAS	24
5D	PCS-LTC, PCS-EPSDT	1
5E	PCS-LTC, PAS	1
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5I	Statewide Management Organization (SMO)	1
5J	Youth Support	1
5K	Family Support	1
5L	Both Youth and Family Support	1
5M	Multi-Systemic Therapy	12
5N	Substance Abuse and Alcohol Abuse Center	1
5Q	CCN-P (Coordinated Care Network, Pre-paid)	1
5R	CCN-S (Coordinated Care Network, Shared Savings	1
5S	Tulane Med School	2
5T	Community Choices Waiver (CCW)	1
5U	Individual	1
5V	Agency/Business	1

Provider Specialty	Description	Associated Provider Types
5W	Community Choices Waiver – Personal Assistance Service	2
5X	Therapeutic Group Home	1
5Y	PRCS Addiction Disorder	1
5Z	Therapeutic Group Home Disorder	1
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6G	Psychologist – Medical	31
6H	LaPOP	1
6N	Endodontist	27
6P	Periodontist	27
6S	E Jefferson Family Practice Center – Residency Program	2
6T	Community Choices Waiver – Physical Therapy	2
6U	Applied Behavioral Analyst	1
6W	Licensed Mid-Wife	1
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38

Provider Specialty	Description	Associated Provider Types
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
7G	Community Choices Waiver – Speech/Language Therapy	2
7H	Community Choices Waiver – Occupational Therapy	2
7M	Retail Convenience Clinics	2
7N	Urgent Care Clinics	2
7P	ABA Therapy Psychologist	1
7R	Aquatic Therapy	1
7T	Art Therapy	1
7U	Art and Music	2
7V	Music Therapy	1
7X	Sensory Integration	1
7Y	Therapeutic Horseback Riding	1
7Z	Hippotherapy	1
7S	Leonard J Chabert Medical Center – Houma	2
8A	Elderly, Community Choices Waiver, DD	2

Provider Specialty	Description	Associated Provider Types
8B	Elderly, Community Choices Waiver	2
8C	DD Services	2
8D	Community Choices Waiver – Caregiver Temporary Support	1
8E	CSoC/Behavioral Health	1, 2
8F	Community Choices Waiver – Caregiver Temporary Support – Home Health	2
8G	Community Choices Waiver – Caregiver Temporary Support – Assisted Living	2
8H	Community Choices Waiver – Caregiver Temporary Support – ADHC	2
8J	Community Choices Waiver – Temporary Support – Nursing Facility	2
8K	ADHC HCBS	1
8L	Hospital-Based PRTF	1
8M	Community Choices Waiver – Home-Delivered Meals	1
8N	Community Choices Waiver – Nursing	2
8O	IP – Doctor of Osteopathic Medicine	1
8P	IP – Physician – MD	1
8Q	EAA Assesor, Inspector, Approver	2
8R	Psychiatric Residential Treatment Facility	96

Provider Specialty	Description	Associated Provider Types
8S	OLOL Med School	2
8U	Residential Treatment Facility – Psychiatric and Substance Abuse	96, AZ
9A	Community Choices Waiver – Nursing and Personal Assistance Services	2
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97
9E	Children's Choice Waiver	1
9F	Therapeutic Foster Care (TFC)	1
9G	Non-Medical Group Home (NMGH)	1
9L	RHC/FQHC OPH Certified SBHC	1
9M	Monitored in-Home Caregiving (MIHC)	1
9P	GNOCHC – Greater New Orleans Community Health Connection	1
9Q	PT 21 – Third-Party Biller/Submitter	2
9R	Electronic Visit Verification Submitter	2
9S	IP – Optical Supplier	1
9T	Exempted from State EW	2
9U	Medicare Advantage Plans	1
9V	OCDD – Point of Entry	1

Provider Specialty	Description	Associated Provider Types
9W	OAAS – Point of Entry	1
9X	OAD – Point of Entry	1
9Y	Juvenile Court/Drug Treatment Center	1
9Z	Other Contract with a State Agency	1
XX	Error Provider	1

Provider Registry File Layout

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 DBP 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 value	
45-74	Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)		30	Character	R
75	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138-167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169-170	Provider Business Mailing Address (State)	USPS state code abbreviation	2	Character	R
171	Delimiter		1	Character, use the ^ character value	
172-181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^ character value	
183-192	Provider Business Mailing Address (Country Code if outside U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216-245	Provider Business Location Address (First line address)	No P.O. Box here, please use a physical address.	30	Character	R
246	Delimiter		1	Character, use the ^ character value	
247-276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	(Country Code if outside U.S)				
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	
345-354	Provider Business Location Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
355	Delimiter		1	Character, use the ^ character value	
356-365	Healthcare Provider Taxonomy Code 1		10	Character	R Note: if a single NPI is used for multiple entities then we require at least 1 taxonomy per NPI. For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separte record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type Code	Provider Type and Provider Specialty	4	1st 2 characters are provider type; last 2 characters (3-4) are provider specialty. See DBPM Companion Guide for list of applicable provider types and specialties.	R
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 6 = American Sign Language	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (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 6 = American Sign Language	1	Character	O
583	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
584	Language Indicator 3 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients 6 = American Sign Language	1	Character	O
585	Delimiter		1	Character, use the ^ character value	
586	Language Indicator 4 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients 6 = American Sign Language	1	Character	O
587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients 6 = American Sign Language			
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. 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 Linkages with DBP	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of DBP enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not DBP) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character value	
610	DBP Enrollment Indicator	**N**=New enrollment **C**=Change to existing enrollment **D**=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	DBP 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 DBPM Companion Guide	2		~~O~~ R for PCPs; otherwise optional.
625	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in DBPM 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 DBPM Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	DBP Contract Name or Number	This should represent the contract name/number that is established between the DBP and the Provider	30	Character	R
662	Delimiter		1	Character, use the ^ character value	
663-670	DBP Contract Begin Date	Date that the contract between the DBP and the provider started	8	Numeric date value in the form YYYYMMDD	R
671	Delimiter		1	Character, use the ^ character value	
672-679	DBP Contract Term Date	Date that the contract between the DBP and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the DBPM Companion Guide.	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 DBPM Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM 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 DBPM 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;	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		otherwise enter 00.			
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 DBPM Companion Guide.	O
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
701	Delimiter		1	Character, use the ^ character value	
702-703	Provider Parish served – 8th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves.	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Use only if necessary; otherwise enter 00.			
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM 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 DBPM 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	2	2-digit parish code value. See the DBPM Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the provider serves. Use only if necessary; otherwise enter 00.			
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 DBPM Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
723-724	Provider Parish served – 15th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the DBPM Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726	PCD Indicator	0=Not a PCD. 1= Regularly servers as a PCD 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	1	Numeric value 0, 1, 2 or 3	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		for general populations. 2=PCD Extenders – must be linked to a supervising PCD 3=PCD Specialized – for designated individuals only (would not show up as a PCD in any registry or directory)			
727	Delimiter		1	Character, use the ^ character value	
728-749	Spaces	End of record filler	24	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

Provider Registry Edit Report (sample)

Report: MW-W-09 *RUN DATE: 20140606* *1*

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Statewide Management Organization
Report MW-W-09: Weekly Provider Registry Edit/Update Report

19:30 Friday, June 6, 2014

SMO_ID=0136558

RECORD TYPE	PROV ID	NPI	NAME	ASSIGNED TAXONOMY	MEDICAID ID	ACC REJ	ERR1	ERR2	ERR3	ERR4	ERR5	ERR6	ERR7	ERR8	ERR9	ERR10
C	0000000	1235219999	TEST TX TRMNT NTWRK MAIN	283Q00000X	7130001	A	025	035	000	000	000	000	000	000	000	000

Error Codes (A=Accepted, R=Rejected):
000=(A) No errors found
001=® Missing/Invalid NPI (not 10 digits)
002=® Missing/Invalid Entity Type (must be 1 or 2)
003=® Provider record must include taxonomy
004=® Missing required information (name, address, contact name, etc.)
005=® Missing/Invalid provider type or specialty
006=® Invalid provider sub-specialty (if one is submitted and it is not a valid value)
007=® Missing/Invalid enrollment indicator (must be N, C, or D)
008=® Missing/Invalid enrollment effective date
009=® Invalid panel open indicator value (must be Y, N)
010=® Invalid Language indicator value (must be 0,1,2,3,4,5. 1st indicator cannot be 0)
011=® Invalid Age Restriction indicator value (must be 0,1,2)
012=® Invalid PCP Linkage Maximum value (must be numeric or zeros)
013=® Invalid PCP Linkage SMO value (must be numeric or zeros)
014=® Invalid PCP Linkage Other value (must be numeric or zeros)
015=® Invalid Family-Only indicator value (must be 0,1)
016=® Missing SMO Contract Name or Number (found only spaces)
017=® Missing/Invalid SMO Contract begin date
018=® Missing/Invalid SMO Contract termination date
019=® Missing provider parish (at least 1 must be submitted)
020=® Invalid provider parish value (for a submitted value)
021=® Duplicate NPI records found. Only first one in the file is accepted
022=® Medicaid Provider ID (Other Provider Identifier) is not found on MMIS Provider File
023=® Missing/Invalid NPPES Enum Date
024=® Missing/Invalid Provider License Data
025=(A) NPI not found on LMMIS Provider Enrollment File
026=® SMO provider not found on LMMIS Provider Enrollment File
027=® Unable to assign a Medicaid provider... too many collisions
028=® Enrollment Ind=N (new), but provider already exists on registry
029=® Enrollment Ind=C or D, but provider does not exist on registry
030=® Invalid taxonomy format (Special characters not allowed)
031=® Missing Replacement NPI for an atypical provider
035=(A) Non-Par Contractor

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: N=New C=Change D=Disenroll
10	Delimiter	Character	1	Value is ^ character.
11-17	Provider ID	Numeric	7 digits	This is the provider's Medicaid ID number
18	Delimiter	Character	1	Value is ^ character.
19-28	Provider NPI	Character	10	
29	Delimiter	Character	1	Value is ^ character.
30-59	Provider Name	Character	30	
60	Delimiter	Character	1	Value is ^ character.
61-70	Provider Taxonomy	Character	10	
71	Delimiter	Character	1	Value is ^ character.
72-78	Provider ID	Numeric	7 digits	
79	Delimiter	Character	1	Value is ^ character.
80	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	
105	Delimiter	Character	1	Value is ^ character.
106-108	Edit Code 7	Character	3	
109	Delimiter	Character	1	Value is ^ character.
110-112	Edit Code 8	Character	3	
113	Delimiter	Character	1	Value is ^ character.
114-116	Edit Code 9	Character	3	
117	Delimiter	Character	1	Value is ^ character.
118-120	Edit Code 10	Character	3	
121	Delimiter	Character	1	Value is ^ character.

Provider Registry Site File

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

www.lamedicaid.com

The MCO must log in to this website before being allowed to get to the menu page. The process for using the site is similar to the Provider Registry where the plan will upload their site file updates to 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 check digit provider ID.

