BAYOU HEALTH Prepaid Plan

Systems Companion Guide

August 2014
Version 4.4

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

Change Control Table

Author of Change	Section(s) Changed	Description	Reason	Date
Darlene White	2	BHT06	Was omitted in error	4/26/11
Darlene White	2	Internal Control Number (ICN)	Was omitted in error	4/26/11
Darlene White	2	Category II CPT Codes	Language deleted	6/27/11
Darlene White	Appendix E	Denied Clams Report	Revised Language	6/27/11
Darlene White	Appendix E	Claims Payment Accuracy Report	Report File Layout	6/27/11
Darlene White	All Sections	Updated with new extract files (Appendix D) and additional information	Extract File Layouts	9/19/11
Darlene White	Appendix D Appendix K	Updated Provider Negotiated Rates File Format with corrections	Extract File Layouts	9/29/11

Darlene White	Section 1	Information on Batch Submissions	Encounter submission and adjustments information	10/10/11 to 10/12/11
	Section 2	Information on ICN and Claims Adjustments information	Extract File Layouts	
	Section 4	Updated Files Table to clarify 834 data		
	Appendix D	Updated Claim Detail File (added claim payment date); updated Prior Authorizations History File (added PA Line Amount used); updated Provider File (added urban-rural indicator); updated 820 File Format to include REF for capitation code		
	Appendix G	Included sample Provider Registry Edit Report		
	Appendix J	Added GSA to Region crosswalk		
	Appendix K	Added Scopes of Coverage		

Darlene White	Appendix L	Capitation Fee Payments Crosswalk and Aid Category and Type Cases definitions		10/28/11
Darlene White	Section 2 Appendix D Appendix G Appendix L	Updated DHH Supplemental Instructions to include Plan Carrier Code Assignment Updated 820 File RMR Segment Updated new edit code values for Provider Registry Edit Report Updated crosswalk to remove inappropriate items		11/28/11
Darlene White	Appendix G	Changed Provider Registry File format: Provider Name (record position 45-74) is now a structured format		12/06/11
Darlene White	Appendix D	Updated Claim Detail Record Layout Updated Provider File Record Layout	Added diagnosis code 2 and place of service to end of claims detail layout Added pay-to-address information	01/06/2012

Darlene White	Section 2	Added File Splitting Criteria Removed allowed amount requirement	Added instructions for file splitting criteria and file extension Allowed amount will not be required in the COB instructions	2/22/2012
Darlene White	Appendix E	Revised Paid Claims Report specifications	Reports are to be delivered quarterly in accordance with ARRA Instructions	02/22/2012
Darlene White	Section 1 Overview	Added note in Batch Submissions paragraph	Added note in Batch Submissions Paragraph about how Plans may distribute encounter types into submission files	04/09/2012 to 04/23/2012
	Appendix D	Updated frequency of Network Provider and Subcontractor Registry and Site File Updated Claim Detail Record Layout (CCN-O-010, CCN-W-010) Updated 820 layout. Also added information regarding 820 adjustments	Updated frequency of Network Provider and Subcontractor Registry to semi-weekly Changed definition of 2100B,NM108,NM109&RMR02. Also added information regarding Adjustments	

		Updated Provider Registry Edit Report (edit codes definitions) and added Provider Registry Edit File Layout Added entire section about Provider Registry Site File	Added new fields: RX Date, Days Supply, Quantity, Prescribing Provider NPI and Claim/Encounter Indicator	
	Appendix L	Updated Recipient Type Case values table to add new codes 200-205		
Darlene White	Section 3	Added 028 to repairable edit codes	The following codes have been set to "D" (Deny): 028 – if the code is missing (Repairable) 813 – (NOT Repairable) The following codes have been set to "E" (Educational) 028 –mif present on claim but not on Molina's file 132 136 402 092 475 (was omitted from Friday's list)	05/17/2012

Darlene White	Appendix D	Updated occurrences of CCN to BAYOU HEALTH, where applicable p. 60: changed schedule of Provider Registry submission from semi-weekly to weekly p. 76: changed CCN-O-010 and CCH-W-010 DETAIL LAYOUT FOR Prescriber NPI (1171-1180) to BLANK value when not a Pharmacy Claim p.88-90: added another REF loop to 2300B to provide recipient region p.154: Registry File Layout: added value X=Remove at position 610 p.135-136: Registry File Layout: added new fields. P167: Site File Layout: added value X=Remove at position 371	Waiver COA information is subject to change	07/17/2012 and 8/17/2012

	Appendix F Appendix L Denied Claims Report Section 2 Appendix K Appendix M Section 2	p.108: added comprehensive list of encounter edit codes p.198: updated Capitation Fee Payment Crosswalk, added HCBS Waiver information, added HCBS Waiver COA information p.107: Denied Claims Report Format Split Billing Claims Correction of title and further clarification Prompt Payment Report further clarification on ICN		
Darlene White	Appendix D	Added 2 additional REF segments to 820 Format. Updated Prior Authorization File (FI to CCN) format to identify Pharmacy PA transaction (RxPA)		10/6/2012

Darlene White	Appendix G	Added PT=26 (Pharmacy) to Provider Type Table Changed Provider Registry Field NPPES Enumeration Date to Optional (O)		10/22/2012
Darlene White	Appendix L	Added 05LLL (LaChip Affordable Plan) and AC=03, TC=134 to crosswalk		12/12/2012
Dianne Griffin	Section 2	Updated instructions for Segment 2300 CLM-CLM01 – Plan ICN including 4-character prefix to ICN		4/17/2013
Dianne Griffin	Cover Page	Updated version to 4.1		4/17/2013
Dianne Griffin	Section 2	Added instructions for submitting Claim Received Date		4/17/2013
Dianne Griffin	Section 2	Added instructions for submitting Claim Paid Date		4/17/2013
Dianne Griffin	Section 2	Added instructions for submitting Interest Payments		4/22/2013
Dianne Griffin	Section 8	Added instructions for Medicare Recovery Process		4/26/2013

Dianne Griffin	Appendix E	Added Denial Reason Code 6 and instructions for reporting on Denied Claims Report P173		4/26/2013
Dianne Griffin	Appendix K	Removed TPL (Third Pary Liability) Web Application; added instructions for TPL Batch File Submissions Parts 1 and 2		04/23/2013
Dianne Griffin	Appendix K	Added TPL File Layout to Plan		04/23/2013
Dianne Griffin	Appendix N	Added Batch Pharmacy Encounters Companion Guide, March 3, 2013 v.1.2		4/26/2013
Dianne Griffin	Appendix M	Added Pharmacy Claim Type (12) to Prompt Payment Report		04/30/2013
Dianne Griffin	Appendix M	Added instructions for the Prompt Payment Report (PI221)		4/30/2013
Dianne Griffin	Appendix D	Added statement for Behavioral Health Encounters/services regarding contractor-Magellan (Edit Code Detail-Molina Report (FIto BYHP) ccn-o-010(Initial) and CCN-W-010(Weekly)		4/22/2013

Dianne Griffin	Cover Page	Updated month of version to April 2013		4/22/2013
Dianne Griffin	Section 2	Claims Paid by DRG: added note: FI Plans to incorporate in conjunction with ICD-10 project sleighted for Implementation 2014		5/8/2013
Dianne Griffin	Section 2	Claim Received Date: added note: FI investigating this requirement – will be updated once investigation complete		5/8/2013
Dianne Griffin	Section 2	Interest Payments: added Note: FI investigating this requirement –m will be updated once investigation complete		5/8/2013
Dianne Griffin	Cover Page	Updated document version and issue date for v4.2 September 2013		9/1/2013
Dianne Griffin	Section 4	Transaction Testing and EDI Certification – expanded statement to read: "Bayou Health Plans shall submit Encounter Data Certification Form concurrently with the certified data"	Clarifying that Plans must submit document at the time files are submitted to Molina for processing	9/1/2013

Dianne Griffin	Section 4	Transaction Testing and EDI Certification – added DHH-LA Department of Health and Hospitals Encounter Data Certification Form	Appropriately added as directive to Plans	09/01/2013
Dianne Griffin	Section 2	Transaction Set Supplemental Instructions – DHH SupplementalInstructions – corrected loop for Plan's unique DHH carrier code from 2300B to 2330B	Corrected typo	9/1/213
Dianne Griffin	Section 2	Transactin Set Supplemental Instructins – subsection titled "Header and Line Item Adjustment Amount" – appropriately moved under "Financial Fields"	Should be positioned under the "Financial Fields" Section	9/1/2013
Dianne Griffin	Section 2	Transaction Set Supplemental Instructions – Claims Paid Based on DRG – defined acronym DRG; updated to include additional instructions for transaction 837-I and loops	Requirement for submitting payments made based on DRG	9/1/2013

Dianne Griffin	Section 2	Transaction Set Supplement Instructions – separated Claim Received Date Instructions from Claim Paid Date Instructions. Claim Received Date – updated to include additional instructions for transactions and loops	Requirement for submitting encounter data; FI investigation completed	9/1/2013
Dianne Griffin	Section 2	Transaction Set Supplemental Instructions – Claim Paid Date – updated to include additional instructions for transactions and loops	Requirement for submitting encounter data; FI investigation completed	9/1/2013
Dianne Griffin	Section 2	Transaction Set Supplemental Instructions – Interest Payments – updated to include additional instructions for transactions and loops; added detailed information for submitting interest payments for inpatient and non-inpatient records	Requirement for submitting encounter data; FI investigatin completed	9/1/213
Dianne Griffin	Appendix O	Added Bayou Health Batch Electronic File Layout for Retro Kick Payments Information	Added to provide instructions to Plans	9/1/2013

Dianne Griffin	Section 3	Repairable Denial Edit Codes and Description		9/1/2013
Dianne Griffin	Appendix F	Updated temporarily removed the list of edit codes		9/1/2013
Dianne Griffin	Cover Page	Updated issue date and version to April 2014 v4.3		4/9/2014
Deborah Davis	Section 2	Transaction Set Supplemental Instruction: added instructions for COB Model of 837 with TPL		4/9/2014
Deborah Davis	Section 2	File Slitting – added note and instructions for identifying A-typical Providers for Non-Emergency Medical Transportation		4/9/2014
Deborah Davis	Section 2	Identified Provider Type 42 and corrected Sample File Name for NEMT		4/9/2014
Dianne Griffin	Appendix N	Removed Batch Pharmacy Companion Guide	Plans will access separately	4/9/2014
Dianne Griffin	Appendix N	Added: Provider Supplemental Record Layout		4/9/2014
Dianne Griffin	Change Control Table	Removed page numbers from "Section Changed" column for dates 4/17/2013 thru 9/1/2013		4/9/2014

Dianne Griffin	Appendix F	Encounter Edit Codes: added Comprehensive List of Encounter Edits		4/9/2014
Dianne Griffin	Appendix D	System Generated Reports: Referenced ICD-10 Modifications to Edit Detail Report, Prior Authorization File (FI to CCN) and Diagnosis File for Pre-Admission Certification (FI to CCN)		4/9/2014
Dianne Griffin	Appendix D	Edit Detail Report updated with ICD-10 changes- Columns 1182-1199		4/9/2014
Dianne Griffin	Appendix D	Prior Authorization (FI to CCN) – updated with ICD-10 changes – Columns 148-159		4/9/2014
Dianne Griffin	Appendix D	Diagnosis File for Pre-Admission Certification (FI to CCN) – updated with ICD-10 changes – columns 7; and 27-35		4/9/2014
Dianne Griffin	Section 2	Transaction Set – added note regarding T-MSIS and reference to Supplemental Provider File Layout in Appendix N		4/21/2014
Dianne Griffin	Section 1	Introduction – updated information - included reference to Appendix A (Definitions)and Appendix B (Frequently Asked		July 2014

		Questions).		
		Responsibilities - Contractors - Proprietary Reports – included reference to Appendix D (System Generated Reports)		July 2014
		File Transfer – included file submission instructions		July 2014
		Responsibilities – Bayou Health Plan – added Reporting to DHH		July 2014
	Section 2	**Section 2** Transaction Testing and EDI Certification **(Transaction Set Supplemental Instructions) v4.3 HAS BEEN MOVED TO SECTION 3 IN THIS VERSION**	To allow easier flow of information based on process	July 2014
	Section 3	Section 3 Transaction Set Supplemental Instructions **(Repairable Denial Edit Codes) v4.3 HAS BEEN MOVED TO APPENDIX F IN THIS VERSION.**		July 2014
		Transformed Medicaid Statistical Information (T-MSIS) – added effective date, information regarding Phase 1 and Phase 2 testing		July 2014

		and integration.		
		Category II CPT Codes - added reference to Appendix C (Code Sets)		July 2014
	Section 4	Section 4 Encounter File Submission and Processing - added information regarding file submission and cut-off times, processing – includes reference to Appendix O updated (LMMIS Encounter Process Flow Chart); and Appendix P (Encounter Data Certification Form). **TRANSACTION TESTING AND EDI CERTIFICATION v4.3 HAS BEEN MOVED TO SECTION 2 IN THIS VERSION.**		July 2014
	Section 5	Section 5 Encounter Edit Code(s) Disposition and Logic – added information regarding encounter edits, and system logic. References made to Appendix F (Encounter Edits) and Appendix Q (MMIS Edit Logic). **DATA MANAGEMENT AND ERROR**		July 2014

		CORRECTION PROCESS v4.3 HAS BEEN MOVED TO SECTION 6 IN THIS VERSION		
	Section 6	Section 6 Data Management and Encounter Correction Process – added information regarding the System Generated Reports and Electronic Notifications. Included references to Appendix D (System Generated Reports) and Appendix F (Encounter Edits) **CONTINUOUS QUALITY IMPROVEMENT v4.3 HAS BEEN MOVED TO SECTION 7 IN THIS VERSION.**		July 2014
	Section 7	Section 7 Continuous Quality Improvement – no updates or changes made. **ADJUSTMENT PROCESS v4.3 HAS BEEN MOVED TO SECTION 8 IN THIS VERSION.**		July 2014
	Section 8	Section 8 Adjustment Process – no changes or updates made. **MEDICARE RECOVERY**		July 2014

		PROCESS v4.3 HAS BEEN MOVED TO SECTION 9 IN THIS VERSION.		
	Section 9	Section 9 Medicare Recovery Process – updated timing of process from quarterly to monthly.		July 2014
	Appendix E	Appendix E Bayou Health Plan Generated Reports – added information regarding the Claims Summary Report and hyperlink for website.		July 2014
	Appendix F	Appendix F Encounter Edit Codes – added categories of edits for Comprehensive List of edit codes; list of Encounter Edit Disposition – Deny (Repairable under Limited Circumstances); list of Encounter Edit Disposition – Deny (Repairable); list of Encounter Edit Disposition – Deny (Not Repairable)		July 2014
	Appendix G	Appendix G – added list of Provide Types, Specialty and Descriptions; added instructions and file layout for Bayou Health Batch Electronic File	To assist Plans in completing data elements for files in Appendix G.	July 2014

		Layout for PCP Linkage Directory; added instructions and file layout for Provider Supplemental File		
	Appendix M	Appendix M Editing and Validation Diagram **– CHART WAS MOVED FROM SECTION 4 v4.3 TO THIS APPENDIX M IN THIS VERSION. CLAIMS SUMMARY REPORT v4.3 HAS BEEN MOVED TO APPENDIX E IN THIS VERSION**		July 2014
	Appendix N	Appendix N – Pharmacy Encounter Batch Guide – provided instructions as Supplement to System Companion Guide; included hyperlink to Making Medicaid Better website. **PROVIDER SUPPLEMENTAL FILE LAYOUT v4.3 HAS BEEN MOVED TO APPENDIX G IN THIS VERSION.**		July 2014
	Appendix O	Appendix O – added LMMIS Encounter Processing Flowchart. Replaces Claims		July 2014

		Processing Flow Chart in APPENDIX D v4.3.		
	Appendix P	Appendix P – Encounter Data Certification Form **ENCOUNTER DATA CERTIFICATION FORM HAS BEEN MOVED FROM SECTION 4 v4.3 TO THIS APPENDIX P IN THIS VERSION.**		July 2014
	Appendix Q	NEW: Appendix Q – Medicaid Management Information System (MMIS) Edit Logic – added examples of system logic for edits in each disposition category: Educational; Deny-Repairable under Limited Circumstances; Deny – Repairable; Deny – Not Repairable	To assist MCO's with correcting encounter edits.	July 2014

TABLE OF CONTENTS

Section 1

Introduction

This System Companion Guide, along with the current version of the Request for Proposal (RFP), provides assistance to the Bayou Health Plans with requirements for submitting and receiving encounter data.

DHH, based on Federal Guidelines, requires BAYOU HEALTH PLANs to report encounters. Reporting of these encounters must include all paid and denied encounters for services provided to Medicaid recipients enrolled in a Prepaid Bayou Health Plan.

A list of services requiring reporting can be found under the **Encounter Definition** segment of this Section.

The BAYOU HEALTH PLAN must submit encounters to the Fiscal Intermediary (FI) on a weekly basis using HIPAA compliant Provider-to-Payer-to-Payer COB 837I (Institutional) and 837P (Professional) transactions.

DHH has provided as quick references in **Appendix A** a list of **Definitions** and **Appendix B Frequently Asked Questions**. The Bayou Health Plan may submit, in writing to their DHH Health Plan Manager, questions not addressed in **Appendix B**.

Encounter Definition

Encounters are records of medically related services rendered by a BAYOU HEALTH PLAN provider to DHH Medicaid recipients enrolled as members with a Prepaid BAYOU HEALTH PLAN on the date of service. It includes all services for which the BAYOU HEALTH PLAN has any financial liability to a provider.

An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. Encounters include services paid as Fee-for-Service (FFS), as well as services paid under a capitated provider arrangement. BAYOU HEALTH PLANs must report all paid and denied services covered under the BAYOU HEALTH PLAN Contract. Encounter services include, but are not limited to the following:

- Hospital services
- Physician visits
- Nursing visits
- Surgical services
- Anesthesia services
- Laboratory tests
- Radiology services
- DME
- Dialysis center services
- Physical therapy services
- EPSDT services
- Case management services
- Home health services

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

The BAYOU HEALTH PLAN shall submit encounter data t monthly. The data is due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed. Data must include encounters that were approved-paid (including encounters reflecting a zero dollar amount $0.00); denied; and encounters in which the BAYOU HEALTH 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 considered actuarially sound if they are; appropriate for the covered Medicaid population and the services are provided under the Contract. In addition, CMS requires that rates be based upon at least one year of recent data that is not more than five years old.

Quality Management and Improvement

The BAYOU HEALTH program is a State Plan program partially funded by CMS. BAYOU HEALTH Plans are 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. DHH will use encounter data to evaluate the performance of each BAYOU HEALTH 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 Balanced Budget Act, a written 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 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 BAYOU HEALTH PLAN 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 BAYOU HEALTH PLANs 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).

Responsibilities

DHH

DHH is responsible for administering the state's Coordinated Care Network Program. Encounter data are an instrumental tool in that administrative effort. Administration includes data analysis, production of feedback and comparative reports to BAYOU HEALTH PLANs, data confidentiality, and the contents of this Bayou Health Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Ruth Kennedy	
Telephone	225 342 3032
Fax	225 342 9508
E-mail	Ruth.Kennedy@la.gov

DHH is responsible for the oversight of the Contract and BAYOU HEALTH PLAN activities. DHH encounter responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with each BAYOU HEALTH PLAN, and BAYOU HEALTH PLAN training. DHH will update the Systems Companion Guide on a periodic basis.

Contractors

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with DHH to provide Louisiana Medicaid Management Information System (MMIS) services including the acceptance of electronic encounter reporting from the BAYOU HEALTH PLANs.

Accepting and Storing Encounters

DHH's FI will be responsible for accepting, editing and storing BAYOU HEALTH PLAN 837 encounter data. The FI will also provide technical assistance to the BAYOU HEALTH PLANs during the 837 testing process.

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 encounter adjudication, an ANSI ASC X12N 835 Remittance Advice (835) is delivered to the BAYOU HEALTH PLAN if requested by the BAYOU HEALTH PLAN. The BAYOU HEALTH PLAN must prearrange for receipt of 835 transactions.

Proprietary Reports

The FI provides to the BAYOU HEALTH PLAN proprietary MMIS encounter adjudication edit reports following the weekly claims payment cycle. **Appendix D** provides the list of **System Generated Reports** that are available to the Bayou Health Plan.

Enrollment Broker

The Enrollment Broker shall make available to the BAYOU HEALTH PLAN via a daily and weekly 834 X12 transaction, updates on members newly enrolled, dis-enrolled or with demographic changes. At the end of each month, the Enrollment Broker shall reconcile enrollment/disenrollment with a full 834 X12 reconciliation file and submit to the FI as scheduled.

Bayou Health Plan

Within sixty (60) days of operation in the applicable geographic service area (GSA), the BAYOU HEALTH 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.

The BAYOU HEALTH PLAN must ensure that providers submit accurate and complete encounters as follows:

Accuracy and Completeness of Encounter Data

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

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

File Transfer

The BAYOU HEALTH 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.

Bayou Health Plans may submit 837 Encounter Files on any day of the week with the exception of Pharmacy Encounter Files. Pharmacy Encounter Files may be submitted any day of the week except on Thursday. The BAYOU HEALTH PLAN may submit batch encounters, up to 99 files per day. Batch encounters maximum recommended file size is 20,000 per file (maximum of 100,000 per week).

Bayou Health Plan Reporting to DHH

On a monthly, quarterly, and yearly basis, the Bayou Health Plan is required to provide DHH with Bayou Health Plan Generated Reports as addressed in **Appendix E** of this Guide.

Section 2

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from each of the BAYOU HEALTH PLANs is treated as HIPAA compliant transactions by DHH and its FI. As such, BAYOU HEALTH PLANs are 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, BAYOU HEALTH PLANs are 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 BAYOU HEALTH PLAN rendering contracted provider has a valid NPI and taxonomy code, the BAYOU HEALTH PLAN will submit those values in the 837. If the provider is an atypical provider, the BAYOU HEALTH PLAN must follow 837 atypical provider guidelines.

Prior to testing, BAYOU HEALTH PLANs 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 BAYOU HEALTH PLANs with a list of provider types and specialties. BAYOU HEALTH PLANs are 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 an approved BAYOU 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 prospective BAYOU 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 BAYOU HEALTH PLANs 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!**

The Electronic Data Interchange (EDI) Incoming ANSI ASC x 12 N 837 Transaction Validation for Syntax Flow Chart can be found in **Appendix M** of this Guide.

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 a BAYOU HEALTH 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.

BAYOU HEALTH PLANs 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

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

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. 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 837 Institutional and 837 Professional Provider-to-Payer-to-Payer Coordination of Benefits (COB) Model, as defined in the HIPAA IGs.

This Guide will not provide detailed instructions on how to map encounters from the Coordinated Care Networks' systems to the 837 transactions. The 837 IGs contain most of the information needed by the BAYOU HEALTH PLANs to complete this mapping.

Health plans 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 in the Federal Register.

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.

Transformed Medicaid Statistical Information System (T-MSIS)

Introduction

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

In order to comply with this mandate, DHH is currently working with BAYOU HEALTH Plans regarding required system changes and testing.

BAYOU HEALTH Plans are required to fully populate 837 data elements in accordance with the existing 5010 Implementation Guide and the Prepaid System Companion Guide.

Testing and Integration

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

Tier 1 Data Elements

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

- **Phase I**

  The Bayou Health Plan is required to utilize the 837 Mapping layouts (I, P, NCPDP) to test data elements currently being captured by the Bayou Health Plan but are not being sent to the FI.

- **Phase II**

  The Bayou Health is required to utilize the 837 Mapping layouts to integrate data elements not currently being captured by the Bayou Health Plan; consequently they are not being sent to the FI.

The FI and/or DHH will provide feedback regarding the status of the data elements tested to the Bayou Health Plan via the **MCO T-MSIS Test Tracking Document**.
Feedback will include comment(s) for data element(s) that FAILED the test. The Bayou Health Plan must correct, provide the reason for the FAILED data elements and then resubmit the corrected data elements to the FI for re-testing until approval of FAILED Data Elements is received from the FI.

Data elements that receive “PASS” status from the FI will receive approval and/or comments from DHH and/or FI to integrate the data elements into the Bayou Health Plan’s System.

Tier 2 Data Elements

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

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

Fiscal Intermediary (FI) 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

Batch Submissions

The BAYOU HEALTH PLAN may submit batch encounters, up to 99 files per day. Batch encounters maximum recommended file size is 20,000 per file (maximum of 100,000 per week). Files must be ASC X 12 N 837 format compliant.

Split Billing Claims

The Bayou Health Plan may refer to Hospital Services Manual for DHH policy on split billing located on the lamedicaid.com website.

COB MODEL 837

DHH requires BAYOU HEALTH PLANs 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:

Loop 2320 (Other Subscriber Information)
Loop 2330B (Other Payer Information)
Loop 2430 (Service Line Adjudication Information).

In COB loop 2320, the BAYOU HEALTH PLAN will be required to include information about BAYOU HEALTH PLAN provider claim adjudication. In t loop 2330B NM109, the BAYOU HEALTH PLAN shall place their unique DHH carrier code. See the table below for the BAYOU HEALTH plan carrier code assignments.

BAYOU HEALTH Plan Carrier Code Assignments

Plan Name	Assigned Carrier Code
AmeriHealth Mercy of Louisiana (LaCARE)	999991
AmeriGroup of Louisiana	999992
Louisiana Healthcare Connection	999993

The BAYOU HEALTH PLAN shall provide DHH with any third-party payments in loop 2430. In these loops, the BAYOU HEALTH PLAN must include the DHH carrier code of the other payer. There can be only one single subsequent loop per unique payer.

COB Model of 837 with TPL

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

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

For Inpatient records, all of the TPL data will be sent (at the Claim-Doc level) in the Loop 2320 through Loop 2330B segments.

For non-Inpatient records where there is Service-Line level TPL data, in addition to the Claim-Doc level COB data segments, the Service-Line level specific TPL data should be sent in the Loop 2430 segments.

When TPL data is being reported at the Claim-Doc level, the LA Medicaid TPL Carrier Code value is sent in Loop 2330B NM109; the TPL amount paid is sent in the Loop 2320 AMT*D segment; the TPL payment date is sent in the Loop 2330B DTP segment; and any Claim Level Adjustments are sent in Loop 2320 CAS segments.

When TPL data is being reported at the Service-Line level, the LA Medicaid TPL Carrier Code value is sent in both Loop 2330B NM109 and in Loop 2430 SVD01; the TPL amount paid is sent in Loop 2430 SVD02; the TPL payment date is sent in the Loop 2430 DTP segment; and any Line Adjustments are sent in Loop 2430 CAS segments.

Identifying Atypical Providers

Non-Emergency Medical Transportation providers are considered A-typical providers and, as such, are not assigned an NPI. The Bayou Health Plan is to follow the instructions below when submitting any of the documents in **Appendix G**, as well as, encounters for this category of providers.

- If they have a LA Medicaid Legacy Provider ID, send that number in Loop 2010BB REF*G2.
- If the provider doesn't have a Legacy Provider ID, send the "Assigned Medicaid Provider ID" in Loop 2010BB REF*G2. This is in the same place in the 837 for either the Legacy Provider ID or the "Assigned Medicaid Provider ID". (The "Assigned Medicaid Provider ID" is the pseudo ID assigned by Molina when a provider is contracted with a Prepaid Plan and not enrolled in Legacy Medicaid.)
- If a provider has an NPI, send the NPI in Loop 2010AA NM109; that is the normal place to send the Billing Provider's NPI in 837s.

File Splitting Criteria

Encounter files must be submitted using the following file extension criteria

Transaction.	Claim Type	Name	File Extension	Sample file name
837P	09	Durable Medical Equip. Provider Type=40	DME	H4599999.DME
837P	04	Physician, Pediatric Day Health Care Professional Identify all 837P claims including EPSDT services, and excluding Rehab.	PHY	H4599999.PHY
837P	05	Rehabilitation Provider Type=65, 59	REH	H4599999.REH
837P	07	Ambulance Transportation EMT: Provider Type=51	TRA	H4599999.TRA
837P	08	Non-Emergency Medical Transportation NEMT Provider Type = 42	NAM	H4599999.UB9
837I	01 & 03	Hospital IP/OP Inpatient: Identify by Place of Service: 1st 2 digits of Bill Type =11 or 12. Outpatient Identify by Place of Service: 1st 2 digits of Bill Type = 13, 14 or 72	UB9	H4599999.UB9
NCPDP Batch	12	NCPDP Batch Pharmacy Provider Type = 26		H4599999.NCP
837I	06	Home Health Bill Type 1st 2 digits of Bill Type=32.	HOM	H4599999.HOM

BHT06

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

Internal Control Number (ICN)

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

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

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

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

Financial Fields

The financial fields that DHH requests the BAYOU HEALTH PLANs to report include:

- Header and Line Item Submitted Charge Amount
- Header and Line Item BAYOU HEALTH PLAN Paid Amount
- Header and Line Item Adjustment Amount

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

Header and Line Item BAYOU HEALTH PLAN Paid Amount — If the BAYOU HEALTH PLAN paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the BAYOU HEALTH PLAN or was covered under a 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 BAYOU HEALTH PLAN is required to report both the Adjustment Amount and the adjustment reason code. The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Claim Received Date

BAYOU HEALTH Plans are required to submit the Plan's Claim Received Date in 837-P and 837-I encounter data.

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

Claim Paid Date

BAYOU HEALTH Plans are required to submit the Plan's Claim Paid Date in 837-P and 837-I encounter data.

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

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

Interest Paid Amount

When the MCO pays Claim Interest, the BAYOU HEALTH Plans are required to submit the MCO's Claim Interest Amount and Paid Date in 837-P and 837-I 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 BAYOU HEALTH Plans use to send their claim adjudication data.

In the Claim Interest set of COB Loops, instead of using the BAYOU HEALTH Plan's unique DHH Carrier Code (99999x), a value in INT99x format will be used; where the last digit is the same last digit from the Plan's unique DHH Carrier Code value.

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

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

Professional Identifiers

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

Supplementation of CMS-1500 and UB-04

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

Newborn Birth Weight

Birth weight is required on encounters for delivery services to report newborn's birth weight. It may be necessary for the BAYOU HEALTH PLANs to crosswalk the diagnosis code from deliveries to populate the patient information for the birth weight. Birth weight is reported on the 837I transaction in Loop 2000B.

Newborn ID Usage

BAYOU HEALTH PLANs shall submit baby's facility bill for child at the time of delivery using the baby's Medicaid ID. The baby's Medicaid ID is to be used on well babies, babies with extended stays (sick babies) past the mother's stay and on all aftercare and professional bills. BAYOU HEALTH PLANs are to hold the encounter until the newborn Medicaid ID can be obtained and submitted with the encounter.

Category II CPT Codes

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

On the ASC X12N 837 professional health care claim transaction, Category II CPT and HCPCS Level II codes are submitted in the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop. The data element for the procedure code is SV101-2 "Product/Service ID." Note that it is also necessary to identify in this segment that you are supplying a Category II CPT/HCPCS Level II G-code by submitting the "HC" code for data element SV101-1. Necessary data elements (or fields) include, but are not necessarily limited to, the following:

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

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

Appendix C provides additional information regarding Code Sets.

Section 4

Encounter File Submission and Processing

Introduction

The Bayou Health Plan is required to submit to the Fiscal Intermediary (FI), on a weekly basis, complete and accurate encounters via ASC X 12N 837 files. Encounter files may be submitted on any day of the week. The exception is to Pharmacy (NCPDP) files which may not be submitted on Thursdays. **Appendix N** references the **Pharmacy Encounters Batch Guide** as a **Supplement** to this Guide.

File Submission

Schedule

Encounter files received, daily, before the cut off time of 6:00 PM CST will be processed in the same day they are received. Files received after 6:00 PM CST will be processed in the next business day's cycle.

Cut off time for encounter files to process in the next week's cycle is 12:00 Noon CST on Thursday. Files received after 12:00 Noon CST will be processed in the following week's cycle.

DHH thru the Fiscal Intermediary will notify the Bayou Health Plan when a holiday occurs on a day of the week in which encounter files are normally submitted and the Fiscal Intermediary is closed and will not be able to receive files.

Processing

Bayou Health Plan encounter files that are accepted in the Louisiana Medicaid Management Information System (LMMIS) will be processed according to the **LMMIS Encounter Process Flow Chart** found in **Appendix O** of this Guide.

The Bayou Health Plan will receive the HIPAA EDI report and/or a courtesy email notification from the FI when a file is rejected or an encounter is denied by the LMMIS (see Section 6 of this Guide)

Encounter Data Certification

The Federal Budget Balance Act (BBA) requires that when State payments to a BAYOU HEALTH PLAN are based on data that is submitted by the BAYOU 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. Encounter files submitted by the

BAYOU HEALTH PLANs, which are used to create payments and/or capitated rates, must be certified by a completed signed Data Certification form.

DHH requires the Bayou Health Plan to submit the completed Encounter Data Certification Form to the appropriate DHH Health Plan Manager. The completed form must be submitted concurrently with each encounter submission.

The data must be certified by one of the following individuals:

1. BAYOU HEALTH PLAN's Chief Executive Officer (CEO); or
2. BAYOU HEALTH PLAN's 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.

The Louisiana Department of Health and Hospital Encounter Data Certification Form can be found in **Appendix P** of this Guide.

Section 5

Encounter Edit Code(s) Disposition and Logic

Introduction

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

Encounter Edits

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

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

A Comprehensive List of Edits along with their dispositions can be found in **Appendix F** of the Guide.

In addition, DHH has also provided in **Appendix Q** of this Guide **Medicaid Management Information System (MMIS) Logic** for edits that may be of particular interest to the Bayou Health Plans.

Educational Edits

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

System logic for edits 813 and 815 can be found in Appendix Q of this Guide.

Deny Edits – Repairable (Under Limited Circumstances)

Encounters set to the "Deny Repairable under limited circumstances" edit disposition may be corrected by the Bayou Health Plan, when applicable, and resubmitted to the FI for processing.

A list of **Deny Edits – Repairable under Limited Circumstances** can be found in this **Appendix F** of this Guide.

System logic for edit 258 can be found in Appendix Q of this Guide.

Deny – Repairable

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

A list of **Deny Edits – Repairable** can be found in **Appendix F** of this Guide.

System logic for the following edits can be found in Appendix Q of this Guide:
120, 130, 796, and 799.

Deny – Not Repairable

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

A list **of Deny-Not Repairable Edits** can be found in **Appendix F** of this Guide.

System logic for the following edits can be found in Appendix Q of this Guide: 794, 801, 805, 806, 807, 808, 810, 816, 817, 818, 819, 822, 823, 828, 830, 833, 837, and 849.

Please note that the system edit logic provided is not all-inclusive. The Bayou Health Plan may request in writing the system logic for edits not included in this Guide.

Section 6

Data Management and Encounter Correction Process

Introduction

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

Rejection Criteria

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

Entire File

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

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

Once the transaction has passed interchange edits, it shall be subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N 999.

Claim

Transactions with errors at the ST or SE level segments are rejected in their entirety. However, if the functional group consists of additional transactions without errors, these transactions are processed. The 999 transaction contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or elements(s) where the error(s) occurred are reported.

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

Service Line

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

A Comprehensive List of encounter edits is contained in **Appendix F**. After processing, an 835 Remittance Advice is returned to the sender.[1]

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

Encounter Correction Process

BAYOU HEALTH PLANs are required to correct and resubmit any encounters that are rejected or denied and are Repairable. DHH, thru its FI, will provide a couple of tools to the Bayou Health Plan in order to assist in this process.

Reports

On a weekly basis, the FI will provide the following weekly edit code reports to the Bayou Health Plan:

- CCN-O-005 – Encounter Edit Code Detail
- CCN-O-010 – Encounter Edit Disposition Summary

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

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

The Encounter Edit Disposition Summary Report (CCN-O-005) and the Edit Code Detail Report (CCN-O-010) can be found in **Appendix D** of this Guide.

Electronic Notifications

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

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

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

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

Entire File

BAYOU HEALTH PLANs will receive either a TA1 or X12N 999 error report. BAYOU HEALTH PLANs are required to work with the FI's Business Support Analysts to determine the cause of the error.

Claim

BAYOU HEALTH PLANs will receive either an X12 835 or proprietary reports for header level rejections. BAYOU HEALTH PLANs are responsible for adherence to the implementation guide, code sets, and looping structures for the transaction. BAYOU HEALTH PLANs 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

BAYOU HEALTH PLANs will receive an X12N 835 for transaction claims that have processed through the MMIS. If the service line fails MMIS encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the CAS segment of loop 2110.
This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

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

Outstanding Issues

After application of the data management and encounter correction process, the BAYOU HEALTH PLAN may present any unresolved issue(s) to DHH thru the FI for clarification or resolution. The Bayou Health Plan is required to include the relevant DHH staff in the copy of their email request/inquiry unless otherwise directed by DHH.

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 BAYOU HEALTH PLAN with their findings. If the outcome is not agreeable to the BAYOU HEALTH PLAN, the BAYOU HEALTH PLAN can re-submit the outstanding issue(s) with supporting documentation to DHH for reconsideration.

The outcome as determined by DHH will prevail.

Dispute Resolution

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

A BAYOU HEALTH 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 BAYOU HEALTH PLAN. The FI, on behalf of DHH, will respond in writing within thirty (30) days of receipt of such notification. DHH encourages BAYOU HEALTH PLANs 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, BAYOU HEALTH PLANs may use the Edit Reports provided by the FI. The BAYOU HEALTH PLAN shall highlight, or otherwise note, the rejected encounters to be researched, and attach a memorandum describing the problem.

The FI will review the BAYOU HEALTH PLAN’s notification and may ask the BAYOU HEALTH PLAN to research the issue and provide additional substantiating documentation, or the FI may disagree with the BAYOU HEALTH PLAN’s 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 BAYOU HEALTH 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 BBA, DHH developed a quality strategy plan that serves as the guiding principles for the establishment of quality improvement efforts for the BAYOU HEALTH PLANs. Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from BAYOU HEALTH PLANs 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 BAYOU HEALTH 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 BAYOU HEALTH PLANs every three (3) months, or as needed. The encounter quality improvement plans are sent by BAYOU HEALTH PLANs to DHH in advance of the meeting. BAYOU HEALTH PLAN meeting attendees are to include claims and EDI experts, and clinical quality assurance staff.

At the site visit, the BAYOU HEALTH 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, BAYOU HEALTH PLANs 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 encounter adjustments, BAYOU HEALTH PLANs are to follow the detailed, payer-specific instructions provided in the FI's Companion Guides found at:

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

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

Line Adjustment Process

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	**Claim Frequency Type Code** 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 adjudication system and printed on the remittance advice, for the previously submitted claim that is being adjusted by this claim.

BAYOU HEALTH Plans must make correction(s) for claim level denials and resubmit them for processing

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)
  0 = Paper
  1 = EDI or Electronic Claim
  2 = Paper Adjustment
  3 = System Void
  4 = Void
  5 = Paper Claim with Attachment
- Digits 6-8 = 3 digit batch number
- Digits 9-11 = 3 digit sequential number in batch
- Digit 12-13 = claim line number

Section 9

Medicare Recovery Process

On a monthly basis, the Fiscal Intermediary will run a Medicare Recovery Process. This process identifies recipients who are retrospectively enrolled in Medicare (i.e., QMB, SLMB, and Part A/B) including PMPM payments and generates voids to recover payments.

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

The report contains the following data elements:

- Recipient ID
- HIC (Health Insurance Claim #)
- Name
- Medicare Type Coverage
- Claim ICN
- Procedure Code
- Dates of Service
- PMPM Payment

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

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

Upon receiving the report and/or the 820 file, BAYOU HEALTH Plan is to note that recipients are identified as Medicare eligible and solicit the Enrollment Broker to send them disenrollment information, and then engage recoveries for claims they have paid.