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

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

Site File Format

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

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

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

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

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

Error Messages

'000'='No errors found'

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

digits)'

'002'='Provider record must include taxonomy'

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

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

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

'006'='Missing/Invalid submission date'

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

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

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

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

'011'='Missing provider site parish'

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

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

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

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

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

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

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

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

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

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

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

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

Error File Format

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

Lookup Taxonomy Table (LTX)

(Effective 7-13-2015)

LTX_Prov_Typ	LTX_Prov_Type_Desc	LTX_Prov_Sp	LTX_Prov_Specialty_Desc	LTX_Taxonom	LTX_Taxonomy_Desc
01	FISCAL AGENT (WVR)	4A	Developmentally Disabled	253Z00000X	Agencies In Home Supportive Care
01	FISCAL AGENT (WVR)	6H	LaPOP	253Z00000X	Agencies In Home Supportive Care
02	TRANSITIONAL SUPPORT	4A	Developmentally Disabled	225C00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers Rehabilitation Counselor
03	CHILDRENS CHOICE (WVR)(IN-ST)	9E	Children's Choice Waiver	101Y00000X	Behavioral Health & Social Service Providers Counselor
04	PEDI DAY HLTH CARE (IN-ST)	1Z	Pediatric Day Health Care	261QM3000X	Ambulatory Health Care Facilities Clinic/Center Medically Fragile Intants and Children Day Care
05	MANAGED CARE ORG -	5Q	CCN-P (Coordinated Care Network, Pre-	302R00000X	Managed Care Organizations Health Maintenance Organization
06	NOW PROFESSIONAL SERVICES	4B	NOW RN	163W00000X	Nursing Service Providers Registered Nurse
06	NOW PROFESSIONAL SERVICES	4C	NOW LPN	363L00000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
06	NOW PROFESSIONAL SERVICES	4D	NOW Psychologist	103T00000X	Behavioral Health & Social Service Providers/Psychologist
06	NOW PROFESSIONAL SERVICES	4E	NOW Social Worker	104100000X	Behavioral Health & Social Service Providers Social Worker
07	CASE MGMT-INFT & TODD (IN- ST)	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
08	OAAS CASE MGMT (IN-ST)	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator

09	HOSPICE SERVICES (IN-ST)	93	Hospice Service for Dual Elig.	315D00000X	Nursing & Custodial Care Facilities Hospice, Inpatient
10	COMPREHENSIVE COMM SUPPORT SRV	70	Clinic or Other Group Practice	253Z00000X	Agencies In Home Supportive Care
11	SHARED LIVING (WVR) (IN-ST)	4A	Developmentally Disabled	372600000X	Nursing Service Related Providers Adult Companion
12	MULTI-SYSTEMIC THER (IN-ST)	5M	Multi-Systemic Therapy	261QP2000X	Ambulatory Health Care Facilities Clinic/Center Physical Therapy
13	PREVOC REHAB (WVR) (IN-ST)	36	Pre-Vocational Habilitation	251C00000X	Agencies Day Training, Developmentally Disabled
14	DAY HABILITAT (WVR) (IN-ST)	50	Day Habilitation	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
15	ENVIR ACC ADAP (WVR) (IN-ST)	80	Environmental Accessibility Adaptations	171W00000X	Other Service Providers Contractor
16	PERS EMERG RESP SYS (WVR)	90	Personal Emergency Response Sys (Waiver)	333300000X	Suppliers Emergency Response System
17	ASSISTIVE DEVICES (WVR)	91	Assistive Devices	225CA2400X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers
18	COMM MENTAL HLTH CTR/PART HOSP	5H	Community Mental Health Center	261QM0801	Ambulatory Health Care Facilities/Clinic/Center, Mental Health
19	DR OF OSTEOPATH MED (IND & GP)	01	General Practice	208D00000X	Allopathic & Osteopathic Physicians/General
19	DR OF OSTEOPATH MED (IND & GP)	02	General Surgery	208600000X	Allopathic & Osteopathic Physicians/Surgery
19	DR OF OSTEOPATH MED (IND & GP)	03	Allergy	207K00000X	Allopathic & Osteopathic Physicians/Allergy and Immunology
19	DR OF OSTEOPATH MED (IND & GP)	04	Otology, Laryngology,	207YX0901X	Allopathic & Osteopathic Physicians/Otolaryngology/Otology

19	DR OF OSTEOPATH MED (IND & GP)	05	Anesthesiology	207L00000X	Allopathic & Osteopathic
19	DR OF OSTEOPATH MED (IND & GP)	06	Cardiovascular Disease	207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Cardiovascular
19	DR OF OSTEOPATH MED (IND & GP)	07	Dermatology	207N00000X	Allopathic & Osteopathic
19	DR OF OSTEOPATH MED (IND & GP)	08	Family Practice	207Q00000X	Allopathic & Osteopathic Physicians/Family
19	DR OF OSTEOPATH MED (IND & GP)	09	Gynecology (DO only)	207V00000X	Allopathic & Osteopathic Physicians/Obstetrics &
19	DR OF OSTEOPATH MED (IND & GP)	10	Gastroenterology	207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine,
19	DR OF OSTEOPATH MED (IND & GP)	12	Manipulative Therapy (DO only)	207R00000X	Allopathic & Osteopathic Physicians/Internal
19	DR OF OSTEOPATH MED (IND & GP)	13	Neurology	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
19	DR OF OSTEOPATH MED (IND & GP)	14	Neurological Surgery	207T00000X	Allopathic & Osteopathic Physicians/Neurological
19	DR OF OSTEOPATH MED (IND & GP)	15	Obstetrics (DO only)	207V00000X	Allopathic & Osteopathic Physicians/Obstetrics &
19	DR OF OSTEOPATH MED (IND & GP)	16	OB/GYN	207VG0400X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Gynecology
19	DR OF OSTEOPATH MED (IND & GP)	17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	207W00000X	Allopathic & Osteopathic
19	DR OF OSTEOPATH MED (IND & GP)	19	Orthodontist	1223X0400X	Orthodontics and Dentofacial Orthopedics
19	DR OF OSTEOPATH MED (IND & GP)	1T	Emergency Medicine	207P00000X	Allopathic & Osteopathic Physicians/Emergency

19	DR OF OSTEOPATH MED (IND & GP)	20	Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic
19	DR OF OSTEOPATH MED (IND & GP)	21	Pathologic Anatomy; Clinical Pathology (DO	207ZP0102X	Allopathic & Osteopathic Physicians/Pathology, Anatomic Pathology &
19	DR OF OSTEOPATH MED (IND & GP)	23	Peripheral Vascular Disease or Surgery (DO only)	246XC2903X	Vascular Specialist
19	DR OF OSTEOPATH MED (IND & GP)	24	Plastic Surgery	208200000X	Allopathic & Osteopathic
19	DR OF OSTEOPATH MED (IND & GP)	25	Physical Medicine	208100000X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation
19	DR OF OSTEOPATH MED (IND & GP)	26	Psychiatry	2084P0800X	Allopathic & Osteopathic
19	DR OF OSTEOPATH MED (IND & GP)	27	Psychiatry; Neurology (DO only)	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
19	DR OF OSTEOPATH MED (IND & GP)	28	Proctology	208C00000X	Allopathic & Osteopathic Physicians/Colon & Rectal
19	DR OF OSTEOPATH MED (IND & GP)	29	Pulmonary Diseases	207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
19	DR OF OSTEOPATH MED (IND & GP)	2Q	Nuclear Medicine	207U00000X	Allopathic & Osteopathic Physicians/Nuclear
19	DR OF OSTEOPATH MED (IND & GP)	30	Radiology	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
19	DR OF OSTEOPATH MED (IND & GP)	31	Roentgenology, Radiology (DO only)	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
19	DR OF OSTEOPATH MED (IND & GP)	32	Radiation Therapy (DO only)	2085R0001X	Allopathic & Osteopathic Physicians/Radiology, Radiation Oncology

19	DR OF OSTEOPATH MED (IND & GP)	33	Thoracic Surgery	208G00000X	Allopathic & Osteopathic Physicians/Thoracic Surgery (Cardiothoracic Vascular
19	DR OF OSTEOPATH MED (IND & GP)	34	Urology	208800000X	Allopathic & Osteopathic Physicians/Urology
19	DR OF OSTEOPATH MED (IND & GP)	37	Pediatrics	208000000X	Allopathic & Osteopathic Physicians/Pediatrics
19	DR OF OSTEOPATH MED (IND & GP)	38	Geriatrics	207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
19	DR OF OSTEOPATH MED (IND & GP)	39	Nephrology	207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
19	DR OF OSTEOPATH MED (IND & GP)	40	Hand Surgery	207XS0106X	Allopathic & Osteopathic Physicians/Orthopae dic Surgery/Hand
19	DR OF OSTEOPATH MED (IND & GP)	41	Internal Medicine	207R00000X	Allopathic & Osteopathic Physicians/Internal
19	DR OF OSTEOPATH MED (IND & GP)	70	Clinic or Other Group Practice	193200000X	Multi-Specialty Group
20	PHYSICIAN (IND & GP)	01	General Practice	208D00000X	Allopathic & Osteopathic Physicians/General
20	PHYSICIAN (IND & GP)	02	General Surgery	208600000X	Allopathic & Osteopathic Physicians/Surgery
20	PHYSICIAN (IND & GP)	03	Allergy	207K00000X	Allopathic & Osteopathic Physicians/Allergy and
20	PHYSICIAN (IND & GP)	04	Otology, Laryngology,	207YX0901X	Allopathic & Osteopathic Physicians/Otolaryngology/Otolo gy
20	PHYSICIAN (IND & GP)	05	Anesthesiology	207L00000X	Allopathic & Osteopathic
20	PHYSICIAN (IND & GP)	06	Cardiovascular Disease	207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine,

					Cardiovascular Disease
20	PHYSICIAN (IND & GP)	0	Dermatology	207N00000X	Allopathic & Osteopathic
20	PHYSICIAN (IND & GP)	0	Family Practice	207Q00000X	Allopathic & Osteopathic Physicians/Family
20	PHYSICIAN (IND & GP)	1	Gastroenterology	207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine,
20	PHYSICIAN (IND & GP)	1	Neurology	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
20	PHYSICIAN (IND & GP)	1	Neurological Surgery	207T00000X	Allopathic & Osteopathic Physicians/Neurological
20	PHYSICIAN (IND & GP)	1	OB/GYN	207VG0400X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Gynecology
20	PHYSICIAN (IND & GP)	1	Ophthalmology	207W00000X	Allopathic & Osteopathic Physicians/Ophthalmology
20	PHYSICIAN (IND & GP)	1	Orthodontist	1223X0400X	Orthodontics and Dentofacial Orthopedics
20	PHYSICIAN (IND & GP)	1T	Emergency Medicine	207P00000X	Allopathic & Osteopathic Physicians/Emergency
20	PHYSICIAN (IND & GP)	2	Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic
20	PHYSICIAN (IND & GP)	2	Pathology	207ZP0102X	Allopathic and Osteopathic Physicians - Pathology - Anatomic Pathology and
20	PHYSICIAN (IND & GP)	2	Plastic Surgery	208200000X	Allopathic & Osteopathic Physicians/Plastic Surgery
20	PHYSICIAN (IND & GP)	2	Physical Medicine	208100000X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation

20	PHYSICIAN (IND & GP)	2	Psychiatry	2084P0800X	Allopathic & Osteopathic Physicians/Psychiatry
20	PHYSICIAN (IND & GP)	2	Proctology	208C00000X	Allopathic & Osteopathic Physicians/Colon & Rectal Surgery
20	PHYSICIAN (IND & GP)	2	Pulmonary Diseases	207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
20	PHYSICIAN (IND & GP)	2Q	Nuclear Medicine	207U00000X	Allopathic & Osteopathic Physicians/Nuclear
20	PHYSICIAN (IND & GP)	3	Radiology	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
20	PHYSICIAN (IND & GP)	3	Thoracic Surgery	208G00000X	Allopathic & Osteopathic Physicians/Thoracic Surgery (Cardiothoracic Vascular
20	PHYSICIAN (IND & GP)	3	Urology	208800000X	Allopathic & Osteopathic Physicians/Urology
20	PHYSICIAN (IND & GP)	3	Pediatrics	208000000X	Allopathic & Osteopathic Physicians/Pediatrics
20	PHYSICIAN (IND & GP)	3	Geriatrics	207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric
20	PHYSICIAN (IND & GP)	3	Nephrology	207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
20	PHYSICIAN (IND & GP)	4	Hand Surgery	207XS0106X	Allopathic & Osteopathic Physicians/Orthopae dic Surgery/Hand
20	PHYSICIAN (IND & GP)	4	Internal Medicine	207R00000X	Allopathic & Osteopathic Physicians/Internal
20	PHYSICIAN (IND & GP)	4	Podiatry - Surgical Chiropody	213E00000X	Podiatric Medicine and Surgery Providers -

20	PHYSICIAN (IND & GP)	49	Miscellaneous (Admin. Medicine)	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
20	PHYSICIAN (IND & GP)	70	Clinic or Other Group Practice	193200000X	Multi-Specialty Group
21	THIRD PARTY BILL AGT/SUBMITTER	9U	Medicare Advantage Plans	NA	
21	THIRD PARTY BILL AGT/SUBMITTER	9V	OCDD - Point of Entry	NA	
21	THIRD PARTY BILL AGT/SUBMITTER	9W	OAAS - Point of Entry	NA	
21	THIRD PARTY BILL AGT/SUBMITTER	9X	OAD - Point of Entry	NA	
21	THIRD PARTY BILL AGT/SUBMITTER	9Y	Juvenile Court/Drug Treatment Center	NA	
21	THIRD PARTY BILL AGT/SUBMITTER	9Z	Other Contract with a State Agency	NA	
22	PERSONAL CARE ATTENDANT (WVR)	82	Personal Care Attendant	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
23	INDEPENDENT LAB	69	Independent Laboratory (Billing Independently)	291U00000X	Laboratories/Clinical Medical Laboratory
23	INDEPENDENT LAB	72	Diagnostic Laboratory	291U00000X	Laboratories/Clinical Medical Laboratory
24	PERSONAL CARE SERVICES (IN-ST)	5A	PCS-LTC	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5B	PCS-EPSDT	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5C	Personal Assistant Service (PAS)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5D	PCS-LTC, PCS-EPSDT	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5E	Personal Assistant Service (PAS)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant

24	PERSONAL CARE SERVICES (IN-ST)	5F	PCS-EPSDT, PAS	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5G	PCS-LTC, PCS-EPSDT, PAS	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
25	MOBILE XRAY/RADIATION	63	Portable X-Ray Supplier (Billing Independently)	261QR0208X	Ambulatory Health Care Facilities/Clinic-Center, Radiology, Mammography
26	PHARMACY (OOS-CROSSOVERS ONLY)	87	All Other	333600000X	Suppliers/Pharmacy
27	DENTIST (IND & GP)	66	General Dentistry (DDS/DMS)	122300000X	Dental Providers Dentist
27	DENTIST (IND & GP)	67	Oral and Maxillofacial Surgery	1223S0112X	Dental Providers - Dentists - Oral and Maxillofacial Surgery
27	DENTIST (IND & GP)	68	Pediatric Dentistry	1223P0221X	Dental Providers - Dentists - Pediatric Dentistry
27	DENTIST (IND & GP)	6N	Endodontist	1223E0200X	Dental Providers - Dentists - Endodontics
27	DENTIST (IND & GP)	6P	Periodontist	1223P0300X	Dental Providers - Dentists - Periodontics
28	OPTOMETRIST (IND & GP)	88	Optician / Optometrist	152W00000	Eye and Vision Service
29	EARLYSTEPS (IND & GP) (IN-ST)	62	Psychologist Crossovers only	103T00000X	Behavioral Health & Social Service Providers/Psychologist
29	EARLYSTEPS (IND & GP) (IN-ST)	64	Audiologist (Billing	231H00000X	Speech, Language and Hearing Service
29	EARLYSTEPS (IND & GP) (IN-ST)	65	Indiv Physical Therapist	225100000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Physical Therapist
29	EARLYSTEPS (IND & GP) (IN-ST)	71	Speech Therapy	235500000X	Speech, Language and Hearing Service Providers Specialist/Technolog
29	EARLYSTEPS (IND & GP) (IN-ST)	74	Occupational Therapy	225X00000X	Respiratory, Developmental, Rehabilitative & Restorative Service

					Providers/Occupational Therapist
30	CHIROPRACTOR (IND & GP)	35	Chiropractor	111N00000X	Chiropractic Providers/Chiropractor
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	62	Psychologist Crossovers only	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6A	Psychologist -Clinical	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6B	Psychologist-Counseling	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6C	Psychologist - School	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6D	Psychologist - Developmental	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6E	Psychologist - Non-Declared	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6F	Psychologist - All Other	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	95	Psychologist (PBS Program Only)	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	96	Psychologist (PBS Program and X-Overs)	103T00000X	Behavioral Health & Social Service Providers/Psychologist
32	PODIATRIST (IND & GP)	48	Podiatry - Surgical Chiropody	213E00000X	Podiatric Medicine & Surgery Service Providers/Podiatrist
33	PRESCRIBING ONLY PROVIDER	92	PRESCRIBING ONLY PROVIDER	NA	
34	AUDIOLOGIST (IN-ST)	64	Audiologist (Billing	231H00000X	Speech, Language and Hearing Service
35	PHYSICAL THERAPIST (IN-ST)	35	Chiropractor	111N00000X	Chiropractic Providers/Chiropractor
35	PHYSICAL THERAPIST (IN-ST)	65	Indiv Physical Therapist	225100000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Physical Therapist
36	NOT ASSIGNED			NA	

37	OCCUPATIONAL THERAPIST (IN- ST)	74	Occupational Therapy	225X00000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Occupational Therapist
38	SCHOOL BSED HEALTH CTR (IN-ST)	7A	SBHC - NP - Part Time - less than 20 hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7B	SBHC - NP - Full Time - 20 or more hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7C	SBHC - MD - Part Time - less than 20 hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7D	SBHC - MD - Full Time - 20 or more hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7E	SBHC - NP + MD - Part Time - total = less than 20 hrs week	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
38	SCHOOL BSED HEALTH CTR (IN-ST)	7F	SBHC - NP + MD - Full Time - total = 20 or more	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
39	SPEECH/LANGUAGE THERAP (IN- ST)	4W	Waiver Services	235500000X	Speech, Language and Hearing Service Providers Specialist/Technologist
39	SPEECH/LANGUAGE THERAP (IN- ST)	71	Speech Therapy	235500000X	Speech, Language and Hearing Service Providers Specialist/Technologist
40	DME (OOS-CROSSOVERS ONLY)	2Y	OPH Genetic Disease	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	51	Med Supply / Certified Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	52	Med Supply / Certified Prosthetist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	53	Direct Care Worker	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	54	Med Supply / Not Included in 51, 52, 53	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	55	Indiv Certified Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies

40	DME (OOS-CROSSOVERS	56	Indiv Certified Prosthetist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS	57	Indiv Certified Prosthetist - Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS	58	Indiv Not Included in 55, 56,	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS	87	All Other	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
41	REGISTERED DIETICIAN (IN-ST)	4R	Registered Dietician	133V00000X	Dietary & Nutritional Service Providers/Dietician,
42	NON-EMER MED TRANSPORT (IN-ST)	45	NEMT - Non-profit	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	46	NEMT - Profit	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	47	NEMT - F+F	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	4W	Waiver Services	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	4X	Waiver-Only Transportation	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
43	CASE MGT - NHV/FTM (IN-ST)	81	Case Management	163WC0400	Nursing Service Providers Registered Nurse Case Management
44	HOME HEALTH AGENCY (IN-ST)	87	All Other	251E00000X	Agencies/Home Health
45	CASE MGMT - CONTRACTOR (IN- ST)	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
46	CASE MGMT - HIV	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
47	CASE MGMT - CMI	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
48	CASE MGMT - PREGNANT WOMEN	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator

49	CASE MGMT - DEVELOP DISABLED	81	Case Management	171M00000X	Other Service Providers Case Manager/Care
50	PACE (ALL-INCLUSIVE CARE-	5P	PACE	251T00000X	Agencies PACE Provider Organization
51	AMBULANCE	59	Ambulance Service Supplier, Private	341600000X	Transportation Services/Ambulance
52	CO-ORDIN CARE NETWORK- SHARED	5R	CCN-S (Coordinated Care Network, Shared	302R00000X	Managed Care Organizations Health Maintenance Organization
53	SELF DIRECTED/DIRECT			172V00000X	Other Service Providers Community Health Worker
54	AMBULATORY SURGI CTR (IN-	70	Clinic or Other Group Practice	261QA1903X	Ambulatory Health Care Facilities/Clinic-Center, Ambulatory Surgical
55	EMERG ACCESS HOSPITAL (IN-ST)	86	Hospitals and Nursing Homes	261QC0050X	Ambulatory Health Care Facilities Clinic/Center Critical Access
56	PRESCRIBER ONLY FOR MCO			NA	
57	OPH REGISTERED NURSE (IN-	60	Public Health or Welfare Agencies & Clinics	163W00000X	Nursing Service Providers Registered Nurse
58	NOT ASSIGNED			NA	
59	NEURO REHAB HOSPITAL (IN-	86	Hospitals and Nursing Homes	273Y00000X	Hospital Units/Rehabilitation Unit
60	HOSPITAL	85	Extended Care Hospital	282N00000X	Hospitals/General Acute Care Hospital
60	HOSPITAL	86	Hospitals and Nursing Homes	282N00000X	Hospitals/General Acute Care Hospital
60	HOSPITAL	87	All Other	282N00000X	Hospitals/General Acute Care Hospital
61	VENERIAL DISEASE CL (IN-ST)	60	Public Health or Welfare Agencies &	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
62	TUBERCULOSIS CLINIC	60	Public Health or Welfare Agencies & Clinics	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
63	TUBERCULOSIS INPT HOSPITAL			NA	
64	MENTAL HLTH HOSP (FREE-STAND)	86	Hospitals and Nursing Homes	283Q00000X	Hospitals/Psychiatric Hospital

65	REHABILITATION CENTER (IN-	75	Other Medical Care	261QR0400	Ambulatory Health Care Facilities/Clinic/Center, Rehabilitation
66	KIDMED SCREENING CLINIC	44	Public Health/EPSDT	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
66	KIDMED SCREENING CLINIC	60	Public Health or Welfare Agencies & Clinics	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
67	PRENATAL HLTH CARE CL (IN-	60	Public Health or Welfare Agencies & Clinics	261QP2300X	Ambulatory Health Care Facilities Clinic/Center Primary Care
68	SUBS/ALCOH ABSE CTR (X-OVERS)	5N	Substance Abuse and Alcohol Abuse Center	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility
68	SUBS/ALCOH ABSE CTR (X-OVERS)	70	Clinic or Other Group Practice	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility
69	DIST PART PSYCH HOSP (IN-ST)	86	Hospitals and Nursing Homes	283Q00000X	Hospitals/Psychiatric Hospital
70	EPSDT HEALTH SERVICES (IN-	44	Public Health/EPSDT	251300000X	Agencies Local Education Agency (LEA)
71	FMLY PLANNING CLINIC (IN-ST)	97	Family Planning Clinic	261QF0050X	Ambulatory Health Care Facilities Clinic/Center Family Planning, Non-Surgical
72	FED QUALIFIED HLTH CTR (IN-	42	Federally Qualified Health Centers	261QF0400X	Ambulatory Health Care Facilities/Federally Qualified Health Center (FQHC)
72	FED QUALIFIED HLTH CTR (IN-	9L	RHC/FQHC OPH Certified	261QF0400X	Ambulatory Health Care Facilities/Federally Qualified Health Center (FQHC)
73	LIC CL SOCIAL WORKER (IN-ST)	73	Social Worker Enrollment	104100000X	Behavioral Health & Social Service Providers Social Worker
74	MENTAL HEALTH CLINIC (IN-ST)	70	Clinic or Other Group	261QM0801	Ambulatory Health Care Facilities/Clinic/Center, Mental Health