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

Section 10

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 are being implemented:

- On or about the 5th of every month, DHH and Molina will review all changes made by the Enrollment Broker (Maximus) for the prior month, to identify retro enrolled newborns and retro disenrolled excluded populations, identify paid claims, and associated adjustments needed to PMPMs.

- Based on this review, mid-month Molina will void identified Shared Savings Plan and 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 Bayou Health Plans and Molina Provider Relations. This report includes detailed information to assist Plans 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.

- For the clean-up of August 2014, a list of all affected providers will be available on the Making Medicaid Better website for review by providers. This list will contain provider's names, partial Medicaid Provider IDs (to maintain privacy), number of claims, number of recipients, and totals of payments to be voided.

- The correct entity (Bayou Health Plan 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, within 30 days of receipt.

- Providers are required to submit **paper/hard copy** claims to the corrected entity (Bayou Health Plan 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.

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

Appendix A

Definition of Terms

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

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 (005010) file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
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).
Benefits or Covered Services	Those health care services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan.
CAS Segment	Used to report claims or line level adjustments.
Case Management	Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources, to promote high quality, cost-effective outcomes. Case Management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).
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.
CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.

Contract	As it pertains to the Louisiana Department of Health and Hospitals (DHH) and the BAYOU HEALTH PLANs, the contract signed by or on behalf of the BAYOU HEALTH PLAN entity and those things established or provided for in R.S. 46:437.11 - 437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the BAYOU HEALTH program. It includes the signed Contract, together with any and all future addendums issued thereto by DHH.
Coordinated Care Network (CCN)	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.
Coordinated Care Network – Prepaid (CCN-P)	The private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid CCN Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22 of the Louisiana Revised Statues, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.
Coordinated Care Network – Shared Savings (CCN-S)	An entity that serves as a primary care case manager by providing enhanced primary care case management in addition to contracting with primary care providers (PCPs) for primary care management.
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 Medicaid BAYOU HEALTH PLAN member is responsible for in accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the

	BAYOU HEALTH PLAN to Medicaid BAYOU HEALTH PLAN members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan.
Corrective Action Plan (CAP)	A plan developed by the BAYOU HEALTH PLAN that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Covered Services	Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a BAYOU HEALTH PLAN are based on data that is submitted by the BAYOU 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.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
Department of Health and Human Services (DHHS; also HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for

	low-income families.
Dispute	An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".
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 the Title XIX or Title XXI of the Social Security Act.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of

	health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Enrollee	Louisiana Medicaid or CHIP recipient who is currently enrolled in a BAYOU HEALTH PLAN or other managed care program.
Enrollment	The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a BAYOU HEALTH PLAN.
Enrollment Broker	The states contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees and enrollees into a BAYOU HEALTH PLAN.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an individual enrolled in Louisiana Medicaid.
File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI)	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 health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any 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 who provides health care services or goods.
Healthcare Effectiveness Data and Information Set (HEDIS)	A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (i.e., BAYOU HEALTH PLAN) performance.
HIPAA – Health Insurance Portability Administration	The Administrative Simplification provisions of

Act	the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Implementation Date	The date DHH notifies the BAYOU HEALTH PLAN of on-site Readiness Review completion and approval. It differs from the service start-up or "go live" date (which should be roughly five months from the implementation date). At implementation, a BAYOU HEALTH PLAN can begin the process of establishing all systems for the subsequent enrollment of Medicaid eligibles and service start-up date, and preparing for DHH's on-site Readiness Review. Enrollment of members will not begin until the BAYOU HEALTH PLAN has signed a Contract with DHH and passed the Readiness Review or at the "go live" date.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	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.
KIDMED	Louisiana's screening component for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).
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 Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered 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 (MMIS)	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.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.

Medical Vendor Administration (MVA)	Refers to the name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).
Medically Necessary Services	Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	As it relates to the Louisiana Medicaid Program and the Contract, refers to a Medicaid eligible who enrolls in a BAYOU HEALTH PLAN under the provisions of the Contract and also refers to "enrollee" as

	defined in 42 CFR 438.10(a).
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Network	As utilized in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a BAYOU HEALTH PLAN to supply a range of primary and acute health care services. Also referred to as Provider Network.
Newborn	A live infant born to a BAYOU HEALTH PLAN member.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the BAYOU HEALTH PLAN.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a BAYOU HEALTH PLAN member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which 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.

Primary Care Provider (Primary Dentist)	An individual physician or licensed nurse practitioner responsible for the management of a member's healthcare who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Primary Care Services	Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Prospective Review	Utilization review conducted prior to an admission or a course of treatment.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Health Plan, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.
Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).
Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the

	service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which a BAYOU 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 Assessment and Performance Improvement Plan (QAIP Plan)	A written plan, required of all BAYOU HEALTH PLAN-P entities, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees.
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 BAYOU 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 BAYOU 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 BAYOU HEALTH PLAN's ability and readiness to render services.
Recipient	An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was

	enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.
Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the BAYOU 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.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.
Risk	The chance or possibility of loss. The member is at risk only for pharmacy co-payments as allowed in the Medicaid State Plan and the cost of non-covered services. The BAYOU HEALTH PLAN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain

	reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Area	Referred to as geographic service area (GSA) in the Contract. The designated geographical service area(s) within which the BAYOU HEALTH PLAN is authorized to furnish covered services to enrollees. A service area shall not be less than one GSA.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Shall	Denotes a mandatory requirement.
Should	Denotes a preference but not a mandatory requirement.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Span of Control	Information systems and telecommunications capabilities that the BAYOU 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 BAYOU HEALTH PLAN.
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Start-Up Date	The date BAYOU HEALTH PLAN providers begin providing medical care to their Medicaid members. Also referred to as “go-live date”.
State	The state of Louisiana.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Surveillance and Utilization Review Subsystems (SURS) Reporting	Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.
Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into

	interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Function Response Time	Based on the specific sub function being performed: • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the BAYOU HEALTH PLAN from the provider and/or switch vendor until the BAYOU HEALTH PLAN hands-off a response to the provider and/or switch vendor.
System Unavailability	Measured within the BAYOU 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, 997. The TA1 is a single segment and is unique in the sense that this

	single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (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.
Utilization Management (UM)	Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.
Will	Denotes a mandatory requirement.

Appendix B

Frequently Asked Questions (FAQs)

What is HIPAA and how does it pertain to BAYOU HEALTH PLANs?

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 BAYOU HEALTH PLAN encounter data reporting.

What is Molina and what is their role with BAYOU HEALTH PLANs?

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 BAYOU HEALTH PLANs 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 BAYOU HEALTH PLANs 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 BAYOU HEALTH PLANs submit encounter data?

The reasons why BAYOU HEALTH PLANs are required to submit encounter data are as follows:

1. Encounter Data: Section 17.5.4 of the CCN-P 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 BAYOU HEALTH 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 BAYOU 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 each BAYOU 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 submitting 837 transactions, DHH requires BAYOU HEALTH PLANs to adhere to HIPAA standards governing Medical data code sets. Specifically, BAYOU HEALTH PLANs 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. BAYOU HEALTH PLANs are 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 BAYOU HEALTH PLANs 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.

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:

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

In addition to the Category I codes described above, DHH requires that BAYOU HEALTH PLANs 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, and
- Durable medical equipment.

Appendix D

System Generated Files and Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH and the submitting BAYOU HEALTH 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 Fiscal Agent's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in summary and repairable edit codes reports and a summary report of the encounter data submitted. These edit codes are listed in this **Appendix F** of this Guide. Those edit codes that indicate encounters as repairable for correction and resubmission by the BAYOU HEALTH PLAN are also found in **Appendix F** of this Guide.

The following reports are generated by the MMIS system and have been selected specifically to provide each BAYOU 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 reports and the process for Data Quality Assessment are discussed in Section 6 of this Guide. These quality reports will also depict accuracy and completeness at a volume and utilization level. Please refer to these reports, as outlined in Section 6.

Modifications for the ICD-10 project have been made to the following documents:

Edit Code Detail (CCN-O-010 and CCN-W-010) – Columns 1182-1199
Prior Authorization File (FI to CCN) Columns 148-149
Diagnosis File for Pre-Admission Certification (FI to CCN) Columns 7; 27-35

ASC X12N 835

As discussed above, and in Section 5, BAYOU HEALTH PLANs 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. ICNs are assigned by claim and can be located in the 835 specific to the encounter.

Encounter Claims Summary — Molina Report (FI to CCN)

CCN-O-001 (initial) and CCN-W-001 (weekly)

This report will serve as the high-level error report for the BAYOU HEALTH PLANs as a summarization of the errors incurred. The format, as depicted below, is by claim type. This report **will be distributed as a delimited text file** and it will produce the overall claim count with the disposition of MMIS paid or denied status occurrence and overall percentage. The number and percent to be denied represent all denials, repairable or not.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-001" or "CCN-O-001"	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 "Claims Summary"	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-001" or "CCN-O-001"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The	8	Numeric

Column(s)	Item	Notes	Length	Format
		detail portion of the file is sorted by this number		
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services. 14=Medicare Crossover Instit. 15=Medicare Crossover Prof	2	Numeric
25	Delimiter		1	Uses the ^ character value
26-33	Number of claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Number of claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Character
2	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
3-12	Report ID	Value is “CCN-W-001” or “CCN-O-001”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Not Used		8	Character value is spaces.
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of Claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Total Number of Claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Overall Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

Encounter Edit Disposition Summary — Molina Report (FI to CCN)

CCN-O-005 (initial) and CCN-W-005 (weekly)

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

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005” or “CCN-O-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	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005” or “CCN-O-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

Column(s)	Item	Notes	Length	Format
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services 14=Medicare Crossover Instit. 15=Medicare Crossover Prof.	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.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005” or “CCN-O-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.

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

Edit Code Detail — Molina Report (FI to CCN)

CCN-O-010 (initial) and CCN-W-010 (weekly)

This report lists encounters all encounters and their error codes, including denied error codes. Some of the denied edits are repairable. Refer to Section 3 of the Guide for a listing of repairable edits. **This report will be distributed as a delimited text file** and it is a detailed listing by header and line item of the edits applied to the encounter data. Claims history includes behavioral health encounter/services processed by Magellan.

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-010" or "CCN-O-010"	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 "Claim Detail"	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
82	End of Record		1	Value is spaces.
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-010" or "CCN-O-010"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record.	8	Numeric

		The detail portion of the file is sorted by this number		
22	Delimiter		1	Uses the ^ character value
23-35	Claim ICN	Internal Claim Number, assigned by Molina. Unique per claim line.	13	Numeric
36	Delimiter		1	Uses the ^ character value
37-66	Medical Record Number	Submitted on the claim by the CCN.	30	Character
67	Delimiter		1	Uses the ^ character value
68-87	Patient Control Number	Submitted on the claim by the CCN	20	Character
88	Delimiter		1	Uses the ^ character value
89-118	Line Control Number	Submitted on the claim by the CCN	30	Character
119	Delimiter		1	Uses the ^ character value
120-128	Remittance Advice Number	Assigned by Molina	9	Numeric
129	Delimiter		1	Uses the ^ character value
130-133	Error Code 1	First error code, if claim was denied.	4	Numeric
134	Delimiter		1	Uses the ^ character value
135-138	Error Code 2 (if necessary)	2nd error code, if claim was denied and if available.	4	Numeric
139	Delimiter		1	Uses the ^ character value
140-143	Error Code 3 (if necessary)	3rd error code, if claim was denied and if available.	4	Numeric
144	Delimiter		1	Uses the ^ character value
145-148	Error Code 4 (if necessary)	4th error code, if claim was denied and if available.	4	Numeric
149	Delimiter		1	Uses the ^ character value

150-153	Error Code 5 (if necessary)	5th error code, if claim was denied and if available.	4	Numeric
154	Delimiter		1	Uses the ^ character value
155-158	Error Code 6 (if necessary)	6th error code, if claim was denied and if available.	4	Numeric
159	Delimiter		1	Uses the ^ character value
160-163	Error Code 7 (if necessary)	7th error code, if claim was denied and if available.	4	Numeric
164	Delimiter		1	Uses the ^ character value
165-168	Error Code 8 (if necessary)	8th error code, if claim was denied and if available.	4	Numeric
169	Delimiter		1	Uses the ^ character value
170-173	Error Code 9 (if necessary)	9th error code, if claim was denied and if available.		
174	Delimiter		1	Uses the ^ character value
175-178	Error Code 10 (if necessary)	10th error code, if claim was denied and if available.		
179	Delimiter		1	Uses the ^ character value
180	Type of Admission		1	Character
181	Delimiter		1	Uses the ^ character value
182-191	Medicaid Paid Units		10	Numeric with decimal point, left zero-fill.
192	Delimiter		1	Uses the ^ character value.
193-195	Patient Status		3	Character
196	Delimiter		1	Uses the ^ character value.
197-204	DOS-From		8	Numeric, YYYYMMDD
205	Delimiter		1	Uses the ^ character value.
206-213	DOS-Through		8	Numeric, YYYYMMDD
214	Delimiter		1	Uses the ^ character value.

215-227	Medicaid Recipient ID	Recipient's current Medicaid ID number	13	Character
228	Delimiter		1	Uses the ^ character value.
229-242	Provider Billed Charges	Billed charges from provider as submitted by Provider on claim	14	Numeric with decimal point, left zero-fill.
243	Delimiter		1	Uses the ^ character value.
244-248	Procedure Code	As submitted by Provider on claim, for all claim types except inpatient hospital.		Character
249	Delimiter		1	Uses the ^ character value.
250-259	Provider Billed Units	As submitted by Provider on claim	10	Numeric with decimal point, left zero-fill.
260	Delimiter		1	Uses the ^ character value.
261-274	Medicaid Payment	Amount Louisiana Medicaid paid on the claim	14	Numeric with decimal point, left zero-fill.
275	Delimiter		1	Uses the ^ character value.
276-286	NDC	If Rx claim, then this is the NDC on the claim	11	
287	Delimiter		1	Uses the ^ character value.
288-290	Therapeutic Class	If Rx claim	3	
291	Delimiter		1	Uses the ^ character value.
292	Rx refill code	If Rx claim: 0=1st script, 1-5=refill number	1	
293	Delimiter		1	Uses the ^ character value.
294-298	Diagnosis Code	ICD-9-CM diag. code, if available	5	Character, does not include the decimal.
299	Delimiter		1	Uses the ^ character value.
300	Admit Date		8	Numeric, YYYYMMDD For inpatient

				hospital claims
308	Delimiter		1	Uses the ^ character value.
309-316	Discharge Date		8	Numeric, YYYYMMDD For inpatient hospital claims
317	Delimiter		1	Uses the ^ character value.
318-319	Servicing Provider Specialty		2	Numeric with leading zero if necessary.
320	Delimiter		1	Uses the ^ character value.
321-330	Prior Authorization Number		10	Numeric, 9 or 10 digits
331	Delimiter		1	Uses the ^ character value.
332-334	Bill Type		3	Claim Bill Type (inpatient and institutional)
335	Delimiter		1	Uses the ^ character value.
336-337	Type of Service		2	See Type of Service values in Appendix J
338	Delimiter		1	Uses the ^ character value.
339-340	Category of Service		2	See Category of Service values in Appendix J
341	Delimiter		1	Uses the ^ character value.
342-351	Billing Provider NPI		10	
352	Delimiter		1	Uses the ^ character value.
353-362	Servicing/ Attending Provider NPI		10	
363	Delimiter		1	Uses the ^ character value.
364-365	Billing Provider Type		2	See Provider Type values in Appendix J
366	Delimiter		1	Uses the ^ character value.
367-368	Servicing/ Attending Provider		2	See Provider Type values in Appendix

	Type			J
369	Delimiter		1	Uses the ^ character value.
370	Claim Status		1	Numeric: 1=Paid Original 2=Adjustment/Void 3=Denied
371	Delimiter		1	Uses the ^ character value.
372	Claim Status Modifier		1	Numeric: 1=Paid Original 2=Adjustment 3=Void (for adjustment) 4=Void (from provider)
373	Delimiter		1	Uses the ^ character value.
374	Claim Type		2	01=Inpatient Hosp 02=LTC/ICF/NH 03=Outpatient Hosp 04=Professional 05=Rehab 06=Home Health 07=EMT 08=NEMT 09=DME 10=Dental EPSDT 11=Dental Adult 12=Pharmacy 13=EPSDT 14=Medicare Institutional Crossover 15=Medicare Professional Crossover 16=ADHC
376	Delimiter		1	Uses the ^ character value.
377	Claim or Encounter Indicator	1=claim 2=encounter	1	Identifies FFS claim vs. pre-paid encounter.
378	Delimiter		1	Uses the ^ character value.
379-380	Not populated		2	Spaces.
381	Delimiter		1	Uses the ^ character value.
382-383	Procedure Modifier 1		2	Character
384	Delimiter		1	Uses the ^ character value.
385-386	Procedure Modifier 2		2	Character
387	Delimiter		1	Uses the ^ character value.
388-389	Procedure Modifier 3		2	Character
390	Delimiter		1	Uses the ^ character value.
The following items represent revenue codes, HCPCS, units				

and charges associated with institutional claims. There are 23 occurrences.				
391-394	Revenue Code 1		4	Numeric
395	Delimiter		1	Uses the ^ character value.
396-400	Revenue HCPCS 1		5	Character
401	Delimiter		1	Uses the ^ character value.
402-406	Revenue Units 1		5	Numeric
407	Delimiter		1	Uses the ^ character value.
408-421	Revenue Charges 1		14	Numeric with decimal point, left zero-fill.
422	Delimiter		1	Uses the ^ character value.
There are 23 occurrences of the revenue items, with each occurrence being 32 bytes in length (consisting of code, HCPCS, Units and Charges, with delimiters).				
1127-1134	Claim Payment Date		8	Numeric data format in the format YYYYMMDD
1135	Delimiter		1	Uses the ^ character value.
1136-1140	Diagnosis Code 2	ICD-9-CM diag code, if available (this represents the secondary diagnosis)	5	Character, does not include the decimal.
1141	Delimiter		1	Uses the ^ character value.
1142-43	Place of Service	Uses the CMS 1500 standard Place of Service code values	1	2-digit numeric value. Only applicable to professional services claims.
1144	Delimiter		1	Uses the ^ character value.
1145-1152	Rx Prescription Date	Only populated on Pharmacy claims; otherwise, will have 0 value	8	Numeric, YYYYMMDD
1153	Delimiter		1	Uses the ^ character value.
1154-1157	Rx Days Supply	Only populated on Pharmacy claims; otherwise, will	4	Numeric, left fill with zero.

		have 0 value		
1158	Delimiter		1	Uses the ^ character value.
1159-1169	Rx Quantity	Only populated on Pharmacy claims; otherwise, will have 0 value	11	Numeric with decimal point, left zero-fill.
1170	Delimiter		1	Uses the ^ character value.
1171-1180	Prescribing Provider NPI	Only populated on Pharmacy claims; otherwise, will have BLANK value	10	Numeric left zero fill.
1181	Delimiter		1	Uses the ^ character
1182	ICD Indicator	Used to identify whether ICFD-9 or ICD-10 CM codes were submitted on claim/encounter	1	0=ICD-10 9= ICD-9
1183	Delimiter		1	Uses the ^ character
1184-1190	ICD-10 CM primary diagnosis code		7	Will contain spaces if only ICD-9 code is submitted. If ICD-10 code was submitted, it will not contain the period.
1191	Delimiter		1	Uses the ^ character
1192-1198	ICD-10 CM		7	Will contain spaces if only ICD-9 code is submitted. If ICFD-10 code was submitted, it will not contain the period.
1199	Delimiter		1	Uses the ^ character
1200	End of Record		1	Character, value is space.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^

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

Provider File (FI to CCN)