75	OPTICAL SUPPLIER	88	Optician / Optometrist	332H00000X	Suppliers Eyewear Supplier (Equipment, not
76	HEMODIALYSIS CENTER (IN-ST)	70	Clinic or Other Group	261QE0700X	Ambulatory Health Care Facilities/End-Stage Renal Disease (ESRD) Treatment
77	MENTAL REHAB AGENCY (IN-	78	Mental Health Rehab	103TR0400X	Behavioral Health & Social Service Providers/Psychologi st, Rehabilitation
78	NURSE PRACTITIONER (IND & GP)	08	Family Practice	363LF0000X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Family
78	NURSE PRACTITIONER (IND & GP)	16	OB/GYN	363LX0001X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Obstetrics & Gynecology
78	NURSE PRACTITIONER (IND & GP)	26	Psychiatry	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental
78	NURSE PRACTITIONER (IND & GP)	37	Pediatrics	363LP0200X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Pediatrics
78	NURSE PRACTITIONER (IND & GP)	79	Nurse Practitioner	363L00000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
79	RURAL HLTH CL(PROV-BSE)(IN-ST)	94	Rural Health Clinic	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center, Rural Health
80	NURSING FACILITY (IN-ST)	86	Hospitals and Nursing Homes	314000000X	Nursing and Custodial Care Facilities/Skilled Nursing
81	CASE MGMT - VENT ASSTD	81	Case Management	171M00000	Other Service Providers Case Manager/Care
82	PERS CARE ATTEND (WVR) (IN-ST)	82	Personal Care Attendant	3747P1801X	Nursing Service Related Providers Technician Personal

82	PERS CARE ATTEND (WVR) (IN-ST)	8D	Community Choices Waiver - Caregiver Temporary Support	3747P1801X	Nursing Service Related Providers Technician Personal
83	CTR BASED RESPITE CARE (IN-	83	Respite Care	385H00000X	Respite Care Facility Respite Care
83	CTR BASED RESPITE CARE (IN-	8D	Community Choices Waiver - Caregiver Temporary Support	385H00000X	Respite Care Facility Respite Care
84	SUBSTIT FMLY CARE (WVR)(IN-ST)	84	Substitute Family Care	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
85	ADLT DAY HLTH CA (WVR) (IN-ST)	76	Adult Day Care	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
85	ADLT DAY HLTH CA (WVR) (IN-ST)	77	Habilitation	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
86	ICF/DD REHABILITATION			261QR0400X	Ambulatory Health Care Facilities/Clinic/Center, Rehabilitation
87	RURAL HLTH CL(INDEPEND)(IN- ST)	94	Rural Health Clinic	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center, Rural
88	ICF/DD - GROUP HOME (IN-ST)	86	Hospitals and Nursing Homes	261QD1600X	Ambulatory Health Care Facilities Clinic/Center Developmental Disabilities
89	SPRVISE INDEP LIV (WVR)(IN-	89	Supervised Independent	372600000X	Nursing Service Related Providers Adult Companion
90	CERTIFIED NURSE MIDWIFE	16	OB/GYN	367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified
91	CERT REG NURS ANEST (IND & GP)	05	Anesthesiology	163W00000	Nursing Service Providers Registered Nurse
91	CERT REG NURS ANEST (IND & GP)	70	Clinic or Other Group Practice	163W00000	Nursing Service Providers Registered Nurse
92	PRIVATE DUTY NURSE			NA	
93	CLINICAL NURSE SPECIALIST	02	General Surgery	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist

93	CLINICAL NURSE SPECIALIST	26	Psychiatry	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist
94	PHYSICIAN ASSISTANT	26	Psychiatry	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental
94	PHYSICIAN ASSISTANT	2R	Physician Assistant	363A00000X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant
95	AMERICAN INDIAN/638	2T	American Indian / Native Alaskan	332800000X	Suppliers Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy
96	PSYCH RESID TREAT FACILITY	8L	Hospital-based PRTF	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
96	PSYCH RESID TREAT FACILITY	8P	IP - Physician - MD	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
96	PSYCH RESID TREAT FACILITY	9B	Psychiatric Residential	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
97	ADULT RESIDENTIAL CARE FAC	9D	Residential Care	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
98	SUPPORTED EMPLYMENT (IN-	98	Supported Employment	251C00000X	Agencies Day Training, Developmentally Disabled
99	GREAT NO COMM HLTH CONN(IN-ST)	9P	GNOCHC - Greater New Orleans Community Health Connection	251K00000X	Agencies/Public Health or Welfare

AA	ASSERTIVE COMM TREAT			261QC1500	Ambulatory Health Care Facilities Clinic/Center Community Health
AB	PREPAID INPATIENT HLTH	5I	Statewide Management	305R00000X	Managed Care Organizations Preferred Provider
AC	FAMILY SUPPORT	5J	Youth Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AC	FAMILY SUPPORT ORGANIZATION	5K	Family Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse
AC	FAMILY SUPPORT ORGANIZATION	5L	Both Youth and Family	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse
AD	TRANSITION COORDINATION	5U	Individual	251C00000X	Agencies Day Training, Developmentally Disabled Services
AD	TRANSITION COORDINATION	5V	Agency/Business	251C00000X	Agencies Day Training, Developmentally Disabled Services
AE	RESPITE CARE SERVICE	83	Respite Care	385H00000X	Respite Care Facility Respite Care
AF	CRISIS RECEIVING CENTER	8E	CSoC/Behavioral Health	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
AG	BEHAVIORAL HLTH REHAB AGENCY	8E	CSoC/Behavioral Health	251S00000X	Agencies Community/Behavioral Health
AH	LIC MARRIAGE & FAMILY THERAPY	8E	CSoC/Behavioral Health	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
AJ	LICENSED ADDICTION	8E	CSoC/Behavioral Health	101YA0400X	Behavioral Health & Social Service Providers Counselor Addiction (Substance Use
AK	LICENSED PROFESSION	8E	CSoC/Behavioral Health	101YP2500X	Behavioral Health & Social Service Providers Counselor
AL	COMMUNITY CHOICE WAIVER- NURS	8K	ADHC HCBS	251K00000X	Agencies/Public Health or Welfare

AM	HOME DELIVERED MEALS	8M	Community Choices Waiver - Home-Delivered Meals	174200000X	Other Service Providers Meals
AN	CAREGIVER TEMPORARY SUPPORT	8D	Community Choices Waiver - Caregiver Temporary Support	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
AN	CAREGIVER TEMPORARY SUPPORT	8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
AQ	NON-MEDICAL GROUP HOME	9G	Non-Medical Group Home (NMGH)	NA	
AR	THERAPEUTIC FOSTER CARE	9F	Therapeutic Foster Care (TFC)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
AS	OPH CLINIC	70	Clinic or Other Group Practice	261QP0905X	Ambulatory Health Care Facilities Clinic/Center Public Health, State or Local
AU	OPH REGISTERED DIETITIAN	4U	OPH Registered Dietitian	133V00000X	Dietary & Nutritional Service Providers/Dietician,
AV	EXTENDED DUTY DENTAL ASSISTANT	3X	Extended Duty Dental	126800000X	Dental Providers Dental Assistant
AW	PERMANENT SUPPOR HOUSING AGENT	3W	Supportive Housing Agency	NA	
AX	CERTIFIED BEHAVIOR ANALYST	6U	Applied Behavioral Analyst	103K00000X	Behavioral Health & Social Service Providers Behavioral
IP	EHR INCENTIVE PROGRAM	IP		NA	
XX	ERROR PROVIDER	XX	Error Provider	NA	

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Provider Supplemental Record Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 615 bytes. If a field is listed as Optional (O), and the CCN 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 *NOTE: For Atypicals, the NPI should be the ASSIGNED-MEDICAID-PROV-ID and the Taxonomy should be "ATYPICAL".*	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	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.
32	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
33	Ownership-Code	A code denoting the ownership interest and/or managing control information. The valid values list is a Medicare standard list. 01 Voluntary – Non-Profit – Religious Organizations 02 Voluntary – Non-Profit – Other 03 Voluntary – multiple owners 04 Proprietary – Individual 05 Proprietary – Corporation 05 Proprietary – Partnership 05 Proprietary – Other 08 Proprietary – multiple owners 09 Government – Federal 10 Government – State 11 Government – City 12 Government – County 13 Government – City-County 14 Government – Hospital District 15 Government – State and City/County 16 Government – other multiple owners 17 Voluntary /Proprietary 18 Proprietary/Government 19 Voluntary/Government 88 N/A – The individual only practices as part of a group, e.g., as an employee	2	Numeric	R
35	Delimiter		1	Character, use the ^ character value	
36	Provider Business Mailing Email Address	The email address of the provider	60	Character	R Note: Although this data field is required, it can be 8 filled when data is not available.
96	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
97	Provider Business Location Email Address	The email address of the provider	60	Character	R Note: Although this data field is required, it can be 8 filled when data is not available.
157	Delimiter		1	Character, use the ^ character value	
158	License Type 1	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other	1	Numeric	R
159	Delimiter		1	Character, use the ^ character value	
160	License Or Accreditation-Number 1	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body	20	Character	R
180	Delimiter		1	Character, use the ^ character value	
181	LICENSE ISSUING ENTITY ID 1	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	R
241	Delimiter		1	Character, use the ^ character value	
242	License Type 2	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other	1	Numeric	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
243	Delimiter		1	Character, use the ^ character value	
244	License Or Accreditation Number 2	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body identified in the LICENSE-ISSUING-ENTITY-ID data element.	20	Character	O
264	Delimiter		1	Character, use the ^ character value	
265	LICENSE ISSUING ENTITY ID 2	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
325	Delimiter		1	Character, use the ^ character value	
326	License Type 3	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other	1	Numeric	O
327	Delimiter		1	Character, use the ^ character value	
328	License Or Accreditation Number 3	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body identified in the LICENSE ISSUING ENTITY ID data element.	20	Character	O
348	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
349	LICENSE ISSUING ENTITY ID 3	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
409	Delimiter		1	Character, use the ^ character value	
410	License Type 4	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other	1	Numeric	O
411	Delimiter		1	Character, use the ^ character value	
412	License Or Accreditation Number 4	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body identified in the LICENSE ISSUING ENTITY ID data element.	20	Character	O
432	Delimiter		1	Character, use the ^ character value	
433	LICENSE ISSUING ENTITY ID 4	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
493	Delimiter		1	Character, use the ^ character value	
494	License Type 5	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation	1	Numeric	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		5 Other			
495	Delimiter		1	Character, use the ^ character value	
496	License Or Accreditation Number 5	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body identified in the LICENSE ISSUING ENTITY ID data element.	20	Character	O
516	Delimiter		1	Character, use the ^ character value	
517	LICENSE ISSUING ENTITY ID 5	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
577	Delimiter		1	Character, use the ^ character value	
578	Social_Security_Number	The 9 digit Social Security Number for this provider.	9	Numeric (Enter zeros if not available)	O Note: Applicable to individual providers only.
587	Delimiter		1	Character, use the ^ character value	
588	Tax_Identification_ID	The 9 digit tax identification number.	9	Numeric (Enter zeros if not available)	R
597	Delimiter		1	Character, use the ^ character value	
598	PROV LICENSE EFF DATE	The first day of the time span during which the values in all data elements in the PROV-LICENSING-INFO record segment are in effect (i.e., the values accurately reflect reality as it is understood to be at the time the record is created.) This date field is necessary when defining a unique row in a database table.	8	Numeric, format YYYYMMDD	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
606	Delimiter		1	Character, use the ^ character value	
607	Date of Birth	Date of birth of the provider. Applicable to individual providers only.	8	Numeric, format YYYYMMDD	O Note: Applicable to individual providers only.
615	End of record delimiter		1	Character, use the ^ character value	

416 Reports

Until DHH determines that the quality of encounters is sufficient to generate 416 reports, DHH will require each MCO to generate 416 reports as instructed below and the FI will generate the 416 EPSDT report for submission to CMS.

The MCO is required to submit the CMS 416 EPSDT Participation Report to DHH for each quarter of the federal fiscal year (FFY), October 1st through September 30th. The final CMS 416 Report is due to DHH no later than March 1st after the FFY reporting period concludes. The MCO is required to complete all line items of the CMS 416 Report and submit separate reports for the SCHIP and TANF/CHIP populations.