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number. This is the internal Louisiana Medicaid provider ID	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit. This is the external Louisiana Medicaid provider ID (the one known by providers)	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-46	Provider Name (Servicing)		30	Character
47	Delimiter		1	Uses the ^ character value
48-57	Provider NPI		10	Character
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character
69	Delimiter		1	Uses the ^ character value
70-71	Provider Type		2	See Provider Type codes in Appendix G
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix G
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				character value
94-123	Provider Street Address (Servicing)		30	
124	Delimiter		1	Uses the ^ character value
125-154	Provider City (Servicing)		30	
155	Delimiter		1	Uses the ^ character value
156-157	Provider State	USPS abbreviation	2	
158	Delimiter		1	Uses the ^ character value
159-168	Provider Phone		10	Numeric
169	Delimiter		1	Uses the ^ character value
170-171	Provider Parish		2	See parish code values in Appendix J
172	Delimiter		1	Uses the ^ character value
173-181	Provider Zip Code		9	Numeric
182	Delimiter		1	Uses the ^ character value
183	Urban-Rural Indicator (applicable to hospitals only)		1	Character: 0=not applicable 1=urban 2=rural 3=sole community hospital
184	Delimiter		1	Uses the ^ character value
185-214	Provider Street Address (Pay-To)		30	
215	Delimiter		1	Uses the ^ character value
216-245	Provider City (Pay-To)		30	
246	Delimiter		1	Uses the ^ character value
247-248	Provider State (Pay-To)	USPS abbreviation	2	
249	Delimiter		1	Uses the ^ character value
250-258	Provider Zip (Pay-To)	USPS ZIP code+4, if available	9	Numeric
259	Delimiter		1	Uses the ^ character value
260	Tax ID number (TIN) or SSN		9	Numeric, left fill with zeros
269	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
270	Medicare-registered or other LLC NPI number First occurrence		10	Numeric if present, otherwise spaces
280	Delimiter		1	
281	Medicare-registered or other LLC NPI number 2nd occurrence		10	Numeric if present, otherwise spaces
291	Delimiter		1	
292	Medicare-registered or other LLC NPI number 3rd occurrence		10	Numeric if present, otherwise spaces
302	Delimiter		1	
303	Medicare-registered or other LLC NPI number 4th occurrence		10	Numeric if present, otherwise spaces
313	Delimiter		1	
314	Medicare-registered or other LLC NPI number 5th occurrence		10	Numeric if present, otherwise spaces
324	Delimiter		1	
325	Medicare-registered or other LLC NPI number 6th occurrence		10	Numeric if present, otherwise spaces
335	Delimiter		1	
336	Medicare-registered or other LLC NPI number 7th occurrence		10	Numeric if present, otherwise spaces
346	Delimiter		1	
347	Medicare-registered or other LLC NPI number 8th occurrence		10	Numeric if present, otherwise spaces
357	Delimiter		1	
358	Medicare-registered or other LLC NPI number 9th occurrence		10	Numeric if present, otherwise spaces
368	Delimiter		1	
369	Medicare-registered or other LLC NPI number 10th occurrence		10	Numeric if present, otherwise spaces
379	Delimiter		1	
380	Medicare-registered or other LLC NPI number 11th occurrence		10	Numeric if present, otherwise spaces

Column(s)	Item	Notes	Length	Format
390	Delimiter		1	
391	Medicare-registered or other LLC NPI number 12th occurrence		10	Numeric if present, otherwise spaces
401	Delimiter		1	
402	Medicare-registered or other LLC NPI number 13th occurrence		10	Numeric if present, otherwise spaces
412	Delimiter		1	
413	Medicare-registered or other LLC NPI number 14th occurrence		10	Numeric if present, otherwise spaces
423	Delimiter		1	
424	Medicare-registered or other LLC NPI number 15th occurrence		10	Numeric if present, otherwise spaces
434	Delimiter		1	
435	Medicare-registered or other LLC NPI number 16th occurrence		10	Numeric if present, otherwise spaces
445	Delimiter		1	
446	Medicare-registered or other LLC NPI number 17th occurrence		10	Numeric if present, otherwise spaces
456	Delimiter		1	
457	Medicare-registered or other LLC NPI number 18th occurrence		10	Numeric if present, otherwise spaces
467	Delimiter		1	
468	Medicare-registered or other LLC NPI number 19th occurrence		10	Numeric if present, otherwise spaces
478	Delimiter		1	
479	Medicare-registered or other LLC NPI number 20th occurrence		10	Numeric if present, otherwise spaces
489	End of Record		1	Value is spaces.

Provider Negotiated Rates File (FI to CCN)

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-46	Provider Name (Servicing)		30	Character
47	Delimiter		1	Uses the ^ character value
48-57	Provider NPI		10	Character
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character
69	Delimiter		1	Uses the ^ character value
70-71	Provider Type		2	See Provider Type codes in Appendix J
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix J
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-101	Rate 1	Inpatient General LOC Per-diem	8	Numeric with decimal and left-fill with zeros
102	Delimiter		1	Uses the ^ character value
103-110	Effective Date 1		8	Numeric, date

Column(s)	Item	Notes	Length	Format
				value in the format YYYYMMDD
111	Delimiter		1	Uses the ^ character value
112-119	Rate 2	Other Inpatient (usually not applicable)	8	Numeric with decimal and left-fill with zeros
120	Delimiter		1	Uses the ^ character value
121-128	Effective Date 2		8	Numeric, date value in the format YYYYMMDD
129	Delimiter		1	Uses the ^ character value
130-137	Rate 9	Outpatient Cost-to-Charge Ratio	8	Numeric with decimal and left-fill with zeros
138	Delimiter		1	Uses the ^ character value
139-146	Effective Date 9		8	Numeric, date value in the format YYYYMMDD
147	Delimiter		1	Uses the ^ character value
The next 40 items depict rates associated with specific revenue codes and/or procedure codes. There are 4 parts to each item: code value, Type of Service, Effective Begin Date and Rate. Each item is 27 bytes in length and there are 40 occurrences. Not all 40 items may be populated… some may contain spaces.				
148-152	Procedure or Revenue Code		5	Character
153	Delimiter		1	Uses the ^ character value
154-155	Type of Service		2	Character, see Type of Service values in Appendix J.
156	Delimiter		1	Uses the ^ character value
157-164	Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
165	Delimiter		1	Uses the ^ character value
166-173	Rate		8	Numeric with decimal and left-fill with zeros

Column(s)	Item	Notes	Length	Format
174	Delimiter		1	Uses the ^ character value
1228	End of Record		1	Value is spaces.

820 File (FI to CCN)

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					
		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.					
BPR=Financial Information					
Sample: BPR*I*1234567.89*C*ACH*CCP*01*123456789*DA*123456*1123456789**01*987654321*DA*654321*20120103~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	ACH=Automated Clearinghouse	S
		BPR05	Payment Format Code	CCP=CCD+ Format	S
		BPR06	(DFI) ID Number Qualifier	Depository Financial Institution (DFI) Identification Number Qualifier 01 – ABA Transit Routing	S

				Number Including Check Digits (9 digits)	
Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction. SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send.					
		BPR07	(DFI) Identification Number	ID number of originating Depository (DHH)	S
		BPR08	Account Number Qualifier	Code indicating type of account "DA" - Demand Deposit	S
		BPR09	Account Number	Premium payer's bank account	S
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	Depository Financial Institution (DFI) Identification Number Qualifier "01" – ABA Transit Routing Number Including Check Digits	S
		BPR13	(DFI) Identification Number	This is the identifying number of the Receiving Depository Financial Institution receiving the transaction into the ACH network. (CCN)	S
		BRP14	Account Number Qualifier	Code indicating type of account "DA" - Demand Deposit "SG" - Savings	S
		BPR15	Account Number	CCN bank account number	
		BPR16	EFT Effective Date	Expressed CCYYMMDD	
TRN=Re-association Trace Number					
Sample: TRN*3*1123456789**~					

	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver's Identification Key					
Sample: REF*18*123456789*CCN Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	
		REF03	Description	'CCN Fee Payment'	S
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	S
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S

		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D
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	
	1000A	N102	Name	Information Receiver Last or Organization Name	
	1000A	N103	Identification Code Qualifier	"FI" – Federal	
	1000A	N104	Identification Code	Receiver Identifier	
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*Louisiana Department of Health and Hospitals*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	
	1000B	N102	Name	Premium Payer Name	
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	
	1000B	N104	Identification Code	Premium Payer ID	
2000B INDIVIDUAL REMITTANCE					
ENT=Individual Remittance					
Sample: ENT*1*2J*34*123456789~					
	2000B	ENT01	Assigned Number	Sequential Number assigned for differentiation within a transaction set	
	2000B	ENT02	Entity Identifier Code	"2J" - Individual	
	2000B	ENT03	Identification Code Qualifier	"34" - Social Security Number	
	2000B	ENT04	Identification Code	Individual Identifier - SSN	
2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	"QE" - Policyholder	

				(Recipient Name)	
	2100B	NM102	Policyholder	"1" - Person	
	2100B	NM103	Name Last	Individual Last Name	
	2100B	NM104	Name First	Individual First Name	
	2100B	NM105	Name Middle	Individual Middle Initial	
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Individual Identifier	
	2100B	NM109	Identification Code	Individual Identifier – Recipient ID number	
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*11*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	
	2300B	RMR02	Reference Identification	Claim ICN (Molina internal claims number).	
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	
REF=Reference Information (1st occurrence)					
Sample: REF*ZZ*0101C~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Capitation Code	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (2nd occurrence)					
Sample: REF*ZZ*01~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Recipient Region code: Values 01 to 09.	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (3rd occurrence)					
Sample: REF*ZZ*01~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Recipient Category of Assistance (aka Aid	

				Category) – 2-digit number.	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (4th occurrence)					
Sample: REF*ZZ*001~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Recipient Type Case (aka Case Type) – 3-digit number	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
DTM=Individual Coverage Period					
Sample: DTM*582****RD8*20120101-20120131~					
	2300B	DTM01	Date/Time Qualifier	"582" - Report Period	
	2300B	DTM02	NOT USED	NOT USED	
	2300B	DTM03	NOT USED	NOT USED	
	2300B	DTM04	NOT USED	NOT USED	
	2300B	DTM05	Date Time Period Format Qualifier	"RD8" – Range of Dates	
	2300B	DTM06	Date Time Period	Coverage Period, expressed as CCYYMMDD-CCYYMMDD	
Transaction Set Trailer					
Sample: SE*39*0001~					
	SE	SE01	Transaction Segment Count		
		SE02	Transaction Set Control Number		
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					

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~
~~DTM*582****RD8*20120201-20120229~~ (removed to comply with HIPAA standard)
ADX*-500*52~

Adjusted Amount sequence:
ENT*107*2J*ZZ*7787998022222~
NM1*QE*1*DOE*JOHN*D***N*1234567890123~
RMR*AZ*1067610041100**600~
REF*ZZ*0101C~ (added to comply with HIPAA standard)
REF*ZZ*01~ (added to provide recipient region)
DTM*582****RD8*20120201-20120229~

Prior Authorization File (FI to CCN)

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
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		5	ICD-9-CM

Column(s)	Item	Notes	Length	Format
	(for Inpatient Pre-Admission Certification) or Diagnosis code if required on the PA			
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 Pre-cert Type	1=PA 2=Pre-cert	1	Character
114	Delimiter		1	Uses the ^ character value
115-116	PA Type Or Pre-cert Type	**Pre-cert**: 03=Inpatient Acute **PA**: 04=Waiver 05=Rehab 06=HH 07=Air EMT 09=DME 10=Dental 11=Dental 14=EPSDT-PCS 16=PDHC 35=ROW 40=RUM 50=LT-PCS 60=Early Steps CM 66=RxPA 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
121-125	Precert Level of Care (this field should be blank for Medical PA transactions, but it will contain the Therapeutic Class for RxPA transactions)	GEN ICU NICU REHAB PICU CCU TU=Telemetry LT=LTAC	5	Character
126	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
127-136	PA Line Amount Used	For an approved PA or Precert line item, this field contains any amount used as a result of claims processing. For an approved RxPA line item, this field contains the HICL in the first 6 characters.	10	Numeric, with decimal and left-zero fill.
137	Delimiter		1	Uses the ^ character value
138-147	PA or Precert Number assigned by Molina		10	9- or 10-digit number
148	Delimiter		1	Uses the ^ character value
149	ICD indicator		1	Identifies if ICD-9 or ICD-10 code was submitted: 0=ICD-10 9=ICD-9
150	Delimiter		1	Uses the ^ character value
151-157	ICD-10 CM diagnosis. Admitting Diagnosis Code (for Inpatient Pre-Admission Certification) or Diagnosis code if required on the PA		7	Will contain spaces if ICD-9 code was submitted. If ICD-10 code was submitted, it will not contain the period.
158	Delimiter		1	Uses the ^ character value
159	End of Record		1	Value is spaces.

Diagnosis File for Pre-Admission Certification (FI to CCN)

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/Not valid for Precert, 3=Not a valid diagnosis	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27-33	ICD-10 Diagnosis Code		7	Character, does not include the period.
34	Delimiter		1	Uses the ^ character value
35	End of Record		1	Value is spaces.

Procedure File for Prior Authorization (FI to CCN)

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

Column(s)	Item	Notes	Length	Format
1-5	Procedure Code		5	Character
6	Delimiter		1	Uses the ^ character value
7	PA Status	1=Applicable 2=Not applicable	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27-28	Type of Service		2	Character. See Appendix J for code values
29	Delimiter		1	Uses the ^ character value
30-39	Maximum Amount		10	Numeric, with decimal and left-fill with zeros, will be zero if not applicable
40	Delimiter		1	Uses the ^ character value
41-43	Minimum Age		3	Numeric, left-fill with zeros. Will be zero if not applicable.
44	Delimiter		1	Uses the ^ character value
45-47	Maximum Age		3	Numeric, left-fill with zeros. Will be zero if not applicable.
48	Delimiter		1	Uses the ^ character value
49	Sex Restriction Indicator	0=n/a 1=Male only 2=Female only	1	Character
50	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
51-53	Pricing Action Code		3	Character See Appendix J for Code values
54	Delimiter		1	Uses the ^ character value
55	End of Record		1	Value is spaces.

CLIA File (FI to CCN)

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

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	Non-check digit Medicaid Provider ID	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider ID (check-digit)	Check-digit Medicaid Provider ID	7	
16	Delimiter		1	Uses the ^ character value
17-26	Provider NPI	NPI	10	
27	Delimiter		1	Uses the ^ character value
CLIA numbers with effective dates, there are up to 15 occurrences of these items per CLIA number. Each occurrence is 31 bytes				
28-37	CLIA number		10	Character
38	Delimiter		1	Uses the ^ character value
39-46	CLIA Effective Begin Date		8	Numeric in date format YYYYMMDD
47	Delimiter		1	Uses the ^ character value
48-55	CLIA Effective End Date		8	Numeric in date format YYYYMMDD
56	Delimiter		1	Uses the ^ character value
57	CLIA Type		1	Space=not avail. 1 = Registration 2 = Regular Certificate 3 = Accreditation 4 = Waiver 5 = Microscopy
58	Delimiter		1	Uses the ^ character value
493	End of Record		1	Value is spaces.

Quality Profiles Submission File (CCN to FI)

There will be 1 single file, formatted as a text, CSV (comma-separated value) file.
There will be 4 record types on the file as shown in the grid below, so the file will have exactly 4 records.

Record Type 1: Performance Standards Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=1	1
Delimiter	2	Character, value='^'	1
QPS_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QPS_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QPS_PHONE_ACCESS_24X7_PERCENT	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QPS_SERVICE_AUTH_PERCENT	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QPS_PRE_PROCESS_CLAIMS_PERCENT	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QPS_REJECTED_CLAIMS_TO_PROV_PERCENT	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1
QPS_CALL_CENTER_CALLS_PERCENT	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QPS_CALL_CENTER_AVERAGE_CALL_ANSWER_TIME	52-57	Numeric, 6 digits, no comma, no decimal, left fill with zeroes. Expressed in seconds.	6
Delimiter	58	Character, value='^'	1
QPS_CALL_CENTER_ABANDON_RATE	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QPS_GRIEVANCES_RESOLVED_RATE	66-71	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	72	Character, value='E'	1

Record Type 2: Incentive-Based Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=2	1
Delimiter	2	Character, value='^'	1
QIB _CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QIB _TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QIB_ADULT_ACCESS_TO_PREV_AMB_SERVICES	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QIB_COMPREHENSIVE_DIABETES_CARE_HGBA1C	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QIB_CHLAMYDIA_SCREENING	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QIB_WELL_CHILD_VISITS_THIRD_YEAR	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1
QIB_WELL_CHILD_VISITS_FOURTH_YEAR	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QIB_WELL_CHILD_VISITS_FIFTH_YEAR	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QIB_WELL_CHILD_VISITS_SIXTH_YEAR	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QIB_ADOLESCENT_WELL_VISITS	66-71	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	72	Character, value='E'	1

Record Type 3: Level I Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=3	1
Delimiter	2	Character, value='^'	1
QLI_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QLI_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QLI_CHILD_AND_ADOL_ACCESS_TO_PCP	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QLI_TIMELINESS_OF_PRENATAL_AND_POSTPARTUM_CARE	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QLI_CHILDHOOD_IMMUN_STATUS	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QLI_IMMUNIZATIONS_FOR_ADOL	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1
QLI_LEAD_SCREENING_CHILDREN	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QLI_CERVICAL_CANCER_SCREENING	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QLI_PERCENT_LIVE_BIRTHS_WEIGHT_LT_2500G	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QLI_WEIGHT_ASSESSMENT_CHILDREN_ADOL	66-71	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	72	Character, value='^'	1
QLI_MEDICATIONS_FOR_PERSONS_WITH_ASTHMA	73-78	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	79	Character, value='^'	1
QLI_COMPREHENSIVE_DIABETES_CARE	80-85	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	86	Character, value='^'	1
QLI_BREAST_CANCER_SCREENING	87-92	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	93	Character, value='^'	1

QLI_EPSDT_SCREENING_RATE	94-99	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	100	Character, value='^'	1
QLI_ADULT_ASTHMA_ADMISSION_RATE	101-106	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	107	Character, value='^'	1
QLI_CHF_ADMISSION_RATE	108-113	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	114	Character, value='^'	1
QLI_UNCONTROLLED_DIABETES_ADMISSION_RATE	115-120	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	121	Character, value='^'	1
QLI_INPATIENT_HOSP_READMISSION_RATE	122-127	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	128	Character, value='^'	1
QLI_WELL_CHILD_VISITS_IN_FIRST_15_MONTHS	129-134	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	135	Character, value='^'	1
QLI_AMBULATORY_CARE_ER_UTILIZATION	136-141	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	142	Character, value='E'	1

Record Type 4: Level II Measures Record

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

		NNN.NN, with the decimal included.	
Delimiter	44	Character, value='^'	1
QLII_CESAREAN_RATE_FOR_LOW_RISK_FIRST_BIRTH_WOMEN	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QLII_APPROP_TESTING_FOR_CHILDREN_WITH_PHARYNGITIS	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QLII_PERCENT_PREG_WOMEN_TOBACCO_SCREEN	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QLII_TOTAL_NUMBER_ELIG_WOMEN_WITH_17OH_PROGESTERONE	66-71	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	72	Character, value='^'	1
QLII_EMER_UTIL_AVG_ED_VISITS_PER_MEMBER	73-78	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	79	Character, value='^'	1
QLII_ANNUAL_NUMBER_ASTHMA_PATIENTS_WITH_1_ER_VISIT	80-85	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	86	Character, value='^'	1
QLII_FREQ_OF_ONGOING_PRENATAL_CARE	87-92	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	93	Character, value='^'	1
QLII_CAHPS_HEALTH_PLAN_SURVEY40_ADULT	94-99	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	100	Character, value='^'	1
QLII_CAHPS_HEALTH_PLAN_SURVEY40_CHILD	101-106	Numeric, 6 digits, no comma, no decimal, left fill with zeroes.	6
Delimiter	107	Character, value='^'	1
QLII_PROVIDER_SATISFACTION	108-113	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	114	Character, value='E'	1

Appendix E

BAYOU HEALTH 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.

416 Reports

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

The BAYOU HEALTH PLAN 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 BAYOU HEALTH PLAN is required to complete all line items of the CMS 416 Report and submit separate reports for the SCHIP and TANF/CHAP populations.

Instructions for the 416 report may be found at

www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage

Denied Claims Report

On a monthly basis, the Bayou Health Plan is required to submit the Denied Claims Report. This report must include denials for ALL claim types that are included in the Bayou Health Program. The template for the Denied Claims Report along with detailed instructions can be found at MakingMedicaidBetter.com.