Instructions for the 416 report may be found at:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/CMS-416-instructions.pdf

Standard Provider File

Overview of Provider Extract

Daily and weekly Provider extracts use the same file layout. For each Provider included in the extracts, there will always be a single Header record for that Provider. There is a 0 to 1 to many possibility for Belongs to and Member record types, and the daily extracts are based on a change in the Provider base record. The daily NPI extract is based on a change in the NPI file. All file layouts are based on a fixed length field fixed length file.

Provider File Layout

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

Column(s)	Item	Notes	Length	Format
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character
69	Delimiter		1	Uses the ^ character value
70-71	Provider Type		2	See Provider Type codes in Appendix H
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix H
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-123	Provider Street Address (Servicing)		30	
124	Delimiter		1	Uses the ^ character value
125-154	Provider City (Servicing)		30	

Column(s)	Item	Notes	Length	Format
155	Delimiter		1	Uses the ^ character value
156-157	Provider State	USPS abbreviation	2	
158	Delimiter		1	Uses the ^ character value
159-168	Provider Phone		10	Numeric
169	Delimiter		1	Uses the ^ character value
170-171	Provider Parish		2	See parish code values in Appendix H
172	Delimiter		1	Uses the ^ character value
173-181	Provider Zip Code		9	Numeric
182	Delimiter		1	Uses the ^ character value
183	Urban-Rural Indicator (applicable to hospitals only)		1	Character: 0=not applicable 1=urban 2=rural 3=sole community hospital
184	Delimiter		1	Uses the ^ character value
185-214	Provider Street Address (Pay-To)		30	
215	Delimiter		1	Uses the ^ character value
216-245	Provider City (Pay-To)		30	

Provider Belongs To (Group Affiliations)

```
05 AHS-PROVIDER-BELONGS-TO.
    05 APBT-PROVIDER-ID          PIC 9(7).
    05 APBT-CHECK-DIGIT-ID       PIC 9(7).
    05 APBT-GROUP-ID             PIC 9(7).
    05 APBT-BEGIN-DATE           PIC 9(8).
    05 APBT-END-DATE             PIC 9(8).
    05 APBT-CANCEL-RSN           PIC XX.
```

Provider Members List (Member Affiliations)

```
05 AHS-PROVIDER-MEMBER-LIST.
    05 APML-PROVIDER-ID          PIC 9(7).
    05 APML-CHECK-DIGIT-ID       PIC 9(7).
    05 APML-PROVIDER-MEMBER-ID   PIC 9(7).
```

Provider NPI Cross Reference

```
05 NPI-RECORD.
    05 NR-LEGACY-ID              PIC 9(07).
    05 NR-CHECK-DIGIT-ID         PIC 9(07).
    05 NR-NPI                    PIC X(10).
    05 NR-TAXONOMY               PIC X(10).
    05 NR-TIE-BREAKER-TYPE       PIC X(01).
```

Appendix H
EDI Test Plan

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

Testing Tier I – Registration and Credentialing Phase

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;
- 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 – Claims Testing Phase

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 – Production Phase

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.

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.

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company**

Website 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 identified by the NUCC for

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

Appendix J

Common Data Element Values

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

Parish Codes

Parish Code	Recipient Parish Description
01	Acadia
02	Allen
03	Ascension
04	Assumption
05	Avoyelles
06	Beauregard
07	Bienville
08	Bossier
09	Caddo
10	Calcasieu
11	Caldwell
12	Cameron
13	Catahoula
14	Claiborne
15	Concordia
16	Desoto
17	East Baton Rouge
18	East Carroll
19	East Feliciana
20	Evangeline
21	Franklin
22	Grant
23	Iberia
24	Iberville
25	Jackson
26	Jefferson
27	Jefferson Davis
28	Lafayette
29	Lafourche
30	LaSalle
31	Lincoln
32	Livingston

Parish Code	Recipient Parish Description
33	Madison
34	Morehouse
35	Natchitoches
36	Orleans
37	Ouachita
38	Plaquemines
39	Pointe Coupee
40	Rapides
41	Red River
42	Richland
43	Sabine
44	St Bernard
45	St Charles
46	St Helena
47	St James
48	St John
49	St Landry
50	St Martin
51	St Mary
52	St Tammany
53	Tangipahoa
54	Tensas
55	Terrebonne
56	Union
57	Vermilion
58	Vermilion
59	Washington
60	Webster
61	West Baton Rouge
62	West Carroll
63	West Feliciana
64	Winn
65	East Jefferson

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)

TOS Code	Description
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

TOS Code	Description
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)

Louisiana Medicaid Claim Type Codes

Claim Type	Description	Trans Type
10	Dental EPSDT	837D, ADA
11	Dental Adult	837D, ADA

Louisiana Medicaid Pricing Action Code (PAC)

PAC	Description
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

Category of Service (COS)

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

State COS	Description
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

State COS	Description
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

State COS	Description
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

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

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
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

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
42	Federally Qualified Health Centers	1
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

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
64	Audiologist (Billing Independently)	1
65	Individual Physical Therapist	1
66	Dentist, DDS, DMS	1
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

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
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
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

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
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
1Q	Pediatric Neurology	2
1R	Pediatric Genetics	2
1S	BRG – Med School	2
1T	Emergency Medicine	1
1U	Pediatric Developmental Behavioral Health	2
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

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
2J	Medical Oncology	2
2K	Nephrology	2
2L	Pulmonary Disease	2
2M	Rheumatology	2
2N	Surgery – Critical Care	2
2P	Surgery – General Vascular	2
2Q	Nuclear Medicine	1
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
3C	Maternal & Fetal Medicine	2
3D	Community Choice Waiver – Respiratory Therapy	2
3E	Community Choices Waiver – PT and OT	2
3F	Community Choices Waiver – PT and S/L T	2
3G	Community Choices Waiver – PT and RT	2
3H	Community Choices Waiver – OT and S/L T	2
3J	Community Choices Waiver – OT and RT	2
3K	Community Choices Waiver – S/L T and RT	2
3L	Community Choices Waiver – PT, OT, & S/L T	2

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
3M	Community Choices Waiver – PT, OT & RT	2
3N	Community Choices Waiver – PT, S/L T & RT	2
3P	Organized Health Care Delivery System (OHCDS)	1
3Q	Community Choices Waiver – OT, S/L T & RT	2
3R	Community Choices Waiver – All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2
3S	LSU Medical Center Shreveport	2
3T	DBPM – Dental Benefit Plan Prescriber	1
3U	Community Choices Waiver – Assistive Devices – Home Health	2
3W	Supportive Housing Agency	1
3X	Extended Duty Dental Assistant	1
3Y	DBPM – Dental Benefit Plan Management	1
4A	Developmental Disability	1
4B	NOW RN	1
4C	NOW LPN	1
4D	NOW Psychologist	1
4E	NOW Social Worker	1
4G	New Provider Domain	1
4H	Conversion, Participant Domain	1
4J	Conversion, Provider Domain	1
4K	Home and Community-Based Services (HCBS)	1
4L	New, Participant Domain	1

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
4M	HER Managed Care (Behavior Health)	2
4P	OAAS	1
4R	Registered Dietician	1
4S	Ochsner Med School	2
4U	OPH Registered Dietician	1
4W	Waiver Services	
4X	Waiver-Only Transportation	1
4Y	EHR Managed Care (Medical)	2
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	
5I	Statewide Management Organization (SMO)	1
5J	Youth Support	1
5K	Family Support	1
5L	Both Youth and Family Support	1
5M	Multi-Systemic Therapy	
5N	Substance Abuse and Alcohol Abuse Center	

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
5P	PACE	1
5Q	CCN-P (Coordinated Care Network, Prepaid) - MCO	1
5R	CCN-S (Coordinated Care Network, Shared Savings)	
5S	Tulane Med School	2
5T	Community Choices Waiver (CCW)	1
5U	Individual	1
5V	Agency/Business	1
5W	Community Choices Waiver – Personal Assistance Service	2
5X	Therapeutic Group Homes	1
5Y	PRCS Addiction Disorder	1
5Z	Therapeutic Group Home Disorder	1
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
6T	Community Choices Waiver – Physical Therapy	2

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
6U	Applied Behavioral Analyst	1
6W	Licensed Mid-Wife	1
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
7G	Community Choices Waiver – Speech/Language Therapy	2
7H	Community Choices Waiver – Occupational Therapy	2
7M	Retail Convenience Clinics	2
7N	Urgent Care Clinics	2
7P	ABA Therapy Psychologist	1
7R	Aquatic Therapy	1
7S	Leonard J Chabert Medical Center - Houma	2
7T	Art Therapy	1
7U	Art and Music	2
7V	Music Therapy	1
7X	Sensory Integration	1
7Y	Therapeutic Horseback Riding	1
7Z	Hippotherapy	1

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
8A	EDA & DD services	2
8B	EDA services	2
8C	DD services	2
8D	Community Choices Waiver – Caregiver Temporary Support	1
8E	CSoC/Behavioral Health	1,2
8F	Community Choices Waiver – Caregiver Temporary Support – Home Health	2
8G	Community Choices Waiver – Caregiver Temporary Support-Assisted Living	2
8H	Community Choices Waiver – Caregiver Temporary Support – ADHC	2
8J	Community Choices Waiver – Caregiver Temporary Support – Nursing Facility	2
8K	ADHC HCBS	1
8L	Hospital-based PRTF	1
8M	Community Choices Waiver – Home-Delivered Meals	1
8N	Community Choices Waiver – Nursing	2
8O	IP – Doctor of Osteopathic Medicine	1
8P	IP – Physician – MD	1
8Q	EAA Assessor, Inspector, Approver	2
8S	OLOL Medical School	2
9A	Community Choices Waiver – Nursing and Personal Assistance Services	2

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
9B	Psychiatric Residential Treatment Facility	1
9D	Residential Care	1
9E	Children's Choice Waiver	1
9F	Therapeutic Foster Care (TFC)	1
9G	Non-Medical Group	1
9L	RHC/FQHC OPH Certified SBHC	1
9M	Monitored In-Home Caregiving (MIHC)	1
9P	GNOCHC – Greater New Orleans Community Health Connection	1
9Q	PT 21 – EDI Independent Billing Company	2
9R	Electronic Visit Verification Submitter	2
9S	IP – Optical Supplier	1
9T	Exempted from State EVV	2
9U	Medicare Advantage Plans	1
9V	OCDD – Point of Entry	1
9W	OASS – Point of Entry	1
9X	OAD	1
9Y	Juvenile Court/Drug Treatment Center	1
9Z	Other Contract with a State Agency	1
XX	Error Provider	1

Pricing Action Code (PAC)

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

Appendix K

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

TPL Requirement Format

The DBPM shall provide DHH Third Party Liability information in a format and medium described by DHH and shall cooperate in any manner necessary, as requested by DHH, with DHH and/or a cost recovery vendor of DHH.

On a weekly basis, the DBPM is required to submit the FI (Molina) the File layout along with the instructions. The Batch File Submission and File Layout can be found on the following pages along with instructions and error codes.

Batch Electronic File Layout for TPL Information

Document Date: 11/20/2012
Edited: 06/10/2016 (Changes are highlighted)
This information is subject to change

PART 1: PLAN FILE SUBMISSIONS

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

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

Plan File submission naming convention: **TPL-BATCH-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is your Plan ID (0136558=MCNA), and YYYYMMDD is the date of submission.