Claims Summary Report Instructions

On a monthly basis, the Bayou Health Plan is required to submit The Claims Summary Report. The report must provide:

- a summary of ALL Paid, and Denied Claims and
- the percentage of clean claims (Paid and Denied) processed in 01-15 business day, 01-30 calendar days, and 31-90 calendar days.

The report template along with detailed instructions can be found at makingmedicaidbetter.com

FQHC and RHC Quarterly Report

The BAYOU HEALTH PLAN shall submit on a quarterly basis by date of service, a report of encounter/claim data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. The report shall be submitted based on timeframes established in Section 18.13 of the CCN-P RFP. The report shall include the following information:

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

Appendix F

Encounter Edit Codes

This Appendix includes tables of the following encounter edit codes, descriptions, and their dispositions:

- Comprehensive List of Encounter Edit Codes
- Edit Disposition – Deny – Repairable (under limited circumstances)
- Edit Disposition – Deny – Repairable
- Edit Disposition – Deny – Not Repairable

Encounter Edits Listing, Comprehensive

Disposition values: D=Deny, E=Explanation only

Edit Code	Change Date	Effective Date	Disposition	Short Description	Long Description
001	20120108	20100101	D	INVALID CLM TYP MOD	INVALID CLAIM TYPE MODIFIER
002	20120108	20100101	D	INVALID PROVIDER NO	PROVIDER NUMBER MISSING OR NOT NUMERIC
003	20120108	20100101	D	RECIPIENT # INVALID	RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
005	20120108	20100101	D	INVAL SERV FROM DATE	SERVICE FROM DATE MISSING/INVALID
006	20120108	20100101	D	INVAL SERV THRU DATE	INVALID OR MISSING THRU DATE
007	20120108	20100101	D	SERV THRU LT SERV FM	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	20120108	20100101	D	SERV FRM GT ENTR DTE	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	20120108	20100101	D	SERV THR GT ENTR DTE	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
013	20120108	20100101	D	ORG CLM W ADJ/VD ICN	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
015	20120108	20100101	D	INVALID ACCIDENT IND	ACCIDENT INDICATOR MUST BE Y,N,SPACE
016	20120108	20100101	D	INVALID ACCID IND	ACCIDENT INDICATOR NOT Y, N OR SPACE
017	20120108	20100101	D	INVALID EPSDT IND	EPSDT INDICATOR NOT Y, N, OR SPACE
020	20120815	20100101	D	INVAL/MISS DIAG CODE	INVALID OR MISSING DIAGNOSIS CODE
021	20120108	20100101	D	INVALID FORMER REFNO	FORMER REFERENCE NUMBER MISSING OR INVALID
022	20120108	20100101	E	INVALID BILLED CHRGS	BILLED CHARGES MISSING OR NOT NUMERIC
023	20120108	20100101	D	INV PARTIAL RECIP	RECIPIENT NAME IS MISSING
024	20120108	20100101	D	INV BILLING PROV NO	BILLING PROVIDER NUMBER NOT NUMERIC
030	20120108	20100101	E	SERV THRU DT TOO OLD	SERV THRU DATE MORE THAN TWO YEARS OLD
035	20120108	20100101	D	REBILL CORRECT HCPC	ASC,OP FAC/PHYS.BILLED DIFF CODE;REBILL CORRECT HC
040	20120108	20100101	D	INV ADMISSION DATE	ADMISSION DATE MISSING OR INVALID
044	20120108	20100101	E	INV NATURE OF ADMIT	NATURE OF ADMISSION MISSING OR INVALID
045	20120108	20100101	D	INV PATIENT STATUS	PATIENT STATUS CODE INVALID OR MISSING
046	20120108	20100101	D	INV PATIENT STAT DTE	PATIENT STATUS DATE MISSING OR INVALID
047	20120108	20100101	D	PAT STAT DTE GT THRU	PATIENT STATUS DATE GREATER THAN THRU DATE
048	20120108	20100101	D	INVALID/MISS PROC	INVALID OR MISSING PROCEDURE CODE

049	20120108	20100101	D	INV/CONFLIC SURG DTE	INVALID/CONFLICT SURGICAL DATE
053	20130802	20100101	E	INV ACCOMODATION DAY	ACCOMODATION DAYS MISSING OR INVALID
055	20130802	20100101	E	INV ACCOM/ANCILL CHG	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID
060	20120108	20100101	E	INVALID COVERED DAYS	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING
063	20130802	20100101	E	INVALID TOTAL CHARGE	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
064	20130802	20100101	E	INVALID NET AMOUNT	THE NET BILLED AMOUNT IS NOT NUMERIC
067	20130802	20100101	E	INVALID NON-COVERED	NON COVERED HOSP DAYS NOT NUMERIC OR MISSING
068	20120917	20100101	E	INV POINT ORIGIN	INVALID POINT OF ORIGIN
069	20120108	20100101	D	INV OCCUR DATE	INVALID OCCURRENCE DATE
071	20120108	20100101	D	INV STMT COVERS FROM	STATEMENT COVERS FROM DATE INVALID
072	20120108	20100101	D	INV STMT COVER THRU	STATEMENT COVERS THRU DATE INVALID
073	20120108	20100101	D	STMT FRM LT SERV FRM	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM
074	20120108	20100101	D	STMT THRU GT SRV THR	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE
081	20120108	20100101	D	INVALID STATUS DATE	INVALID OR MISSING PATIENT STATUS DATE
082	20120108	20100101	D	INVALID STATUS CODE	INVALID PATIENT STATUS CODE
084	20120108	20100101	E	INVALID TREAT PLACE	INVALID OR MISSING PLACE OF TREATMENT
093	20130802	20100101	E	REVENUE CODE MISSING	REVENUE CODE MISSING/INVALID
094	20120108	20100101	D	MISSING PINTS BLOOD	MISSING PINTS BLOOD
097	20130802	20100101	E	NON-COVCHG > BILLCHG	NON-COVERED CHARGES EXCEED BILLED CHARGES
115	20130802	20100101	E	HCPC CD NOT ON FILE	HCPC CODE NOT ON FILE
120	20120108	20100101	D	QTY INVALID/MISSING	QUANTITY INVALID/MISSING
127	20120108	20100101	D	MISSING NDC	NDC CODE MISSING OR INCORRECT.
130	20130401	20100101	D	DENY PROV. 9999999	ALL PROVIDERS 9999999 TO BE DENY.
131	20120108	20100101	D	PRIMARY DX NOF	PRIMARY DIAGNOSIS NOT ON FILE
132	20120108	20100101	E	SECONDARY DX NOF	SECONDARY DIAGNOSIS NOT ON FILE
134	20130930	20100101	D	ENC DENIED BY PLAN	DENIED ENCOUNTER SUBMITTED BY PLAN
136	20120523	20100101	E	NO ELIG SERVICE PAID	NO ELIGIBLE SERVICE PAID - ENCOUNTER DENIED
180	20120108	20100101	D	INVALID ADMIT DATE	THE ADMISSION DATE WAS NOT A VALID DATE
183	20120108	20100101	D	SURGERY PROC NOF	SURGICAL PROCEDURE NOT ON FILE
186	20120108	20100101	D	USE CORRECT MODIFIER	CRNA'S MUST BILL CORRECT MODIFIER
200	20120108	20100101	D	PROV/ATTEND NOF	PROVIDER/ATTENDING PROVIDER NOT ON FILE
201	20120108	20100101	E	PROVIDER NOT ELIG	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE

202	20120108	20100101	E	PROV CLAIM TYP CONFL	PROVIDER CANNOT SUBMIT THIS TYPE CLAIM
203	20120108	20100101	E	PROVIDER ON REVIEW	PROVIDER ON REVIEW
206	20120108	20100101	D	BILL PROV NOT ON FIL	BILLING PROVIDER NOT ON FILE
210	20120108	20100101	E	PROV PROC CONFLICT	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
211	20120108	20100101	D	DOS LESS THAN DOB	DATE OF SERVICE LESS THAN DATE OF BIRTH
212	20120108	20100101	E	PROV MUST BE INDIV	ATTENDING PROVIDER MUST BE INDIVIDUAL
215	20120108	20100101	D	RECIPIENT NOT ON FIL	RECIPIENT NOT ON FILE
216	20120108	20100101	D	RECIPIENT NOT ELIG	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
217	20120108	20100101	E	RECIP NAME MISMATCH	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RE
222	20120108	20100101	D	SVC OVERLAPS REC ELI	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S
231	20120108	20100101	E	NDC NOT ON P/F FILE	NDC CODE NOT ON FILE
232	20120108	20100101	E	PROCEDURE CODE NOF	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
234	20130802	20100101	E	P/F AGE RESTRICTION	P/F AGE RESTRICTION
235	20130802	20100101	E	P/F SEX RESTRICTION	P/F SEX RESTRICTION
237	20130802	20100101	E	P/F PROV SPEC RESTRT	P/F PROVIDER SPECIALTY RESTRICTION
252	20120108	20100101	D	DIAGNOSIS NOT ON FIL	DIAGNOSIS NOT ON FILE
254	20130802	20100101	E	DIAG AGE RESTRICTION	DIAGNOSIS AGE RESTRICTION
255	20130802	20100101	E	DIAG SEX RESTRICTION	DIAG SEX RESTRICTION
258	20120813	20100101	D	SPAN DATES/QUANT DIF	DIFFERENCE BETWEEN SERVICE DATES AND QUANT
263	20130802	20100101	E	PROCEDURE-AGE-RESTRT	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
266	20120108	20100101	D	INVALID AMB SURG REV	REV CODE INVALID FOR AMBULATORY SURG PROC.
267	20120108	20100101	D	REQ-ICD9-SURGICAL-CD	REVENUE CODE 490 REQUIRES VALID ICD9 SURGICAL PROC
272	20120108	20100101	E	CLAIM OVER 1 YEAR	CLAIM EXCEEDS 1 YEAR FILING LIMIT
275	20120108	20100101	E	RECIP MEDICARE ELIG	RECIPIENT IS MEDICARE ELIGIBLE
278	20120108	20100101	E	RECIP ELIG MEDICARE	RECIPIENT POSSIBLY ELIGIBLE FOR MEDICARE
279	20120108	20100101	E	PROF COMP INVLD POT	INVALID PLACE OF TREATMENT FOR PROF COMP
289	20120108	20100101	D	INV DENY FOR PROV NO	INVALID PROVIDER NUMBER WHEN DENY APPLIED
299	20120108	20100101	E	PROC/DRUG NOTCOVERED	PROC/DRUG NOT COVERED BY MEDICAID
307	20120108	20100101	D	SURG PROC MISSING	SURGICAL PROCEDURE MISSING
309	20120108	20100101	D	SURG DATE MISSING	DATE OF SURGERY MISSING
310	20120108	20100101	D	SURG DTE LT SRV FROM	DATE OF SURGERY LESS THAN SERVICE FROM DATE
318	20120108	20100101	D	SUSP CON MIS/REQ-RF2	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFER

319	20120108	20100101	D	SUSP CON MIS/REQ-RF3	SUSPECTED CONDITION MISSING REQUIRED FOR REFERRAL
329	20120108	20100101	E	CLIA NOT CERT DOS	CLIA # DOES NOT COVER DATE OF SERVICE
339	20120108	20100101	D	OCCUR DATES CONFLICT	OCCUR CODES/DATES CONFLICT
340	20130813	20100101	E	SPAN DAYS CONFLICT	SPAN DAYS/NON COVERED DAYS CONFLICT
364	20120108	20100101	D	RECIP INELIG/DECEASE	RECIPIENT INELIGIBLE/DECEASED
386	20120108	20100101	E	NOT PAY W/CLIA CERT	NOT PAYABLE WITH CLIA CERT TYPE
387	20130813	20100101	E	CLIA # NOT ON FILE	NO CLIA # ON OUR FILE
400	20120108	20100101	D	REFER PHYSICIAN REQD	REFERRING/ATTENDING PHYSICIAN REQUIRED
401	20120108	20100101	E	CONCURRENT CARE	CONCURRENT CARE IS NOT COVERED BY THE PROGRAM
410	20140401	20100101	E	ENC PREFIX ERROR	LICN PREFIX ON ENCOUNTER IS MISSING OR INVALID
414	20140401	20100101	E	ENC PLAN PMT DT ERR	PLAN PAYMENT DATE ON ENCOUNTER IS MISSING OR INVALID
416	20140401	20100101	E	ENC RCV DT ERROR	PLAN RECEIVE DATE ON ENCOUNTER IS MISSING OR INVALID
417	20140401	20100101	E	ENC INT PMT ERROR	INTEREST PAYMENT ON PLAN ENCOUNTER IS INVALID
433	20120813	20100101	D	MISSING/INVALID DIAG	MISSING/INVALID DIAGNOSIS CODE
444	20120108	20100101	D	M/I SERVICE PROVIDER	MISSING/INVALID SERVICE PROVIDER
475	20120108	20100101	E	QW MODIFIER NEEDED	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE
506	20120108	20100101	D	SUB PROV NON PAR BYU	SUBMIT TO RECIPIENTS SHARED PLAN
513	20120108	20100101	D	HCPCS REQ	HCPCS REQUIRED
522	20130904	20100101	E	MOTH/NEWBRN BILL SEP	MOTHER/NEWBORN MUST BE BILLED SEPARATE
539	20120917	20100101	E	CLAIM REQ DETAIL	CLAIM REQUIRES DETAILED BILLING
545	20120108	20100101	D	REV CODE INVALID NDC	REVENUE CODE INVALID FOR REPORTING NDC INFO
550	20120108	20100101	E	NO MULTI - PROVIDERS	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCE
556	20120108	20100101	E	ATND PRV NOT LNK BYU	ATTENDING/SERVICING PROVIDER NOT LINKED TO BYU PLA
563	20120108	20100101	D	ADJ-ADD-ON-WITH-51	ADJ ADD-ON CODE WITH 51 MOD THEN REBILL PRIMARY PR
578	20120108	20100101	E	INV POS/MOD COMBO	INVALID PLACE OF SERVICE/PROCEDURE MODIFIER COMBIN
618	20120108	20100101	E	URINALYSIS NOT BILLE	URINEALYSIS BILLED INCORRECTLY
631	20120108	20100101	D	EPSDT AGE ERROR	EPSDT AGE OVER 21
644	20120108	20100101	D	VISIT CODE PD/DOS	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
663	20130813	20100101	E	NO ABORTION DONE	ABORTION NOT DONE-FETUS NOT ALIVE AT TIME OF PROCE
673	20120108	20100101	D	EVAL & MGT PD DOS	EVAL AND MGT CODE PAID FOR THIS DOS
675	20130813	20100101	D	VACCINE/ADM CONFLICT	VACC & ADM MUST PAY/AGREE;IF ONLY ONE PAYS TOTAL D
676	20120108	20100101	D	PRIMARY CODE DENIED	PAYABLE ONLY IF PRIMARY CODE IS PAID

678	20120108	20100101	E	GLOBAL CODE PD	GLOBAL CODE PD THIS DOS THIS RECIP
679	20120108	20100101	E	COMPONENT CODE PD	COMPONENT CODE PD THIS DOS RECIP
680	20120108	20100101	E	ABORT PD MOTHER LIFE	ABORTION PAID MOTHERS LIFE ENDANGERED
695	20120108	20100101	D	HOSP DISCHARGE PAID	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
702	20120108	20100101	D	NEW PT/EST PT CD CON	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
704	20120108	20100101	D	ER VISIT/INP HOS SER	ER VISIT ON DATE OF INP HOS SERVICES
706	20120108	20100101	D	SEPARATE NB CARE CHG	FOLLOWUP NB CARE BILLED SEPARATELY
711	20120108	20100101	E	SAME SPEC/SUBSP PAID	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF S
712	20120108	20100101	D	INITIAL HOSP INPT PD	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER AD
715	20120108	20100101	E	2ND. VISIT SAME DAY	FOUND DUPLICATE VISIT SAME DAY
716	20120108	20100101	D	PROC INCLUDED IN OV	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT
720	20120108	20100101	D	TO BE BILLED BY PROV	MUST BE BILLED BY PROVIDER OF SERVICE
721	20120108	20100101	E	SUR ASST NOT NEEDED	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST
735	20120108	20100101	D	PREV PD ANES-SAME RE	PREVIOUSLY PAID ANES.OR SUPERVISING ANES,SAME RECI
746	20120108	20100101	D	SAME ATTD PD IP CONS	SAME ATTENDING PROV PAID INPT CONSULTATION SAME ST
748	20120108	20100101	D	1 DEL.ALLOW. 6MTH.SP	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN
749	20120108	20100101	D	DEL HYST/STER CONFLI	DELIVERY BILLED AFTER HYSTERECTOMY/STERLIZ WAS DON
750	20120108	20100101	E	STERILIZATION INDIC	FOUND PROC. 2 X INDICATES STERILIZATION
753	20120108	20100101	D	REBILL-DELIVERY	REBILL DELIVERY (DELIVERY-SURGERY) CODE & OFFICE V
755	20120108	20100101	D	BILL AS ADJ/CNT STAY	THIS SHOULD BE BILLED AS ADJUST.FOR CNT STAY
757	20120108	20100101	D	ADJ PD LINE 51 MOD	ADJUST PAID LINE WITH 51 MODIFIER THEN RESUBMIT M
758	20120108	20100101	D	FND DUP SERV SM DAY	FOUND DUPLICATE SERVICE SAME DAY
777	20120108	20100101	E	ABORTION RAPE-PAID	ABORTION DUE TO RAPE PAID
781	20130813	20100101	E	MODIFIER NOT CORRECT	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL
789	20120108	20100101	E	ABORTION INCEST-PAID	ABORTION DUE TO INCEST PAID
794	20120108	20100101	D	INPT SER PD SAME ATT	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING
796	20120108	20100101	D	ORIG/ADJ PROV DIFF	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
797	20120108	20100101	D	DUP ADJ. RECORD	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	20120108	20100101	D	HIST ALREADY ADJSTED	HISTORY RECORD ALREADY ADJUSTED
799	20120108	20100101	D	NO ADJ HISTORY	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
800	20120108	20100101	D	ON-LINE DUPE DENY	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	20120108	20100101	D	EXACT DUPE 01 TO 01	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS

805	20120108	20100101	D	EXACT DUPE 03 TO 03	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	20120108	20100101	D	EXACT DUPE 03 TO 05	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVIC
807	20120108	20100101	D	EXACT DUPE 03 TO 06	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
808	20120108	20100101	D	EXACT DUPE 03 TO 07	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE
810	20120108	20100101	D	EXACT DUPE 03 TO 09	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUI
813	20140205	20100101	E	EXACT DUPE 04 TO 04	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
815	20140205	20100101	E	EXACT DUPE 05 TO 05	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CL
816	20120108	20100101	D	EXACT DUPE 05 TO 06	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEA
817	20120108	20100101	D	EXACT DUPE 05 TO 07	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANC
818	20120108	20100101	D	EXACT DUPE 05 TO 08	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBU
819	20120108	20100101	D	EXACT DUPE 05 TO 09	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE
822	20120108	20100101	D	EXACT DUPE 06 TO 06	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIM
823	20120108	20100101	D	EXACT DUPE 06 TO 07	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
828	20120108	20100101	D	EXACT DUPE 07 TO 07	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
830	20120108	20100101	D	EXACT DUPE 07 TO 09	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP
833	20120108	20100101	D	EXACT DUPE 08 TO 08	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLA
837	20120108	20100101	D	EXACT DUPE 09 TO 09	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLA
843	20120108	20100101	D	EXACT DUPE 12 TO 12	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
849	20120815	20100101	D	PD SAME ATTEN/DIF BL	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROV
851	20120108	20100101	E	SUSPCT DUPE 01 TO 01	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	20120108	20100101	E	SUSPCT DUPE 03 TO 03	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIM
857	20120108	20100101	E	SUSPCT DUPE 01 TO 06	SUSPCT DUPLICATE ERROR: OUTPATIENT AND HOME-HEALTH
859	20120108	20100101	E	SUSPCT DUPE 03 TO 08	SUSPCT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULAN
860	20130930	20100101	E	ENCOUNTER DATA ERROR	INVALID/MISSING DATE OF RCPT, ICN, BATCH CLAIM TYP
863	20120108	20100101	E	SUSPCT DUPE 04 TO 04	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
865	20120108	20100101	E	SUSPCT DUPE 05 TO 05	SUSPEC DUPLICATE ERROR: IDENTICAL REHAB-SERVICES C
866	20120108	20100101	E	SUSPCT DUPE 05 TO 06	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND HOME HE
867	20120108	20100101	E	SUSPCT DUPE 05 TO 07	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND AMBULAN
868	20120108	20100101	E	SUSPCT DUPE 05 TO 08	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMB
869	20120108	20100101	E	SUSPCT DUPE 05 TO 09	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND DME
872	20120108	20100101	E	SUSPCT DUPE 06 TO 06	SUSPCT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAI
873	20120108	20100101	E	SUSPCT DUPE 06 TO 07	SUSPCT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE

874	20120108	20100101	E	SUSPCT DUPE 06 TO 08	SUSPCT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULA
878	20120108	20100101	E	SUSPCT DUPE 07 TO 07	SUSPCT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
879	20120108	20100101	E	SUSPCT DUPE 07 TO 08	SUSPCT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANC
884	20120108	20100101	E	SUSPCT DUPE 08 TO 09	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND DME CLA
887	20120108	20100101	E	SUSPCT DUPE 09 TO 09	SUSPECT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP C
893	20120108	20100101	E	SUSPCT DUPE 12 TO 12	SUSPECT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
898	20120108	20100101	D	EXACT DUPE SAME ICN	EXACT DUPE SAME ICN - DROPPED
900	20120108	20100101	D	LIFETIME LIMITS-ONE	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED
917	20120108	20100101	D	OVER LIFETIME LIMIT	LIFETIME LIMITS FOR THIS SERVICE HAVE BEEN EXCEEDE
924	20120108	20100101	E	EFF 11/5/10 NDC REQU	EFF 11/5/10 PAS FOR THIS HCPC REQUIRES CORRECT NDC
946	20120108	20100101	E	SPLIT BILL FOR PART.	SPLIT BILL FOR PARTIAL ELIGIBILITY.
948	20120108	20100101	E	INC IN MAJ SUR PROC	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	20120108	20100101	E	DISCH DATE NOT COV	DATE OF DISCHARGE NOT COVERED
952	20120108	20100101	E	INC IN OV/RELAT PROC	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
957	20120108	20100101	E	PROC/DIAG NO MED NEC	PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY
970	20120108	20100101	D	INAPPROPRIATE CODE,	INAPPROPRIATE CODE, BILL LAB OR SPECIFIC HANDLING.
973	20120108	20100101	E	NO SURGERY MODIFIER	CLAIM DESCRIPT INDICATES PROC CODE SHOULD HAVE MOD
980	20120108	20100101	E	INVALID ADJ REASON	INVALID ADJUSTMENT REASON
983	20120108	20100101	D	SYS CALC NET TOTAL	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANC
991	20120108	20100101	E	PROCEDURE IN PANEL	PROCEDURE INCLUDED IN PANEL

Encounter Edit Disposition – Deny (Repairable Under Limited Circumstances)

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[2] 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

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

Encounter Edit Disposition – Deny (Repairable)

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

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
074	STMT THRU GT SRV THR
081	INVALID STATUS DATE
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
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

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
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

Encounter Edit Disposition – Deny (Not Repairable)

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

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

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

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

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 (G)**.

It is the Health 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.

BAYOU HEALTH PLANs are required to populate the Provider Type field to a DHH valid provider type code as shown in the list below:

Provider Type	Description
07	Case Mgmt - Infants & Toddlers
08	Case Mgmt - Elderly
09	Hospice Services
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services(EarlySteps)
30	Chiropractor and Chiropractor Group
31	Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
39	Speech Therapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother

Provider Type	Description
44	Home Health Agency
46	Case Mgmt - HIV
51	Ambulance Transportation
54	Ambulatory Surgery Center
55	Emergency Access Hospital
57	OPH Public Health Registered Nurse
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
64	Mental Health Hospital Freestanding
65	Rehabilitation Center
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital – Distinct Part Psychiatric
69	Hospital - Distinct Part Psychiatric Unit
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
73	Social Worker
74	Mental Health Clinic
75	Optical Supplier
76	Hemodialysis Center
77	Mental Health Rehabilitation
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
80	Nursing Facility
81	Case Mgmt - Ventilator Assisted Care Program
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home

Provider Type	Description
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care
AS	OPH Public Health Clinic
AU	Public Health Registered Dietitian

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

Provider Specialty	Description	Associated Provider Types
01	General Practice	19,20
02	General Surgery	19,20,93
03	Allergy	19,20
04	Otology, Laryngology, Rhinology	19,20
05	Anesthesiology	19,20,91
06	Cardiovascular Disease	19,20
07	Dermatology	19,20
08	Family Practice	19,20,78
09	Gynecology (DO only)	19
10	Gastroenterology	19,20
12	Manipulative Therapy (DO only)	19
13	Neurology	19,20
14	Neurological Surgery	19,20
15	Obstetrics (DO only)	19
16	OB/GYN	19,20,78,90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	19

Provider Specialty	Description	Associated Provider Types
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
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	20,32

Provider Specialty	Description	Associated Provider Types
	Chiropody	
49	Miscellaneous (Admin. Medicine)	20
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included in 51, 52, 53	40
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	57,61,62,66,67, AU
62	Psychologist Crossovers only	29,31
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27
69	Independent Laboratory (Billing Independently)	23
70	Clinic or Other Group Practice	19,20,68,74,76, AS
71	Speech Therapy	29
72	Diagnostic Laboratory	23
73	Social Worker Enrollment	73
74	Occupational Therapy	29,37
75	Other Medical Care	65
76	Adult Day Care	85

Provider Specialty	Description	Associated Provider Types
77	Habilitation	85
78	Mental Health Rehab	77
79	Nurse Practitioner	78
81	Case Management	07,08,43,46,81
83	Respite Care	83
85	Extended Care Hospital	60
86	Hospitals and Nursing Homes	55,59,60,64,69, 80,88
87	All Other	26,40,44
88	Optician / Optometrist	28,75
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
1T	Emergency Medicine	19,20
2R	Physician Assistant	94
2T	American Indian/Native Alaskan	95
4R	Registered Dietician	41
5B	PCS-EPSDT	24
5C	PAS	24
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5M	Multi-Systemic Therapy	12
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6N	Endodontist	27
6P	Periodontist	27

Provider Specialty	Description	Associated Provider Types
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38
7C	SBHC - MD - Part Time - less than 20 hrs week	38
7D	SBHC - MD - Full Time - 20 or more hrs week	38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	38
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97

BAYOU HEALTH PLANs must submit this information in the Provider Registry File Layout shown below.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the Plan elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
1-20	NPI	National Provider ID number	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to include them.	R
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	**1**=Individual, **2**=Organization	1		R
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the		30	Character If the entity	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Legal Business Name for Organizations.			type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-30th characters=last name, If names do not fit in these positions, please truncate the end of the item so that it fits in the positions**.** **DO NOT include suffixes or titles in the last name see columns 761-765 Provider Suffix and 767-776 Provider Title**	
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				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
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business	Do not enter dashes or	10	Numeric	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Mailing Address (Fax Number)	parentheses.			
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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
					both units… each sent in a separate record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type Code	Provider Type and Provider Specialty	4	1st 2 characters are provider type; last 2 characters (3-4) are provider specialty. See Companion Guide for list of applicable provider types and specialties.	R
401	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	O
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	**M**=Male, **F**=Female, **N**=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider		20	Character, left-	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	License Number			justified, right-fill with spaces.	
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
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.

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		patients			
587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	**0**=no age restrictions **1**=adult only **2**=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the **maximum number** of patients that can be linked to the PCP within **this**	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				plan. It should be left all zeroes if the provider is not a PCP/specialist.	
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Actual Linkages with Plan	Numeric	5	Numeric, left fill with zeroes. This number represents the actual number of plan enrollees that are currently linked to the PCP. It should be left all zeroes if the provider is not a PCP	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with **all** BAYOU HEALTH Plans	Numeric	5	Numeric, left fill with zeroes. **Leave this field all zeroes.**	R
609	Delimiter		1	Character, use the ^ character value	
610	CCN Enrollment Indicator	**N**=New enrollment **C**=Change to existing enrollment **D**=Disenrollment **X**=Remove	1	Use this field to identify new providers, changes to existing providers, disenrolled providers and remove records from the registry	R
611	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
612-619	CCN Enrollment Indicator Effective Date	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	**0**=no restrictions **1**=family members only	1		R for PCPs; otherwise optional.
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in CCN Companion Guide	2		R for PCPs; otherwise optional.
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in the Companion Guide	2		O
628	Delimiter		1	Character, use the ^ character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in the Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	CCN Contract Name or	This should represent the contract	30	Character	R, but you may enter 0s or spaces to

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Number	name/number that is established between the CCN and the Provider			indicator a non-contracted network provider.
662	Delimiter		1	Character, use the ^ character value	
663-670	CCN Contract Begin Date	Date that the contract between the CCN and the provider started	8	Numeric date value in the form YYYYMMDD	R, but you may enter 0s.
671	Delimiter		1	Character, use the ^ character value	
672-679	CCN Contract Term Date	Date that the contract between the CCN and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O, you may enter 0s. If Contract Begin Date is not 0, then Contract End date must be greater than or equal to Contract Begin Date. Open End Date=20991231
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the Companion Guide.	R
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	Parish code value that represents a secondary or other parish that the provider serves.	2	2-digit parish code value. See the Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Use only if necessary; otherwise enter 00.			
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 Companion Guide.	O
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
695	Delimiter		1	Character, use the ^ character	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
698	Delimiter		1	Character, use the ^ character value	
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 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 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	2	2-digit parish code value. See the Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the provider serves. 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 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 Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	
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 Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726	PCP Indicator	0=Not a PCP. 1=Regularly	1	Numeric, value 0,1,2 or 3.	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		serves as a PCP for a general population group (i.e. can have age or gender limits, but not other specialized limitations on populations served) This would include appropriate provider types and have agreed to fulfill PCP responsibilities for general populations. 2=PCP Extenders – must be linked to a supervising PCP 3=PCP Specialized – for designated individuals only (would not show up as a PCP in any registry or directory.			
727	Delimiter		1	Character, use the ^ character	
728	Display Online indicator	0=don't display on EB website 1=display on EB website.		Numeric, value 0 or 1	R
729	Delimiter		1	Character, use the ^ character	
730-759	Expanded Age Restriction	To allow free-form entry for provider to expand for their practice	30	Character	O
760	Delimiter		1	Character, use	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				the ^ character	
761-765	Provider Suffix	Example: JR, SR, etc.	5	Character	O
766	Delimiter		1	Character, use the ^ character	
767-776	Provider Title	Example: MD, RN, etc.	10	Character	O
777	Delimiter		1	Character, use the ^ character	
778-779	Spaces	End of record filler	2	Enter all spaces	
780	End of record delimiter		1	Character, use the ^ character value	

Provider Registry Edit Report (sample)

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


CCN ID: NNNNNNN - PROVIDER NAME FROM LMMIS PROVIDER FILE


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


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


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

Provider Registry Edit file layout

Columns	Field Name	Format	Size	Comments
1-7	BAYOU HEALTH 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 X=Remove.
10	Delimiter	Character	1	Value is ^ character.
11-17	Provider ID	Numeric	7 digits	This is the provider's LA Medicaid ID number
18	Delimiter	Character	1	Value is ^ character.
19-28	Provider NPI	Character	10	
29	Delimiter	Character	1	Value is ^ character.
30-59	Provider Name	Character	30	
60	Delimiter	Character	1	Value is ^ character.
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

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

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

Site File Format

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

Column ID	Field Position in record	Field	Type	Length	Required or Optional	Valid values	Other notes	Applicable Error Code(s) (see table below).
1	1-7	Plan ID	Numeric	7	Required	Must be your assigned Plan ID	Use your Plan ID formatted 2162nnn, where nnn is your specific assigned number. Once, assigned It must remain consistent.	016
2	8	Delimiter	Character	1	Required	^		023
3	9-18	Provider NPI	Numeric	10	Required	Must be the provider's NPI		001, 004, 013, 015 017. (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. **Do not send multiple site records that share the exact**	003, 013, 021

							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. 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.	010
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	BAYOU HEALTH Plan ID	7	numeric
8	Delimiter	1	^
9	SUBMISSION TYPE	1	alphanumeric
10	Delimiter	1	^
11	PROVIDER NPI	10	numeric
21	Delimiter	1	^
22	PROVIDER NAME	30	alphanumeric
52	Delimiter	1	^
53	PROVIDER TAXONOMY	10	alphanumeric
63	Delimiter	1	^
64	SITE NUMBER	3	numeric
67	Delimiter	1	^
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	^

Provider Supplemental File Instructions

On a weekly basis, the Bayou Health Plan is required to submit to the FI, their **Provider Supplemental File**. The File Layout can be found on the following pages of this **Appendix (G)** along with the Transaction Type required for completing the information in this file.

The file must be kept current and must include all changes and updates to provider information that occur within the reporting week.

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
					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	
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 Proprietary – Individual 04 Proprietary – Corporation 05 Proprietary – Partnership 06 Proprietary – Other 07 Government – Federal 08 Government – State	2	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		09 Government – City 10 Government – County 11 Government – City-County 12 Government – Hospital District 88 N/A - The individual only practices as part of a group, e.g., as an employee			
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	
97	Provider Business Location Email Address	The email address of the provider	60	Character	R Note: Although this data field is required, it

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
					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	A free text field to capture the identity of the entity issuing the	60	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	ENTITY ID 1	license or accreditation.			
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
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	A free text field to capture the identity of the entity	60	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	ENTITY ID 2	issuing the license or accreditation.			
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	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 5 Other	1	Numeric	O
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	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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	8	Numeric, format YYYYMMDD	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		is created.) This date field is necessary when defining a unique row in a database table.			
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	

Bayou Health Batch Electronic File Layout for PCP Linkage Directory Instructions

On a weekly basis, the Bayou Health Plan is required to submit the PCP Linkage file.

File submissions are required once per week on or before Friday COB (5:00 p.m. CT) by the Bayou Health Plan. If the day of submission is a holiday, the Bayou Health Plan may submit the file on the previous applicable work day. If the Friday is applicable to your processing environment and it is a holiday, the Bayou Health Plan may submit the file on the holiday Friday, if it so chooses.

The Bayou Health Plan may submit only one file per week. The file must contain all records that the Plan expects to submit during that week; and must be a full file representing all PCP-to-recipient linkages (current and historical) that is in the Bayou Health Plan's system. There is no incremental update process; instead, a full replacement file will be generated from your weekly file submission.

Bayou Health Plans are required to utilize the FI's (Molina's) non-EDI FTP service.

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

The file layout for the PCP Linkage Directory can be found on the following pages.

BAYOU HEALTH BATCH ELECTRONIC FILE LAYOUT for PCP Linkage Directory

Document Date: 4/30/2014
Subject to Change

PART 1: PLAN FILE SUBMISSIONS

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

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*R=Required O=Optional*	*Notes*
001	1-7	PCP_LINKAGE_PLAN_ID	number(7)	R	Use your assigned plan ID: 2162934=ACLA, 2162519=Amerigroup, 2162446=CHS, 2162845=LHC, 2162438=UHC.
002	8-17	PCP_LINKAGE_PCP_NPI	number(10)	R	10-digit NPI of the PCP.
003	18-27	PCP_LINKAGE_PCP_TAXONOMY	char(10)	R	10-character taxonomy of the PCP.
004	28-40	PCP_LINKAGE_RECIPIENT_MEDICAID_ID	char(13)	R	13-digit Medicaid ID number of the Recipient. Left-fill with zero(s).
005	41-49	PCP_LINKAGE_RECIPIENT_SSN	char(9)	R	9-digit Social Security Number of the Recipient. Left-fill with zero(s).
006	50-57	PCP_LINKAGE_RECIPIENT_DOB	number(8)	R	Recipient Date of Birth. Format=YYYYMMDD.
007	58-65	PCP_LINKAGE_BEGIN_DATE_YYMMDD	number(8)	R	Beginning date of Recipient's Linkage to PCP. Format=YYYYMMDD. Value should not precede 20120201.
008	66-73	PCP_LINKAGE_END_DATE_YYMMDD	number(8)	R	Ending date of Recipient's Linkage to PCP. Format=YYYYMMDD. Value for an open-ended linkage should be 99991231.
009	74-100	FILLER	char(27)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, archive it, edit it, and use it to update Molina's Data Warehouse. Molina's update process performs edits and produces an error text file that we will send 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.

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

The error text file will have this layout:

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

ERROR CODES

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

002 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The field may have a non-numeric value, or it may have a value that does not represent a valid NPI, or it may have a value that we do not find on your registry, or we may find the value on your registry but the record does not represent a PCP.

003 Invalid value for Field 003 (PCP_LINKAGE_PCP_TAXONOMY). The field may have a value that does not represent a valid taxonomy, or it may have a value that, when combined with the NPI, is not found on your registry, or does not represent a PCP.

004 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). The field may have a non-numeric value, or it may have a value that we do not find on the MMIS Eligibility File, or it may be a recipient who is not linked to your plan during the dates you send in fields 007 and 008. Be sure to left-fill field 004 with zero(s) when necessary.

005 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). The field may have a non-numeric value, or it may have a value that we do not find on the MMIS Eligibility File, or it may be an SSN value that is not associated with the recipient ID sent in field 004. Be sure to left-fill field 005 with zero(s) when necessary.

006 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). The field may have a non-numeric value, or it may not represent a valid date value, or it may be a DOB that is not associated with the recipient sent in field 004.

007 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The field may have a non-numeric value, or it may not represent a valid date value, or it may be a date that does not correspond with the recipient's BYU linkage from the MMIS Eligibility File.

008 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The field may have a non-numeric value, or it may not represent a valid date value, or it may be a date that does not correspond with the recipient's BYU linkage from the MMIS Eligibility 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 PCP Linkage File. If you receive no error record for a submitted record, you may assume that the record passed all edits and was applied to the LMMIS PCP Linkage File.

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

END OF DOCUMENT

Appendix H

Test Plan

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

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each BAYOU HEALTH PLAN must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. In most cases, the BAYOU HEALTH PLANs 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 BAYOU HEALTH PLANs 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 a BAYOU HEALTH PLAN has passed or failed the EDIFECS portion of testing.

EDI must certify each BAYOU 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 (837I and 837P) must be in the 5010 format, not in the 4010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
- validate the test submission with 997 Acceptance transactions; and

- generate IRL or paired transaction

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

The Editing and Validation Diagram in **Appendix M** of this Guide depicts the flow of encounter data and timing of applied edits.

Testing Tier II

Once each BAYOU 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 BAYOU HEALTH PLANs via IDEX. Each BAYOU 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 BAYOU HEALTH PLANs and DHH/Mercer for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. Molina is available to answer any questions that any BAYOU HEALTH PLAN may have concerning the edit codes.

Testing Tier III

Once satisfactory test results are documented, Molina will move the BAYOU HEALTH PLAN into production. Molina anticipates receiving files from each of the BAYOU HEALTH PLANs in production mode at least once monthly.

Appendix I

Websites

The following websites are provided as references for useful information not only for BAYOU 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.lamedicaid.com or http://www.lmmis.com	DHH FI Provider Web site You need a valid Louisiana Medicaid Provider ID or CCN ID in order to register on the web site. Provider Applications (such as those used to upload and download files) are available on this web site to authorized, registered providers or CCN organizations.

Website Address	Website Contents
	Links available to CCN-P entities on the FI Provider Web site are: • 820 File Download • Claims File Download • Provider Enrollment File Download • Provider Registry Upload • Provider Registry Error Report Download • Third-Party Liability Data Entry • Provider Negotiated Rates File Download • PA and Precert Requests History File • MMIS Claims Processing Information: ❖ Procedure Codes Requiring PA ❖ Diagnosis Codes Requiring Precert ❖ CLIA File
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that

Website Address	Website Contents
	allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information 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.

Website Address	Website Contents
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 CCN entities.