The submission file has a fixed-length record format. Each record is 700 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields are optional (O). If a field is optional, then a value of space(s) is acceptable, unless otherwise noted. If you enter a value that is not spaces, the value will be edited appropriately. The file does not use delimiters and is formatted as an ASCII text file. For update records (Field 53 value = 3), fields that you may update/change are highlighted in blue below.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-8	TPL_CREATE_DATE	char(8)	R	YYYYMMDD, e.g. 20121017 Date that the TPL record was created.
2	9-14	TPL_CREATE_TIME	char(6)	R	HHMMSS in military time, e.g. 235959 Time that the TPL record was created.
3	15	TPL_RECORD_SOURCE_CD	char(1)	R	Value: **1=general TPL update.**
4	16-27	TPL_PRI_INDIV_NAME_LAST	char(12)	R	Left Justify
5	28-34	TPL_PRI_INDIV_NAME_FIRST	char(7)	R	Left Justify
6	35	TPL_PRI_INDIV_NAME_MI	char(1)	R	Use a space if not available
7	36-48	TPL_PRI_MED_ID_NO	char(13)	R	Medicaid recipient ID
8	49-57	TPL_PRI_INSURED_SSN	char(9)	R	Enter a valid SSN
9	58-59	TPL_INITIATOR_CODE	char(2)	R	Value:

					02= Title IV-D-SES 19=MCNA
10	60-71	TPL_CASE_NAME_LAST	char(12)	O	Left justify
11	72-78	TPL_CASE_NAME_FIRST	char(7)	O	Left justify
12	79	TPL_CASE_NAME_MI	char(1)	O	Use a space if not available
13	80-92	TPL_CASE_ID	char(13)	O	Leave spaces if not used
14	93-96	TPL_CASELOAD_NO	char(4)	O	Leave spaces if not used
15	97-108	TPL_POLICY_HOLDER_NAME_LAST	char(12)	O	Left justify
16	109-115	TPL_POLICY_HOLDER_NAME_FIRST	char(7)	O	Left justify
17	116	TPL_POLICY_HOLDER_NAME_MI	char(1)	O	Use a space if not available
18	117-141	TPL_POLICY_HOLDER_STREET	char(25)	O	Left justify
19	142-161	TPL_POLICY_HOLDER_CITY	char(20)	O	Left Justify
20	162-163	TPL_POLICY_HOLDER_STATE	char(2)	O	USPS abbreviation
21	164-172	TPL_POLICY_HOLDER_ZIP	char(9)	O	Left Justify
22	173-181	TPL_POLICY_HOLDER_SSN	char(9)	O	Use all zeros if not available
23	182-234	TPL_EMPLOYER_GRP_MAINT_COVERAGE	char(53)	O	Left Justify
24	235-259	TPL_EMPLOYER_CLAIM_FIL_STREET	char(25)	O	Left Justify
25	260-279	TPL_EMPLOYER_CLAIM_FIL_CITY	char(20)	O	Left Justify
26	280-281	TPL_EMPLOYER_CLAIM_FIL_STATE	char(2)	O	Left Justify
27	282-290	TPL_EMPLOYER_CLAIM_FIL_ZIP	char(9)	O	Left Justify
28	291-343	TPL_INSURANCE_NAME	char(53)	R	Left Justify
29	344-349	TPL_INSURANCE_NUMBER	char(6)	R	Use the appropriate Louisiana MMIS Carrier Code
30	350-374	TPL_INSURANCE_CLAIM_FIL_STREET	char(25)	R	Left Justify
31	375-394	TPL_INSURANCE_CLAIM_FIL_CITY	char(20)	R	Left Justify
32	395-396	TPL_INSURANCE_CLAIM_FIL_STATE	char(2)	R	USPS abbreviation
33	397-405	TPL_INSURANCE_CLAIM_FIL_ZIP	char(9)	R	Left Justify
34	406-418	TPL_POL_NBR	char(13)	R	Left Justify
35	419-433	TPL_GROUP_NBR	char(15)	O	Left Justify, leave blank if not used.
36	434-435	TPL_SCOPE_OF_COVERAGE_1	char(2)	R	See Scopes of Coverage in SCG.
37	436-437	TPL_SCOPE_OF_COVERAGE_2	char(2)	O	See Scopes of Coverage in SCG, if possible
38	438	TPL_SCOPE_OF_COVERAGE_CD_1	char(1)	O	Leave space.
39	439	TPL_SCOPE_OF_COVERAGE_CD_2	char(1)	O	Leave space.
40	440-447	TPL_BEGIN_DATE_YYMMDD	char(8)	R	YYYYMMDD

41	448-455	TPL_END_DATE_YYMMDD	char(8)	R	YYYYMMDD, use 20991231 if the entry is open-ended.
42	456-480	TPL_AGENT_NAME	char(25)	O	Left Justify
43	481-490	TPL_AGENT_PHONE	char(10)	O	Left Justify
44	491-515	TPL_AGENT_STREET	char(25)	O	Left Justify
45	516-535	TPL_AGENT_CITY	char(20)	O	Left Justify
46	536-537	TPL_AGENT_STATE	char(2)	O	Left Justify
47	538-546	TPL_AGENT_ZIP	char(9)	O	Left Justify
48	547-548	TPL_PARISH	char(2)	O	**Use a parish code value from 01-64 or 77.** See Parish Code table in SCG.
49	549	FILLER	char(1)	O	Leave space.
50	550-562	TPL_PRIV_INSUR_SUBMIT_ID	char(13)	O	Leave spaces.
51	563-567	TPL_PRIV_DOB	char(5)	O	Leave spaces.
52	568-569	TPL_PRIV_CAT	char(2)	O	Leave spaces.
53	570	TPL_PROCESS_TYPE	char(1)	R	Values: **1=new entry,** **3=update existing entry,**
54	571-577	TPL_SEQUENCE_NUMBER	char(7)	R	File record sequence number: The first record in the file should have number 0000001, the second 0000002, etc.
~~55~~	~~578-585~~	~~TPL_LAHIPP_BEGIN_DATE~~	~~char(8)~~	~~O~~	~~Leave spaces.~~
~~56~~	~~586-593~~	~~TPL_LAHIPP_END_DATE~~	~~char(8)~~	~~O~~	~~Leave spaces.~~
57	594-700	TPL_FILLER	char(123)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

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

IMPORTANT NOTE: If you do NOT receive an error text file (even one with 0 bytes) on a given work day, then it is an indication that Molina did not receive a file from you on that date.

The error text file will use the naming convention: **TPL-ERROR-NNNNNNN-YYYYMMDD.txt**
Where NNNNNNN is your Plan ID (0136558=MCNA), and YYYYMMDD is the date from your submission file.

The error text file will have this layout:

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*Notes*
1	1-7	TPL_SEQUENCE_NUMBER	char(7)	File record sequence number from your submission.
2	8-20	TPL_PRI_MED_ID_NO	char(13)	Medicaid recipient ID from your submission.
3	21-29	TPL_PRI_INSURED_SSN	char(9)	SSN from your submission.
4	30-32	ERROR CODE 1	char(3)	3-digit number representing error code (see below).
5	33-35	ERROR CODE 2	char(3)	2nd 3-digit error code, if necessary.
6	36-38	ERROR CODE 3	char(3)	3rd 3-digit error code, if necessary.
7	39-41	ERROR CODE 4	char(3)	4th 3-digit error code, if necessary.
8	42	END-OF-RECORD INDICATOR	char(1)	Value is "#".

ERROR CODES

Error codes are associated with the Field values shown in the submission record layout shown above. So, for example:

001 Invalid value for Field 1 (TPL_CREATE_DATE). Field does not contain a valid date or date<20120101.

002 Invalid value for Field 2 (TPL_CREATE_TIME). Field does not contain a valid time format.

003 Invalid value for Field 3 (TPL_RECORD_SOURCE_CD). A value other than 1 was found on the record.

004 Invalid value for Field 4 (TPL_PRI_INDIV_NAME_LAST). The value of the field was all spaces.

005 Invalid value for Field 5 (TPL_PRI_INDIV_NAME_FIRST). The value of the field was all spaces.

006 Invalid value for Field 6 (TPL_PRI_INDIV_NAME_MI). The value of the field was a space.

007 Invalid value for Field 7 (TPL_PRI_MED_ID_NO). The field contains spaces, or the field is not numeric, or the field is not 13 digits.

008 Invalid value for Field 8 (TPL_PRI_INSURED_SSN). The field contains spaces, or the field is not numeric, or the field is not 9 digits.

009 Invalid value for Field 9 (TPL_INITIATOR_CODE). Your assigned initiator code must correspond to your Plan ID.

010 Invalid value for Field 10 (TPL_CASE_NAME_LAST). This field is not edited, so you should not see edit error 010 in the edit response file.

011 Invalid value for Field 11 (TPL_CASE_NAME_FIRST). This field is not edited, so you should not see edit error 011 in the edit response file.

012 Invalid value for Field 12 (TPL_CASE_NAME_MI). This field is not edited, so you should not see edit error 012 in the edit response file.

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

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

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

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

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

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

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

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

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

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

023 Invalid value for Field 23 (TPL_EMPLOYER_GRP_MAINT_COVER). This field is not edited, so you should not see edit error 023 in the edit response file.
024 Invalid value for Field 24 (TPL_EMPLOYER_CLAIM_FIL_STREET). This field is not edited, so you should not see edit error 024 in the edit response file.
025 Invalid value for Field 25 (TPL_EMPLOYER_CLAIM_FIL_CITY). This field is not edited, so you should not see edit error 025 in the edit response file.
026 Invalid value for Field 26 (TPL_EMPLOYER_CLAIM_FIL_STATE). This field is not edited, so you should not see edit error 026 in the edit response file.
027 Invalid value for Field 27 (TPL_EMPLOYER_CLAIM_FIL_ZIP). This field is not edited, so you should not see edit error 027 in the edit response file.
028 Invalid value for Field 28 (TPL_INSURANCE_NAME). Value submitted is spaces.
029 Invalid value for Field 29 (TPL_INSURANCE_NUMBER). Value submitted is spaces or value is not found on LMMIS Carrier Code file. If TPL_PROCESS_TYPE=3 then value was not found on Recipient's TPL record. Carrier Code HXXXXX reported and SOC code not = 30. SOC reported and Carrier Code not = HXXXXX.
030 Invalid value for Field 30 (TPL_INSURANCE_CLAIM_FIL_STREET). Value submitted is spaces.
031 Invalid value for Field 31 (TPL_INSURANCE_CLAIM_FIL_CITY). Value submitted is spaces.
032 Invalid value for Field 32 (TPL_INSURANCE_CLAIM_FIL_STATE). Value submitted is spaces.
033 Invalid value for Field 33 (TPL_INSURANCE_CLAIM_FIL_ZIP). Value submitted is spaces.
034 Invalid value for Field 34 (TPL_POL_NBR). Value is spaces, special characters, punctuation marks or all 0s or all 9s.
035 Invalid value for Field 35 (TPL_GROUP_NBR). Value is spaces or all 0s or all 9s.
036 Invalid value for Field 36 (TPL_SCOPE_OF_COVERAGE_1). Not a valid scope of coverage.
037 Invalid value for Field 37 (TPL_SCOPE_OF_COVERAGE_2). Not a valid scope of coverage.
038 Invalid value for Field 38 (TPL_SCOPE_OF_COVERAGE_CD_1). Value should be a space.
039 Invalid value for Field 39 (TPL_SCOPE_OF_COVERAGE_CD_2). Value should be a space.
040 Invalid value for Field 40 (TPL_BEGIN_DATE_YYMMDD). Must be a valid date value. Must be greater than 19650101 and must be less than 20201231.
041 Invalid value for Field 41 (TPL_END_DATE_YYMMDD). Must be a valid date value and must be >= Field 40. If the value is 20991231 or 29991231 or 99999999 or is greater than 20201231 then it is automatically changed to 20201231.
042 Invalid value for Field 42 (TPL_AGENT_NAME). This field is not edited, so you should not see edit error 042 in the edit response file.
043 Invalid value for Field 43 (TPL_AGENT_PHONE). This field is not edited, so you should not see edit error 043 in the edit response file.
044 Invalid value for Field 44 (TPL_AGENT_STREET). This field is not edited, so you should not see edit error 044 in the edit response file.