Type of Service (TOS)

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

14	Psychological and Behavioral Services (PBS)
15	Outpatient Ambulatory Surgical Services
16	Personal Attendant Services (PAS) -- Ticket to Work Program
17	Home Health
18	Expanded Dental Services for Pregnant Women (EDSPW)
19	Personal Care Services (LTC)
20	Enhanced Outpatient Rehab Services
21	EPSDT, EPSDT Dental
22	Childnet (Early Steps)
23	Waiver - Children's Choice
24	Waiver - ADHC
25	Waiver - EDA
26	Waiver - PCA
27	Special Purpose Facility
28	Center Based Special Purpose Facility
29	American Indian
30	Acute Care Outpatient Services
31	Family Planning Waiver
32	Supports Waiver
33	New Opportunity Waiver (NOW)
34	DME Special Rates
35	Residential Options Waiver (ROW)
36	Community Mental Health Center
37	Small Rural Hospital Outpatient
38	Adult Residential Care (ARC)
39	State Hospital Outpatient Services
40	Sole Community Hospital
41	Psychiatric Residential Treatment Facility
42	Mental Health Rehabilitation
43	LaPOP, Louisiana Personal Options Program
44	Pediatric Day Health Care Facility (PDHC)
45	Coordinated Care Network - Pre-paid (CCN-P)
46	Coordinated Care Network - Shared Services (CCN-S)

Category of Service (COS)

State COS	Description
00	Inpatient Service in TB Hospital
01	Inpatient Service in General Hospital
02	Inpatient Service in Mental Hospital
03	SNF Service
04	ICF-DD
05	ICF-I Service
06	ICF-II Service
07	Physician Services
08	Outpatient Hospital Services
09	Clinic - Hemodialysis
10	Clinic - Alcohol & Substance Abuse
11	Clinic - Mental Health
12	Clinic - Ambulatory Surgical
13	Rehab Services
14	Adult Day Care
15	Independent Lab
16	Chiropractic Services
17	Home Health
18	Prescribed Drugs and Immunizations by Pharmacists
19	Habilitation
20	DME (Appliances)
21	Rural Health Clinics
22	Family Planning Service
23	Non-Emergency Medical Transportation
24	Medical Transportation
25	Adult Dental Services
26	EPSDT - Screening Services
27	EPSDT - Dental
28	EPSDT - Other
29	Homemaker Services
30	Other Medical Services
31	Default
32	Administrative Error State Funds Only
33	Recovery Unidentified Services
34	EPSDT Health Services Non-School Board
35	Medical TPL
36	Title XIX Health Insurance Payment
37	Case Management
38	FQHC

39	PCA
40	Personal Health Care Clinic Services
41	HMO Over 65
42	Rehab for Chronically Mentally Ill
43	Children's' Choice Waiver
44	EPSDT - Personal Care Services
45	Dental Services for Pregnant Women
46	EPSDT Health Services
47	VD Clinic
48	TB Clinic
49	Title XIX Part-A Premium
50	Psychology
51	Audiology
52	Physical Therapy
53	Multi-Specialty Clinic Services
54	Certified Registered Nurse (CRNA)
55	Private Duty Nurse
56	Occupational Therapy
57	CM - HIV
58	CM - CMI
59	CM - PW
60	Rehab - ICF/DD
61	CM - DD
62	DD Waiver
63	CM - Infants & Toddlers
64	Home Care Elderly Waiver
65	Head Injury Maintenance Waiver
66	Hospice / NF
67	Social Worker Services
68	Contractors / CM
69	Nurse Home Visits - First Time Mothers Program
70	NOW Waiver
71	LTC - Personal Care Services
72	PAS - Personal Care Services
73	Early Steps
74	Behavior Management Services
75	PACE
76	American Indian/Native Alaskans
77	Family Planning Waiver
78	Support Waiver
79	Community Mental Health Center
80	Residential Options Waiver (ROW)
81	Coordinated Care Network

91	Coded for internal purposes only
99	LTC Administrative Cost

Provider Type

Provider Type Code	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver
04	Pediatric Day Health Care (PDHC) facility
05	CCN-P Organization (Coordinated Care Network, Pre-Paid)
06	NOW Professional (RN LPN PHD SW)
07	Case Mgmt - Infants & Toddlers
08	Case Mgmt - Elderly
09	Hospice Services
10	Comprehensive Community Support Services
11	Shared Living
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation
14	Adult Day Habilitation - Waiver
15	Environmental Modifications - Waiver
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
18	Community Mental Health Center
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
21	EDI Billing Agent
22	Waiver Personal Care Attendant
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy
27	Dentist and 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 in Use

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 Mgmt - Contractor
46	Case Mgmt - HIV
47	Case Mgmt - CMI
48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
52	CCN-S Organization (Coordinated Care Network, Shared Savings)
53	Not in Use
54	Ambulatory Surgical Center
55	Emergency Access Hospital
56	Not in Use: to-be used for Licensed Professional Counselor
57	Not in Use: to-be used for RN
58	Not in Use: to-be used for LPN
59	Neurological Rehabilitation Unit (Hosp)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
64	Mental Health Hospital (Free-Standing)
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	Respite Care (Center Based)- Waiver
84	Substitute Family Care - Waiver
85	ADHC Home and Community Based Services
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home
89	Supervised 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	Adult Residential Care
98	Supported Employment - Waiver
99	Not in Use

Provider Specialty, Sub-specialty

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
00	All Specialties	1
01	General Practice	1
02	General Surgery	1
03	Allergy	1
04	Otology, Laryngology, Rhinology	1
05	Anesthesiology	1
06	Cardiovascular Disease	1
07	Dermatology	1
08	Family Practice	1
09	Gynecology (DO only)	1
10	Gastroenterology	1
11	Not in Use	n/a
12	Manipulative Therapy (DO only)	1
13	Neurology	1
14	Neurological Surgery	1
15	Obstetrics (DO only)	1
16	OB/GYN	1
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1
18	Ophthalmology	1
19	Orthodontist	1
20	Orthopedic Surgery	1
21	Pathologic Anatomy; Clinical Pathology (DO only)	1
22	Pathology	1
23	Peripheral Vascular Disease or Surgery (DO only)	1
24	Plastic Surgery	1
25	Physical Medicine Rehabilitation	1
26	Psychiatry	1
27	Psychiatry; Neurology (DO only)	1
28	Proctology	1
29	Pulmonary Diseases	1
30	Radiology	1
31	Roentgenology, Radiology (DO only)	1
32	Radiation Therapy (DO only)	1
33	Thoracic Surgery	1
34	Urology	1
35	Chiropractor	1
36	Pre-Vocational Habilitation	1

37	Pediatrics	1
38	Geriatrics	1
39	Nephrology	1
40	Hand Surgery	1
41	Internal Medicine	1
42	Federally Qualified Health Centers	1
43	Not in Use	n/a
44	Public Health	1
45	NEMT - Non-profit	1
46	NEMT - Profit	1
47	NEMT - F+F	1
48	Podiatry - Surgical Chiropody	1
49	Miscellaneous (Admin. Medicine)	1
50	Day Habilitation	1
51	Med Supply / Certified Orthotist	1
52	Med Supply / Certified Prosthetist	1
53	Med Supply / Certified Prosthetist Orthotist	1
54	Med Supply / Not Included in 51, 52, 53	1
55	Indiv Certified Orthotist	1
56	Indiv Certified Protherist	1
57	Indiv Certified Protherist - Orthotist	1
58	Indiv Not Included in 55, 56, 57	1
59	Ambulance Service Supplier, Private	1
60	Public Health or Welfare Agencies & Clinics	1
61	Voluntary Health or Charitable Agencies	1
62	Psychologist Crossovers only	1
63	Portable X-Ray Supplier (Billing Independently)	1
64	Audiologist (Billing Independently)	1
65	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
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
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
1S	BRG - Med School	2
1T	Emergency Medicine	1
1Z	Pediatric Day Health Care	1
2A	Cardiac Electrophysiology	2
2B	Cardiovascular Disease	2
2C	Critical Care Medicine	2

2D	Diagnostic Laboratory Immunology	2
2E	Endocrinology & Metabolism	2
2F	Gastroenterology	2
2G	Geriatric Medicine	2
2H	Hematology	2
2I	Infectious Disease	2
2J	Medical Oncology	2
2K	Nephrology	2
2L	Pulmonary Disease	2
2M	Rheumatology	2
2N	Surgery - Critical Care	2
2P	Surgery - General Vascular	2
2R	Physician Assistant	1
2S	LSU Medical Center New Orleans	2
2T	American Indian / Native Alaskan	2
2Y	OPH Genetic Disease Program	1
3A	Critical Care Medicine	2
3B	Gynecologic oncology	2
3C	Maternal & Fetal Medicine	2
3S	LSU Medical Center Shreveport	2
4A	Developmental Disability	1
4B	NOW RN	1
4C	NOW LPN	1
4D	NOW Psychologist	1
4E	NOW Social Worker	1
4R	Registered Dietician	1
4S	Ochsner Med School	2
4X	Waiver-Only Transportation	1
4W	Waiver Services	1
5A	PCS-LTC	1
5B	PCS-EPSDT	1
5C	PAS	1
5D	PCS-LTC, PCS-EPSDT	1
5E	PCS-LTC, PAS	1
5F	PCS-EPSDT, PAS	1
5G	OCS-LTC, PCS-EPSDT, PAS	1
5H	Community Mental Health Center	

5M	Multi-Systemic Therapy	
5P	PACE	1
5Q	CCN-P (Coordinated Care Network, Prepaid)	1
5R	CCN-S (Coordinated Care Network, Shared Savings)	
5S	Tulane Med School	2
6A	Psychologist -Clinical	1
6B	Psychologist-Counseling	1
6C	Psychologist - School	1
6D	Psychologist - Developmental	1
6E	Psychologist - Non-Declared	1
6F	Psychologist - All Other	1
6H	LaPOP	1
6N	Endodontist	1
6P	Periodontist	1
6S	E Jefferson Fam Practice Ctr - Residency Program	2
7A	SBHC - NP - Part Time - less than 20 hrs week	1
7B	SBHC - NP - Full Time - 20 or more hrs week	1
7C	SBHC - MD - Part Time - less than 20 hrs week	1
7D	SBHC - MD - Full Time - 20 or more hrs week	1
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	1
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	1
7M	Retail Convenience Clinics	2
7N	Urgent Care Clinics	2
7S	Leonard J Chabert Medical Center - Houma	2
8A	EDA & DD services	2
8B	EDA services	2
8C	DD services	2
9B	Psychiatric Residential Treatment Facility	1
9D	Residential Care	1
9E	Children's Choice Waiver	1
9L	RHC/FQHC OPH Certified SBHC	1
9Q	PT 21 - EDI Independent Billing Company	2
9U	Medicare Advantage Plans	1
9V	OCDD - Point of Entry	1
9W	OASS - Point of Entry	1
9X	OAD	1
9Z	Other Contract with a State Agency	1

Region

Region	Description
1	New Orleans
2	Baton Rouge
3	Thibodaux
4	Lafayette
5	Lake Charles
6	Alexandria
7	Shreveport
8	Monroe
9	Mandeville

GSA

GSA A or GSA 1 is comprised of Regions 1 and 9
GSA B or GSA 2 is comprised of Regions 2, 3, and 4
GSA C or GSA 3 is comprised of Regions 5, 6, 7 and 8.

Parish

Parish Code	Recipient Parish Description	Recipient Medicaid Region
01	ACADIA	4
02	ALLEN	5
03	ASCENSION	2
04	ASSUMPTION	3
05	AVOYELLES	6
06	BEAUREGARD	5
07	BIENVILLE	7
08	BOSSIER	7
09	CADDO	7
10	CALCASIEU	5
11	CALDWELL	8
12	CAMERON	5
13	CATAHOULA	6
14	CLAIBORNE	7
15	CONCORDIA	6
16	DESOTO	7
17	EAST BATON ROUGE	2
18	EAST CARROLL	8
19	EAST FELICIANA	2
20	EVANGELINE	4
21	FRANKLIN	8
22	GRANT	6
23	IBERIA	4
24	IBERVILLE	2
25	JACKSON	8
26	JEFFERSON	1
27	JEFFERSON DAVIS	5
28	LAFAYETTE	4
29	LAFOURCHE	3
30	LASALLE	6
31	LINCOLN	8
32	LIVINGSTON	9
33	MADISON	8
34	MOREHOUSE	8
35	NATCHITOCHES	7
36	ORLEANS	1
37	OUACHITA	8

38	PLAQUEMINES	1
39	POINTE COUPEE	2
40	RAPIDES	6
41	RED RIVER	7
42	RICHLAND	8
43	SABINE	7
44	ST BERNARD	1
45	ST CHARLES	3
46	ST HELENA	9
47	ST JAMES	3
48	ST JOHN	3
49	ST LANDRY	4
50	ST MARTIN	4
51	ST MARY	3
52	ST TAMMANY	9
53	TANGIPAHOA	9
54	TENSAS	8
55	TERREBONNE	3
56	UNION	8
57	VERMILION	4
58	VERNON	6
59	WASHINGTON	9
60	WEBSTER	7
61	WEST BATON ROUGE	2
62	WEST CARROLL	8
63	WEST FELICIANA	2
64	WINN	6
87	Texas	10
88	Mississippi	11
89	Arkansas	12
90	Texas Border County	10
91	Mississippi Border County	11
92	Arkansas Border County	12
99	Other Out-of-State	13

Pricing Action Code (PAC)

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

Appendix K

Third Party Liability (TPL) Batch File Submission Instructions

On a weekly basis, the Bayou Health Plan is required to submit a TPL Batch File. The file must contain any new TPL information as well as all updates and changes to TPL information that occurred for Bayou Health enrollees.

The Bayou Health Plan must submit the TPL Batch File on or before Thursday COB (5:00 p.m. CT). If the submission day is a holiday, the Bayou Health Plan may submit the file on the previous applicable work day. If the Bayou Health Plan chooses to do so because it is applicable to your processing environment, the file may be submitted on Thursday if the submission day is a holiday.
The Bayou Health Plan is required to submit only one file per week. The file must contain all records that the Bayou Health Plan expects to submit during that week.

If there are no (0) records to submit in a given week, then the Bayou Health Plan is required to submit an empty file.

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

The File Layout to Plan, and Scope of Coverage Codes can be found on the following pages of this **Appendix (K)**.

TPL BATCH FILE SUBMISSIONS

BAYOU HEALTH BATCH ELECTRONIC FILE LAYOUT for TPL INFORMATION.
Document Date: 11/20/2012
Subject to Change

PART 1: PLAN FILE SUBMISSIONS

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.

Field R=Required
Nbr Column(s) Field Format/Length 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:
15=Amerigroup
16=ACLA
17=LHC
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) R Left justify
16 109-115 TPL_POLICY_HOLDER_NAME_FIRST char(7) R Left justify
17 116 TPL_POLICY_HOLDER_NAME_MI char(1) R Use a space if not available
18 117-141 TPL_POLICY_HOLDER_STREET char(25) R Left justify
19 142-161 TPL_POLICY_HOLDER_CITY char(20) R Left Justify
20 162-163 TPL_POLICY_HOLDER_STATE char(2) R USPS abbreviation
21 164-172 TPL_POLICY_HOLDER_ZIP char(9) R Left Justify
22 173-181 TPL_POLICY_HOLDER_SSN char(9) O Use all zeros if not available

23 182-234 TPL_EMPLOYER_GRP_MAINT_COVER char(53) O Left Justify
24 235-259 TPL_EMPLOYER_CLAIM_FIL_STREET char(25) O Left Justify
25 260-279 TPL_EMPLOYER_CLAIM_FIL_CITY char(20) O Left Justify
26 280-281 TPL_EMPLOYER_CLAIM_FIL_STATE char(2) O Left Justify
27 282-290 TPL_EMPLOYER_CLAIM_FIL_ZIP char(9) O Left Justify
28 291-343 TPL_INSURANCE_NAME char(53) R Left Justify
29 344-349 TPL_INSURANCE_NUMBER char(6) R Use the appropriate Louisiana MMIS

Carrier Code
30 350-374 TPL_INSURANCE_CLAIM_FIL_STREET char(25) R Left Justify
31 375-394 TPL_INSURANCE_CLAIM_FIL_CITY char(20) R Left Justify
32 395-396 TPL_INSURANCE_CLAIM_FIL_STATE char(2) R USPS abbreviation
33 397-405 TPL_INSURANCE_CLAIM_FIL_ZIP char(9) R Left Justify
34 406-418 TPL_POL_NBR char(13) R Left Justify
35 419-433 TPL_GROUP_NBR char(15) O Left Justify, leave blank if not used.
36 434-435 TPL_SCOPE_OF_COVERAGE_1 char(2) R See Scopes of Coverage in SCG.
37 436-437 TPL_SCOPE_OF_COVERAGE_2 char(2) O See Scopes of Coverage in SCG, if provided.
38 438 TPL_SCOPE_OF_COVERAGE_CD_1 char(1) O Leave space.
39 439 TPL_SCOPE_OF_COVERAGE_CD_2 char(1) O Leave space.
40 440-447 TPL_BEGIN_DATE_YYMMDD char(8) R YYYYMMDD
41 448-455 TPL_END_DATE_YYMMDD char(8) R YYYYMMDD
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(107) R Leave all spaces.
END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, archive it, and send it to HMS, the DHH TPL contractor. HMS will perform limited edits on the file and send them back to Molina for update processing on the LMMIS TPL Resource File. Molina's update process performs extensive edits and produces an error report for HMS, 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.

The error text file will use the naming convention: **TPL-ERROR-NNNNNNN-YYYYMMDD.txt**

Where NNNNNNN is your Plan ID (2162934=ACLA, 2162519=Amerigroup, 2162845=LHC),

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:
003 Invalid value for Field 3 (TPL_RECORD_SOURCE_CD)
004 Invalid value for Field 4 (TPL_PRI_INDIV_NAME_LAST)
009 Invalid value for Field 9 (TPL_INITIATOR_CODE). Your assigned initiator code must correspond to your Plan ID.
029 Invalid value for Field 29 (TPL_INSURANCE_NUMBER). Value is not found on LMMIS Carrier Code file. If TPL_PROCESS_TYPE=3 then value was not found on Recipient's TPL record.
034 Invalid value for Field 34 (TPL_POL_NBR). Value is blank or all 0s or all 9s.
035 Invalid value for Field 35 (TPL_GROUP_NBR). Value is blank or all 0s or all 9s.
040 Invalid value for Field 40 (TPL_BEGIN_DATE_YYMMDD). Must be a valid date value.
041 Invalid value for Field 41 (TPL_END_DATE_YYMMDD). Must be a valid date value and must be >= Field 40.
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.
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.
054 Invalid value for Field 54 (TPL_SEQUENCE_NUMBER). Must be a number and must be unique in the file.
The above examples represent some of the error codes, all of which range from 001 to 056.