045 Invalid value for Field 45 (TPL_AGENT_CITY). This field is not edited, so you should not see edit error 044 in the edit response file.
046 Invalid value for Field 46 (TPL_AGENT_STATE). A non-blank value was submitted and it does not represent a valid USPS state code.
047 Invalid value for Field 47 (TPL_AGENT_ZIP). A non-blank value was submitted and it is not a 5-digit or 9-digit number.
048 Invalid value for Field 48 (TPL_PARISH). A non-blank value was submitted and it is not a valid LMMIS parish code value.
049 Invalid value for Field 49 (FILLER). This field is not edited, so you should not see edit error 044 in the edit response file.
050 Invalid value for Field 50 (TPL_PRIV_INSUR_SUBMIT_ID). This field is not edited, so you should not see edit error 044 in the edit response file.
051 Invalid value for Field 51 (TPL_PRIV_DOB). This field is not edited, so you should not see edit error 044 in the edit response file.
052 Invalid value for Field 52 (TPL_PRIV_CAT). This field is not edited, so you should not see edit error 044 in the edit response file.
053 Invalid value for Field 53 (TPL_PROCESS_TYPE). Must be 1 or 3. If value is 1, then a record must not exist on the LMMIS TPL Resource File. If value is 3, then a record must exist on the LMMIS TPL Resource File. Type 3 records must match on policy and carrier code. If value is 3 and Policy and Carrier Code do not match, the record will reject with 053. Carrier code is not a field that can be updated. See rule #7.
054 Invalid value for Field 54 (TPL_SEQUENCE_NUMBER). Must be a number and must be unique in the file.

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

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

SPECIAL NOTE: The records that are clean (do not have edit errors on the front-end process) are sent to Molina's back-end mainframe process to update the MMIS TPL Resource File. The back-end mainframe process also engages edits, and some of the records that pass through the front-end may experience edit errors in the mainframe process. When this occurs, you may also receive a TP13 file on the Molina sFTP server in your From_Molina folder. The filename is:
TP13-ERROR-nnnnnnn-yyyymmdd.TXT
Where **nnnnnnn** is the plan ID and **yyyymmdd** is the date.
[TP13 is the name of the mainframe edit error report].

RULES for PROCESSING TPL RECORDS

1. An Existing TPL Record is a record that is on the MMIS system and has not been logically deleted (end date = begin date).
2. If a TPL record exists for an individual on the MMIS System, based on Recipient ID (Field 7) and Policy Number (Field 34), then you should submit an update record (Field 53 value = 3) when you wish to update the record. The rule is that if a record already exists on the MMIS System, and you wish to update that record, then you should submit an update transaction (Field 53 value = 3).
3. If you submit a New Entry record (Field 53 value = 1) for a record that exists on the MMIS System, then the record will be rejected with error code 053. The rule is that you may not add a new record if a TPL record already exists on the MMIS System.
4. If you wish to "remove" a record that exists on the MMIS System, you will need to logically delete the record by submitting an update record (Field 53 value = 3) with the end date (Field 041) equal to the begin date (Field 040). This will effectively cancel the record. There is no provision to physically delete a TPL record. Because AMG's system cannot send a record with an end date = begin date. If AMG wishes to "remove" a record that exists on the MMIS System, AMG should send a type 4 record (Field 53 value = 4).
5. If you attempt to update a TPL record that does not exist on the MMIS System, based on Recipient ID (Field 7) and Policy Number (Field 34), the record will be rejected with error code 053. Therefore, if a TPL record does not exist for an individual and you wish to add one, submit a New Entry record (Field 53 value = 1).
6. For update records (Field 53 value = 3), the fields that you may update are highlighted in blue in the record layout of Part 1 of this document.
7. To change the carrier code (TPL_INSURANCE_NUMBER (Field 29)), on an existing TPL record for an individual, based on Recipient ID (Field 7), and Policy Number (Field 34), complete the follow process:
    a. Day 1, logically delete the existing record (end date same as begin date) on a type 3 record (Field 53 value = 3). AMG is the exception to this rule. AMG should delete existing records by sending type 4 record (Field 53 value = 4). Verify in your response file the Record was accepted in Molina's system.
    b. Day 2, send a new record (Field 53 value =1) for same policy with correct carrier code.
8. Medicare Advantage Plan Carrier Codes begin with HXXXXX, and SOC is 30.

    If you submit a record for a Medicare Advantage Plan, the Carrier Code (Field 29), should be reported as HXXXXX, and the Scope of Coverage (Fields 36-37)) should be reported as 30.
    a. If you submit a record whose SOC is 30 and the Carrier Code is not HXXXXX, the record will reject with error code 029 (edit pending-effective date TBD).

b. If you submit a record whose Carrier Code is HXXXXX, and the SOC is not 30, the record will reject with error code 029 (edit pending-effective date TBD).

9. If you identify a second SOC in addition to the SOC reported on your TPL reconciliation file, report the primary scope of coverage in Field 36 (TPL_SCOPE_OF_COVERAGE_1), and report the secondary SOC in Field 37 (TPL_SCOPE_OF_COVERAGE_2).
10. For new records (Field 53 value = 1), Policy Number (Field 29), **must not contain spaces or special characters or punctuation marks**. For new records (Field 53 value = 1) where the policy number has spaces, special characters or punctuation marks will reject with error code 034 (edit pending-effective date TBD).
11. ~~**For new records** (Field 53 value = 1), **alpha characters reported in Policy Number** (Field 29), **must be in UPPER CASE.** New records (Field 53 value = 1), where policy number (Field 29) reports lower case characters will reject with error code 034 (edit pending-effective date TBD).~~

12. **For new records** (Field 53 value = 1), **alpha characters reported in Policy Number** (Field 29), **must be in UPPER CASE**. New records (Field 53 value = 1), where policy number (Field 29) reports lower case characters will reject with error code 034 (edit pending-effective date TBD).
13. **For update records** (Field 53 value = 3**) policy number must exactly match that of the policy number on file**. For example, Member 123, Carrier Code, 22270, policy number 45a567B-00 on Molina TPL Resource File. The policy number reported in the update record (Field 53 value = 3), for member 123, Carrier code 22270 must mirror the policy on file which is : 45a567B-00; otherwise, the record will reject with error code 053.
14. How to report records where there exist gaps in coverage. (TBD)

END OF SECTION

Molina TPL File Layout to Plans

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

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 coverage meaning no major medical coverage identified
20	Nursing Home Only
21	Cancer Only
22	CHAMPUS/CHAMPVA
23	Veterans Administration
24	Transportation
25	HMO
26	Carrier declared Bankruptcy
27	Major Medical without maternity benefits
28	HMO/Insurance Premium Paid by Medicaid GHIPP Program
29	Skilled Nursing Care
30	Medicare HMO (Part C)
31	Physician Only HMO
32	Pharmacy (PBM) Rx Coverage with known major medical coverage
33	HMO No Maternity

TPL Carrier Code File Layout

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

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

Cols 1-6: Carrier Code (Payer ID)

Col 7: delimiter, value is ^

Cols 8-60: Insurance company name

Col 61: delimiter, value is ^

Cols 62-86: Street Address 1

Col 87: delimiter, value is ^

Cols 88-112: Street Address 2

Col 113: delimiter, value is ^

Cols 114-133: City

Col 134: delimiter, value is ^

Cols 135-136: State (abbrev)

Col 137: delimiter, value is ^

Cols 138-146: zip+4

Col 147: delimiter, value is ^.

Appendix L

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 Plan reports discrepancies to the DHH MEDS unit for disposition/resolution, which may require the Plan to correct their records.

Appendix M

File Transfer Schedule

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

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

OUTBOUND FILES FROM MOLINA						
File Name	**File Description**	**Frequency**	**Send On**	**Turn Around Time:**	**File From:**	**File To:**
MLN-<DAILY8>-PRV-DAILY.ZIP	Daily Provider updated records extracts	Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing		MOLINA	MCNA
MLN-<DAILY8>-RECI-DAILY.ZIP	Daily Recipient updated records extracts	Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing		MOLINA	MCNA
CCNPlanID_TPLCCYYMMDD2135.txt	Weekly TPL file for MCOs	Weekly	Each Tuesday by COB		MOLINA	MCNA
MLN-<DAILY8>-CLMDENT-WKLY.ZIP	FFS and Encounters weekly Dental claims	Weekly	Every weekend		MOLINA	MCNA
MLN-<DAILY8>-PRV-WKLY.ZIP	Weekly full Provider extracts	Weekly	Every Weekend		MOLINA	MCNA
MLN-<DAILY8>-RECI-WKLY.ZIP	Weekly full Recipent extracts	Weekly	Every Weekend		MOLINA	MCNA
MLN-<RUNDT8>-WKLY-ENCRPT.ZIP	Weekly Denied Encounter Error Analysis and Encounter EOB Analysis CP-0-90-D Reports	Weekly	Every Thursday night		MOLINA	MCNA
PROVIDER REGISTRY	Weekly Provider Registry edit reports	Weekly	Every Friday Night		MOLINA	MCO, MCNA, MAGELLAN
Recipient Voided IDs.txt	Daily Duplicate Medicaid ID file	Daily	Each working Monday – Thursday Evening and Friday after weekly processing		MOLINA	MCNA MAGELLAN

SMO-W-001-PlanID-CCYYMMDD.txt	Weekly summarization of the errors incurred for encounters processing	Weekly	Each Tuesday by COB		MOLINA	MAGELLAN, MCNA
SMO-W-005-PlanID-CCYYMMDD.txt	Weekly summarization of the edit codes for encounters processing	Weekly	Each Tuesday by COB		MOLINA	MAGELLAN, MCNA
SMO-W-010-PlanID-CCYYMMDD.zip	Weekly list of all encounters and their error codes, including denied error codes, for encounter processing	Weekly	Each Tuesday by COB		MOLINA	MAGELLAN, MCNA
TPL-ERROR-PlanID-CCYYMMDD.TXT	Weekly edit report of TPL records submitted by MCOs	Weekly	Every Thursday Night		MOLINA	MAGELLAN, MCNA
MMIS_PLAN_EXTRACT_<DAILY8>.TXT	Supplement to Fee Schedule	Weekly	File is available to the MCO on Fridays, is sent to the MCO's sFTP verified site address		MOLINA	MCO, MAGELLAN, MCNA
CCN_Carrier_File_CCYYMMDD.txt	List of LMMIS TPL carrier code assignments	Monthly	COB on first work day of each month		MOLINA	MCO, MAGELLAN, MCNA
Monthly 820 DOC recovery files	DOC recoveries 820 file	Monthly	On payment schedule		MOLINA	MCNA
Monthly 820 DOD recovery files	DOD recoveries 820 file	Monthly	On payment schedule		MOLINA	MCNA, MAGELLAN
Monthly 820 files	Monthly PMPM 820 file	Monthly	On payment schedule		MOLINA	MCNA, MAGELLAN
Monthly 820 LaHIPP recovery files	LaHIPP recoveries 820 file	Monthly	On payment schedule		MOLINA	MCNA
Monthly 820 retro files	Retro PMPM payments 820 file	Monthly	On payment schedule		MOLINA	MCNA, MAGELLAN

NOTE: subject to change by DHH

INBOUND FILES TO MOLINA

File Name	File Description	Frequency	Send On	Turn Around Time:	File From:	File To:
CCYYMMDD_PlanID_SMO_PR.txt	Weekly provider registry records submitted by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCNA	MOLINA

CCYYMMDD_PLANID_Provider_Suppl_WEEKLY.txt	Weekly provider supplemental records submitted by MCOs for TMSIS	Weekly	Every Friday COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
TPL-BATCH-PLANID-CCYYMMDD.txt	TPL records submitted by MCOs for processing	Weekly	Every Thursday COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PlanSubmitterID_MCO_PA_History.txt	Monthly list of historical Prior Authorizations submitted by MCOs	Weekly	Every Friday COB until 2 years of history are submitted	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
Encounter files	837 and NCPDP encounter submission files	Weekly	By Thursday 12:00 noon CT. Note that NCPDP encounters may not be submitted on Thursday	On Check Write Schedule	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PLANID_Provider_Suppl_Monthly.txt	Monthly provider supplemental records submitted by MCOs for TMSIS	Monthly	1st Friday of month COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA

NOTE: subject to change by DHH

Appendix N
Prior Authorization Request Data Elements

On a weekly basis, Managed Care Organization is required to submit ALL Prior Authorization Requests, in a file format, to the FI. The files are to be sent to the FI's non-EDI SFTP server and must be submitted on Fridays by 2:00 P.M. If more than one (1) file is sent for the same Plan ID/PA#/Line# primary key combination, the FI will keep the latest file.

DHH is requesting the following from the MCO:

A one-time historical Prior Authorization file with naming convention as follows: "ccyymmdd_xxxxxxx_MCO_PA_History.txt", where "ccyymmdd" = date of transmission; and "xxxxxxx"= MCO's Provider ID as indicated in the Plan Submitter ID field of the file layout.

All Prior Authorization requests – Approved and Denied with naming convention as follows: "ccyymmdd_xxxxxxx_MCO_PA.txt" , where "ccyymmdd" is the date of transmission and "xxxxxxx" is the MCO's Provider ID as indicated in the Plan Submitter ID field of the file layout.

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

Field Name	Usage Notes	Date Type	Purpose
Plan submitter ID	4508073, 4508063, 4508067, 4508090,4508062,4508178,4508846	Int (Primary Key)	Health Plans Submitter ID
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Number		varchar(30)	The PA Authorization Number
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Line Number		int	The PA line Number
Delimiter	'^'	char(1)	Column Separator

Field Name	Usage Notes	Date Type	Purpose
Authorization Type	05 Rehabilitation Services 06 Home Health Care 09 DME 12 Pharmacy 16 Personal Care Service 17 Medical --(Procedures and Diagnostics test) 18 Transportation 19 Dental 40 Imaging 70 LTC 71 Pediatric Day Health Care 88 Hospice 90 Specialized Behavioral Health 99 Other	Char(2)	Prior Authorization Type
Delimiter	'^'	char(1)	Column Separator
Medicaid Recipient ID		char(13)	Current Medicaid Recipent ID
Delimiter	'^'	char(1)	Column Separator
Provider NPI		Char(10)	Requesting provider NPI
Delimiter	'^'	char(1)	Column Separator
Provider Taxonomy		char(10)	Requesting provider taxonomy
Delimiter	'^'	char(1)	Column Separator
CDT		char(13)	Requested service code (CDT)
Delimiter	'^'	char(1)	Column Separator
CDT Modifiers 1		char(2)	CDT modifier up to 4 Tooth Letter or Number
Delimiter	'^'	char(1)	Column Separator
CDT Modifiers 2		char(2)	CDT modifier up to 4 Tooth Surface
Delimiter	'^'	char(1)	Column Separator
CDT Modifiers 3		char(2)	CDT modifier up to 4 Oral Cavity Designator
Delimiter	'^'	char(1)	Column Separator
CDT Modifiers 4		char(2)	CDT modifier up to 4
Delimiter	'^'	char(1)	Column Separator

Field Name	Usage Notes	Date Type	Purpose
Refering Provider NPI		char(10)	Refering Provider NPI
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Status	A=authorized D=Denied R=Reduced authorized N=No Decision, Pending V=Void	char(1)	The Prior Authorization Line status
Delimiter	'^'	char(1)	Column Separator
Auth begin date	Format=CCYYMMDD	int	The beginning date of service associated with the PA request.
Delimiter	'^'	char(1)	Column Separator
Auth end date	Format=CCYYMMDD	int	The ending date of service associated with the PA request.
Delimiter	'^'	char(1)	Column Separator
Requested Units		int	Maximum Units Requested by Provider
Delimiter	'^'	char(1)	Column Separator
Auth Units		int	Maximum Units authorized by plan
Delimiter	'^'	char(1)	Column Separator
Auth amount ($)		Money	Maximum dollar amount authorized by plan
Delimiter	'^'	char(1)	Column Separator
Auth received date	Format=CCYYMMDD	Int	The date health Plan received PA request
Delimiter	'^'	char(1)	Column Separator
Auth notice date	Format=CCYYMMDD	int	The date health Plan notice the decision
Delimiter	'^'	char(1)	Column Separator
Auth Denied Reason	1 Not Medically Appropriate 2 Not a Covered Benefit 3 Administrative - Lack of Information 4 Reduced Authorized 5 Other	Char(2)	Reasons if PA was Denied
Delimiter	'^'	char(1)	Column Separator

Louisiana Medicaid Recipient Aid Category Codes

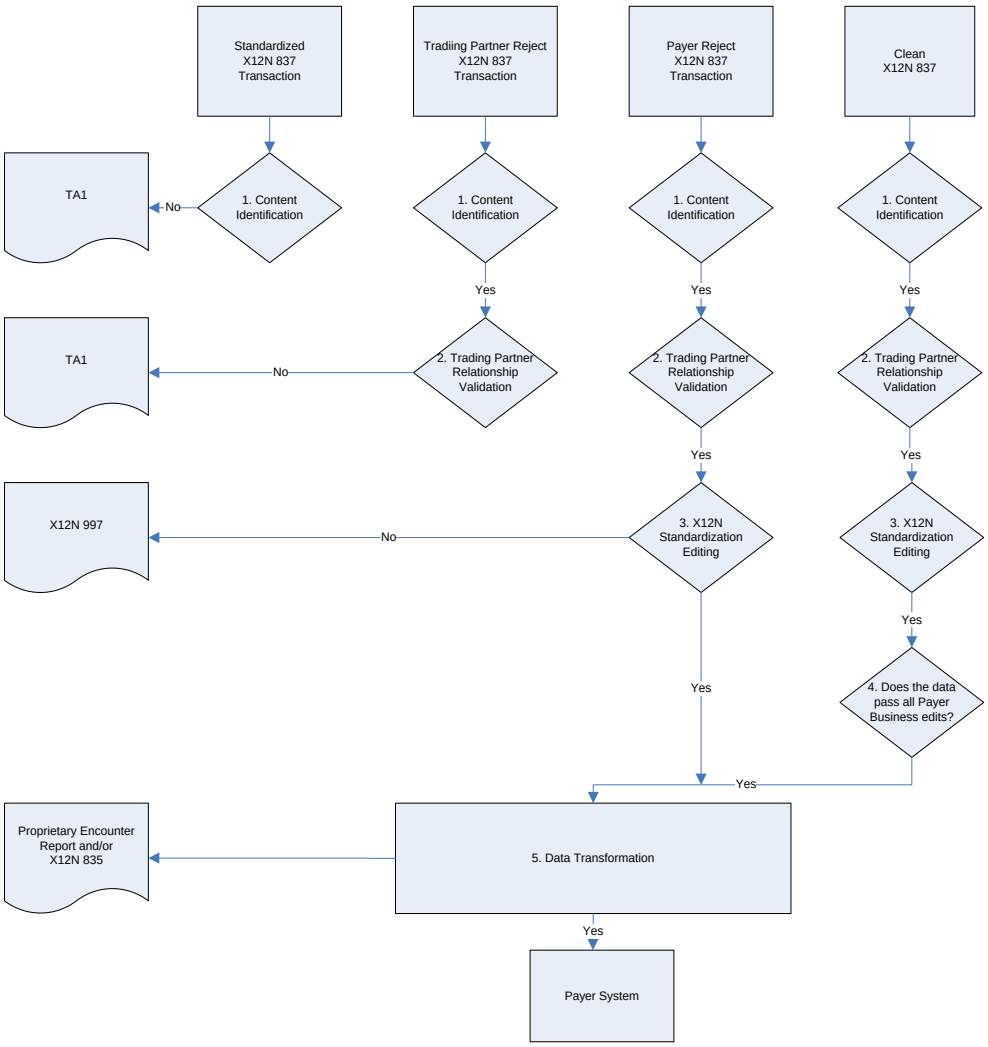
Aid Category	Short Description	Long Description
01	Aged	Persons who are age 65 or older.
02	Blind	Persons who meet the SSA definition of blindness.
03	Families and Children	Families with minor or unborn children.
04	Disabled	Persons who receive disability-based SSI or who meet SSA defined disability 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

Aid Category	Short Description	Long Description
40	Family Planning	Family Planning Waiver

Appendix O
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).

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



Appendix P

Encounter Data Certification Form

DHH – LA DEPARTMENT OF HEALTH AND HOSPITALS
ENCOUNTER DATA CERTIFICATION FORM

Please Type or Print Clearly

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

Plan DATA Certification Statement

On behalf of the above-named 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 Plan contract.

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

Date Form Submitted:_____

Please circle as appropriate. Original Submission? Y N Void? Y N
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

Appendix Q

Claims ICD-10 Extract Change

The claims extract will include the following new fields (marked in yellow). The AHS-DIAGNOSIS-REC file length will increase from 22 to 29. The AHS-SURGICAL-DX-REC file length will increase from 28 to 35.

> > > > > START OF LAYOUT NUMBER 4 < < < < <					
AHS-DIAGNOSIS-REC			1	29	29
5 DX-CHECKWRITE-DATE	9(8)	1	1	8	8
5 DX-CLAIMID	9(8)	2	9	16	8
5 DX-ICD9-CODE	X(5)	3	17	21	5
5 DX-ICD9-SEQUENCE	9	4	22	22	1
5 DX-DX10-CODE	X(7)	5	23	29	7
> > > > > START OF LAYOUT NUMBER 5 < < < < <					
AHS-SURGICAL-DX-REC			1	35	35
5 SDX-CHECKWRITE-DATE	9(8)	1	1	8	8
5 SDX-CLAIMID	9(8)	2	9	16	8
5 SDX-ICD9-CODE	X(4)	3	17	20	4
5 SDX-ICD9-DATE	9(8)	4	21	28	8
5 SDX-DX10-CODE	X(7)	5	29	35	7

Appendix R

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

Louisiana Medicaid Recipient Aid Category and Type Case Codes

Louisiana Medicaid Recipient Aid Category Codes

Louisiana Medicaid Recipient Type Case Codes

LAMMIS Type Case	Description	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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
018	ADHC (Adult Day Health Services Waiver)	0
019	SSI/ADHC	1
020	Regular MNP (Medically Needy Program)	0
021	Spend-Down MNP	0
022	LTC Spend-Down MNP (Income > Facility Fee)	0
023	SSI Transfer of Resource(s)/LTC	1
024	Transfer of Resource(s)/LTC	0
025	LTC Spend-Down MNP	0
026	SSI/EDA Waiver	1
027	EDA Waiver	0
028	Tuberculosis (TB)	0
029	Foster Care IV-E - Suspended SSI	0
030	Regular Foster Care Child	0
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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
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
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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
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

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
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 CSoC Waiver Children - 1915(c) waiver. Children under age 22, meeting a hospital and nursing facility LOC of CSoC will be eligibile up to 300% of FBR, using institutional eligibility criteria. LOC 60=hospital, 61=NF.	0
201	LBHP1915(i) NON MEDICAID ADULT 19 &OLDER CSoC Waiver Adults - 1915(i) only; non-Medicaid. Adults over the age of 18, not otherwise eligible for Medicaid, meeting the 1915(i) LON criteria up to 150% of FPL.	0
202	CSoC 1915(i)-LIKE MEDICAID CHILD sgmt 1915(i)-like Children (aka 1915(b)(3) children): temp type case on LTC segment if recipient is in LTC/NH/ICF. Otherwise Medicaid eligible children under age 22, meeting a LON of CSoC and eligible for additional services under 1915(b)(3) savings.	0

LAMMIS Type Case	Description	SSI Status (1=SSI, 0=Non-SSI)
203	LBHP1915(i) MEDICAID ADULT 19 &OLDER sgmt CSoC Waiver Adults - 1915(i): temp type case on LTC segment if recipient is in LTC/NH/ICF. Adults over the age of 21, otherwise eligible for Medicaid, meeting the 1915(i) LON criteria.	0
204	LBHP1115-NON-MEDICAID ADULTS 19 & OLDER 1115 waiver for 1915(i) persons whose income is below 150% of 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
205	LBHP Spend down (Adult)	

Appendix S

Recipient Valid-Invalid Crosswalk File Layout

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

END OF DOCUMENT