Anytime you receive a record in the edit text file, it indicates that the associated record in your submission file failed to update the LMMIS TPL Resource File. If you receive no error record for a submitted record (based on the TPL_SEQUENCE_NUMBER), you may assume that the record passed all edits and was applied to the LMMIS TPL Resource File.
Edits are applicable to Required fields and may apply to Optional fields if you submit a value. If you receive an edit record, you may correct the issue and resubmit the record in a future submission.
END OF DOCUMENT

TPL File Layout to Plan

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

Scopes of coverage

Below is the list from the MDW DED:

Scope of Coverage	Description
00	Not Available
01	Major Medical
02	Medicare Supplement
03	Hospital, Physician, Dental and Drugs
04	Hospital, Physician, Dental
05	Hospital, Physician, Drugs
06	Hospital, Physician
07	Hospital, Dental and Drugs
08	Hospital, Dental
09	Hospital, Drugs
10	Hospital Only
11	Inpatient Hospital Only
12	Outpatient Hospital Only
13	Physician, Dental and Drugs
14	Physician and Dental
15	Physician and Drugs
16	Physician Only
17	Dental and Drugs Only
18	Dental Only
19	Drugs Only
20	Nursing Home Only
21	Cancer Only
22	CHAMPUS/CHAMPVA
23	Veterans Administration
24	Transportation
25	HMO
26	Carrier declared Bankruptcy
27	Major Medical without maternity benefits
28	HMO/Insurance Premium Paid by Medicaid GHIPP Program
29	Skilled Nursing Care

30	Medicare HMO (Part C)
31	Physician Only HMO
32	Pharmacy (PBM)
33	HMO No Maternity

Appendix L

Capitation Fee Payments Cross Walk

COA Identification

01=SSI
02=Family and Children
03=Foster Care Children
04=Breast and Cervical Cancer
05=Pregnant Women or LaCHIP Affordable
06=HCBS Waiver

CCN-P (Pre-paid) Capitation Codes

Publication Date: 07/18/2012

SUBJECT TO CHANGE

COA Code	RC Code	Start Date	End Date	
01	01C	20120201	20201231	SSI
01	02C	20120201	20201231	SSI
01	03C	20120201	20201231	SSI
01	04C	20120201	20201231	SSI
01	05C	20120201	20201231	SSI
01	06C	20120201	20201231	SSI
01	07C	20120201	20201231	SSI
02	01C	20120201	20201231	Families and Children
02	02C	20120201	20201231	Families and Children
02	03C	20120201	20201231	Families and Children
02	04C	20120201	20201231	Families and Children
02	05F	20120201	20201231	Families and Children
02	05M	20120201	20201231	Families and Children
02	06F	20120201	20201231	Families and Children
02	06M	20120201	20201231	Families and Children
02	07F	20120201	20201231	Families and Children
02	07M	20120201	20201231	Families and Children
03	FLL	20120201	20201231	Foster Care
04	BLL	20120201	20201231	Breast and Cervical Cancer
05	KLL	20120201	20201231	Kick Payment for Deliveries
05	LLL	20130101	20201231	LaCHIP Affordable Plan
06	H01	TBD	TBD	HCBS Waiver SSI
06	H02	TBD	TBD	HCBS Waiver Families and Children

Note: The combination of COA Code + RC Code represents the capitation code for CCN-P

Aid Category	Type Case	Age Type (M=months,Y=years)	Start Age	End Age (inclusive)	Sex (1=M, 2=F)	COA	RC
01	001	Y	045	150	1	01	07C
01	001	Y	045	150	2	01	07C
01	003	Y	045	150	1	01	07C
01	003	Y	045	150	2	01	07C
01	050	Y	045	150	1	01	07C
01	050	Y	045	150	2	01	07C
01	056	Y	045	150	1	01	07C
01	056	Y	045	150	2	01	07C
01	059	Y	045	150	1	01	07C
01	059	Y	045	150	2	01	07C
01	078	Y	045	150	1	01	07C
01	078	Y	045	150	2	01	07C
01	081	Y	045	150	1	01	07C
01	081	Y	045	150	2	01	07C
01	083	Y	045	150	1	01	07C
01	083	Y	045	150	2	01	07C
01	125	Y	045	150	1	01	07C
01	125	Y	045	150	2	01	07C
02	001	M	000	002	1	01	01C
02	001	M	000	002	2	01	01C
02	001	M	003	011	1	01	02C
02	001	M	003	011	2	01	02C
02	001	Y	001	005	1	01	03C
02	001	Y	001	005	2	01	03C
02	001	Y	006	013	1	01	04C
02	001	Y	006	013	2	01	04C
02	001	Y	014	018	1	01	05C
02	001	Y	014	018	2	01	05C
02	001	Y	019	044	1	01	06C
02	001	Y	019	044	2	01	06C
02	001	Y	045	150	1	01	07C
02	001	Y	045	150	2	01	07C
02	003	M	000	002	1	01	01C
02	003	M	000	002	2	01	01C
02	003	M	003	011	1	01	02C
02	003	M	003	011	2	01	02C
02	003	Y	001	005	1	01	03C
02	003	Y	001	005	2	01	03C
02	003	Y	006	013	1	01	04C

02	003	Y	006	013	2	01	04C
02	003	Y	014	018	1	01	05C
02	003	Y	014	018	2	01	05C
02	003	Y	019	044	1	01	06C
02	003	Y	019	044	2	01	06C
02	003	Y	045	150	1	01	07C
02	003	Y	045	150	2	01	07C
02	050	M	000	002	1	01	01C
02	050	M	000	002	2	01	01C
02	050	M	003	011	1	01	02C
02	050	M	003	011	2	01	02C
02	050	Y	001	005	1	01	03C
02	050	Y	001	005	2	01	03C
02	050	Y	006	013	1	01	04C
02	050	Y	006	013	2	01	04C
02	050	Y	014	018	1	01	05C
02	050	Y	014	018	2	01	05C
02	050	Y	019	044	1	01	06C
02	050	Y	019	044	2	01	06C
02	050	Y	045	150	1	01	07C
02	050	Y	045	150	2	01	07C
02	059	M	000	002	1	01	01C
02	059	M	000	002	2	01	01C
02	059	M	003	011	1	01	02C
02	059	M	003	011	2	01	02C
02	059	Y	001	005	1	01	03C
02	059	Y	001	005	2	01	03C
02	059	Y	006	013	1	01	04C
02	059	Y	006	013	2	01	04C
02	059	Y	014	018	1	01	05C
02	059	Y	014	018	2	01	05C
02	059	Y	019	044	1	01	06C
02	059	Y	019	044	2	01	06C
02	059	Y	045	150	1	01	07C
02	059	Y	045	150	2	01	07C
02	060	M	000	002	1	01	01C
02	060	M	000	002	2	01	01C
02	060	M	003	011	1	01	02C
02	060	M	003	011	2	01	02C
02	060	Y	001	005	1	01	03C
02	060	Y	001	005	2	01	03C
02	060	Y	006	013	1	01	04C
02	060	Y	006	013	2	01	04C
02	060	Y	014	018	1	01	05C

02	060	Y	014	018	2	01	05C
02	060	Y	019	044	1	01	06C
02	060	Y	019	044	2	01	06C
02	060	Y	045	150	1	01	07C
02	060	Y	045	150	2	01	07C
02	061	M	000	002	1	01	01C
02	061	M	000	002	2	01	01C
02	061	M	003	011	1	01	02C
02	061	M	003	011	2	01	02C
02	061	Y	001	005	1	01	03C
02	061	Y	001	005	2	01	03C
02	061	Y	006	013	1	01	04C
02	061	Y	006	013	2	01	04C
02	061	Y	014	018	1	01	05C
02	061	Y	014	018	2	01	05C
02	061	Y	019	044	1	01	06C
02	061	Y	019	044	2	01	06C
02	061	Y	045	150	1	01	07C
02	061	Y	045	150	2	01	07C
02	078	M	000	002	1	01	01C
02	078	M	000	002	2	01	01C
02	078	M	003	011	1	01	02C
02	078	M	003	011	2	01	02C
02	078	Y	001	005	1	01	03C
02	078	Y	001	005	2	01	03C
02	078	Y	006	013	1	01	04C
02	078	Y	006	013	2	01	04C
02	078	Y	014	018	1	01	05C
02	078	Y	014	018	2	01	05C
02	078	Y	019	044	1	01	06C
02	078	Y	019	044	2	01	06C
02	078	Y	045	150	1	01	07C
02	078	Y	045	150	2	01	07C
02	081	M	000	002	1	01	01C
02	081	M	000	002	2	01	01C
02	081	M	003	011	1	01	02C
02	081	M	003	011	2	01	02C
02	081	Y	001	005	1	01	03C
02	081	Y	001	005	2	01	03C
02	081	Y	006	013	1	01	04C
02	081	Y	006	013	2	01	04C
02	081	Y	014	018	1	01	05C
02	081	Y	014	018	2	01	05C
02	081	Y	019	044	1	01	06C

02	081	Y	019	044	2	01	06C
02	081	Y	045	150	1	01	07C
02	081	Y	045	150	2	01	07C
02	088	M	000	002	1	01	01C
02	088	M	000	002	2	01	01C
02	088	M	003	011	1	01	02C
02	088	M	003	011	2	01	02C
02	088	Y	001	005	1	01	03C
02	088	Y	001	005	2	01	03C
02	088	Y	006	013	1	01	04C
02	088	Y	006	013	2	01	04C
02	088	Y	014	018	1	01	05C
02	088	Y	014	018	2	01	05C
02	088	Y	019	044	1	01	06C
02	088	Y	019	044	2	01	06C
02	088	Y	045	150	1	01	07C
02	088	Y	045	150	2	01	07C
03	001	M	000	002	1	02	01C
03	001	M	000	002	2	02	01C
03	001	M	003	011	1	02	02C
03	001	M	003	011	2	02	02C
03	001	Y	001	005	1	02	03C
03	001	Y	001	005	2	02	03C
03	001	Y	006	013	1	02	04C
03	001	Y	006	013	2	02	04C
03	001	Y	014	018	1	02	05M
03	001	Y	014	018	2	02	05F
03	001	Y	019	044	1	02	06M
03	001	Y	019	044	2	02	06F
03	001	Y	045	150	1	02	07M
03	001	Y	045	150	2	02	07F
03	002	M	000	002	1	02	01C
03	002	M	000	002	2	02	01C
03	002	M	003	011	1	02	02C
03	002	M	003	011	2	02	02C
03	002	Y	001	005	1	02	03C
03	002	Y	001	005	2	02	03C
03	002	Y	006	013	1	02	04C
03	002	Y	006	013	2	02	04C
03	002	Y	014	018	1	02	05M
03	002	Y	014	018	2	02	05F
03	002	Y	019	044	1	02	06M
03	002	Y	019	044	2	02	06F
03	002	Y	045	150	1	02	07M

03	002	Y	045	150	2	02	07F
03	007	M	000	002	1	02	01C
03	007	M	000	002	2	02	01C
03	007	M	003	011	1	02	02C
03	007	M	003	011	2	02	02C
03	007	Y	001	005	1	02	03C
03	007	Y	001	005	2	02	03C
03	007	Y	006	013	1	02	04C
03	007	Y	006	013	2	02	04C
03	007	Y	014	018	1	02	05M
03	007	Y	014	018	2	02	05F
03	007	Y	019	044	1	02	06M
03	007	Y	019	044	2	02	06F
03	007	Y	045	150	1	02	07M
03	007	Y	045	150	2	02	07F
03	008	M	000	002	1	02	01C
03	008	M	000	002	2	02	01C
03	008	M	003	011	1	02	02C
03	008	M	003	011	2	02	02C
03	008	Y	001	005	1	02	03C
03	008	Y	001	005	2	02	03C
03	008	Y	006	013	1	02	04C
03	008	Y	006	013	2	02	04C
03	008	Y	014	018	1	02	05M
03	008	Y	014	018	2	02	05F
03	008	Y	019	044	1	02	06M
03	008	Y	019	044	2	02	06F
03	008	Y	045	150	1	02	07M
03	008	Y	045	150	2	02	07F
03	013	M	000	002	1	02	01C
03	013	M	000	002	2	02	01C
03	013	M	003	011	1	02	02C
03	013	M	003	011	2	02	02C
03	013	Y	001	005	1	02	03C
03	013	Y	001	005	2	02	03C
03	013	Y	006	013	1	02	04C
03	013	Y	006	013	2	02	04C
03	013	Y	014	018	1	02	05M
03	013	Y	014	018	2	02	05F
03	013	Y	019	044	1	02	06M
03	013	Y	019	044	2	02	06F
03	013	Y	045	150	1	02	07M
03	013	Y	045	150	2	02	07F
03	014	M	000	002	1	02	01C

03	014	M	000	002	2	02	01C
03	014	M	003	011	1	02	02C
03	014	M	003	011	2	02	02C
03	014	Y	001	005	1	02	03C
03	014	Y	001	005	2	02	03C
03	014	Y	006	013	1	02	04C
03	014	Y	006	013	2	02	04C
03	014	Y	014	018	1	02	05M
03	014	Y	014	018	2	02	05F
03	014	Y	019	044	1	02	06M
03	014	Y	019	044	2	02	06F
03	014	Y	045	150	1	02	07M
03	014	Y	045	150	2	02	07F
03	015	M	000	002	1	02	01C
03	015	M	000	002	2	02	01C
03	015	M	003	011	1	02	02C
03	015	M	003	011	2	02	02C
03	015	Y	001	005	1	02	03C
03	015	Y	001	005	2	02	03C
03	015	Y	006	013	1	02	04C
03	015	Y	006	013	2	02	04C
03	015	Y	014	018	1	02	05M
03	015	Y	014	018	2	02	05F
03	015	Y	019	044	1	02	06M
03	015	Y	019	044	2	02	06F
03	015	Y	045	150	1	02	07M
03	015	Y	045	150	2	02	07F
03	020	M	000	002	1	02	01C
03	020	M	000	002	2	02	01C
03	020	M	003	011	1	02	02C
03	020	M	003	011	2	02	02C
03	020	Y	001	005	1	02	03C
03	020	Y	001	005	2	02	03C
03	020	Y	006	013	1	02	04C
03	020	Y	006	013	2	02	04C
03	020	Y	014	018	1	02	05M
03	020	Y	014	018	2	02	05F
03	020	Y	019	044	1	02	06M
03	020	Y	019	044	2	02	06F
03	020	Y	045	150	1	02	07M
03	020	Y	045	150	2	02	07F
03	052	Y	000	150	2	04	BLL
03	053	M	000	002	1	02	01C
03	053	M	000	002	2	02	01C

03	053	M	003	011	1	02	02C
03	053	M	003	011	2	02	02C
03	053	Y	001	005	1	02	03C
03	053	Y	001	005	2	02	03C
03	053	Y	006	013	1	02	04C
03	053	Y	006	013	2	02	04C
03	053	Y	014	018	1	02	05M
03	053	Y	014	018	2	02	05F
03	053	Y	019	044	1	02	06M
03	053	Y	019	044	2	02	06F
03	053	Y	045	150	1	02	07M
03	053	Y	045	150	2	02	07F
03	055	M	000	002	1	02	01C
03	055	M	000	002	2	02	01C
03	055	M	003	011	1	02	02C
03	055	M	003	011	2	02	02C
03	055	Y	001	005	1	02	03C
03	055	Y	001	005	2	02	03C
03	055	Y	006	013	1	02	04C
03	055	Y	006	013	2	02	04C
03	055	Y	014	018	1	02	05M
03	055	Y	014	018	2	02	05F
03	055	Y	019	044	1	02	06M
03	055	Y	019	044	2	02	06F
03	055	Y	045	150	1	02	07M
03	055	Y	045	150	2	02	07F
03	071	M	000	002	1	02	01C
03	071	M	000	002	2	02	01C
03	071	M	003	011	1	02	02C
03	071	M	003	011	2	02	02C
03	071	Y	001	005	1	02	03C
03	071	Y	001	005	2	02	03C
03	071	Y	006	013	1	02	04C
03	071	Y	006	013	2	02	04C
03	071	Y	014	018	1	02	05M
03	071	Y	014	018	2	02	05F
03	071	Y	019	044	1	02	06M
03	071	Y	019	044	2	02	06F
03	071	Y	045	150	1	02	07M
03	071	Y	045	150	2	02	07F
03	085	M	000	002	1	02	01C
03	085	M	000	002	2	02	01C
03	085	M	003	011	1	02	02C
03	085	M	003	011	2	02	02C

03	085	Y	001	005	1	02	03C
03	085	Y	001	005	2	02	03C
03	085	Y	006	013	1	02	04C
03	085	Y	006	013	2	02	04C
03	085	Y	014	018	1	02	05M
03	085	Y	014	018	2	02	05F
03	085	Y	019	044	1	02	06M
03	085	Y	019	044	2	02	06F
03	085	Y	045	150	1	02	07M
03	085	Y	045	150	2	02	07F
03	104	M	000	002	1	02	01C
03	104	M	000	002	2	02	01C
03	104	M	003	011	1	02	02C
03	104	M	003	011	2	02	02C
03	104	Y	001	005	1	02	03C
03	104	Y	001	005	2	02	03C
03	104	Y	006	013	1	02	04C
03	104	Y	006	013	2	02	04C
03	104	Y	014	018	1	02	05M
03	104	Y	014	018	2	02	05F
03	104	Y	019	044	1	02	06M
03	104	Y	019	044	2	02	06F
03	104	Y	045	150	1	02	07M
03	104	Y	045	150	2	02	07F
03	127	M	000	002	1	02	01C
03	127	M	000	002	2	02	01C
03	127	M	003	011	1	02	02C
03	127	M	003	011	2	02	02C
03	127	Y	001	005	1	02	03C
03	127	Y	001	005	2	02	03C
03	127	Y	006	013	1	02	04C
03	127	Y	006	013	2	02	04C
03	127	Y	014	018	1	02	05M
03	127	Y	014	018	2	02	05F
03	127	Y	019	044	1	02	06M
03	127	Y	019	044	2	02	06F
03	127	Y	045	150	1	02	07M
03	127	Y	045	150	2	02	07F
03	148	Y	000	150	1	03	FLL
03	134	Y	000	018	1	05	LLL
03	134	Y	000	018	2	05	LLL
03	148	Y	000	150	2	03	FLL
03	151	M	000	002	1	02	01C
03	151	M	000	002	2	02	01C

03	151	M	003	011	1	02	02C
03	151	M	003	011	2	02	02C
03	151	Y	001	005	1	02	03C
03	151	Y	001	005	2	02	03C
03	151	Y	006	013	1	02	04C
03	151	Y	006	013	2	02	04C
03	151	Y	014	018	1	02	05M
03	151	Y	014	018	2	02	05F
03	151	Y	019	044	1	02	06M
03	151	Y	019	044	2	02	06F
03	151	Y	045	150	1	02	07M
03	151	Y	045	150	2	02	07F
04	001	M	000	002	1	01	01C
04	001	M	000	002	2	01	01C
04	001	M	003	011	1	01	02C
04	001	M	003	011	2	01	02C
04	001	Y	001	005	1	01	03C
04	001	Y	001	005	2	01	03C
04	001	Y	006	013	1	01	04C
04	001	Y	006	013	2	01	04C
04	001	Y	014	018	1	01	05C
04	001	Y	014	018	2	01	05C
04	001	Y	019	044	1	01	06C
04	001	Y	019	044	2	01	06C
04	001	Y	045	150	1	01	07C
04	001	Y	045	150	2	01	07C
04	003	M	000	002	1	01	01C
04	003	M	000	002	2	01	01C
04	003	M	003	011	1	01	02C
04	003	M	003	011	2	01	02C
04	003	Y	001	005	1	01	03C
04	003	Y	001	005	2	01	03C
04	003	Y	006	013	1	01	04C
04	003	Y	006	013	2	01	04C
04	003	Y	014	018	1	01	05C
04	003	Y	014	018	2	01	05C
04	003	Y	019	044	1	01	06C
04	003	Y	019	044	2	01	06C
04	003	Y	045	150	1	01	07C
04	003	Y	045	150	2	01	07C
04	050	M	000	002	1	01	01C
04	050	M	000	002	2	01	01C
04	050	M	003	011	1	01	02C
04	050	M	003	011	2	01	02C

04	050	Y	001	005	1	01	03C
04	050	Y	001	005	2	01	03C
04	050	Y	006	013	1	01	04C
04	050	Y	006	013	2	01	04C
04	050	Y	014	018	1	01	05C
04	050	Y	014	018	2	01	05C
04	050	Y	019	044	1	01	06C
04	050	Y	019	044	2	01	06C
04	050	Y	045	150	1	01	07C
04	050	Y	045	150	2	01	07C
04	056	M	000	002	1	01	01C
04	056	M	000	002	2	01	01C
04	056	M	003	011	1	01	02C
04	056	M	003	011	2	01	02C
04	056	Y	001	005	1	01	03C
04	056	Y	001	005	2	01	03C
04	056	Y	006	013	1	01	04C
04	056	Y	006	013	2	01	04C
04	056	Y	014	018	1	01	05C
04	056	Y	014	018	2	01	05C
04	056	Y	019	044	1	01	06C
04	056	Y	019	044	2	01	06C
04	056	Y	045	150	1	01	07C
04	056	Y	045	150	2	01	07C
04	057	M	000	002	1	01	01C
04	057	M	000	002	2	01	01C
04	057	M	003	011	1	01	02C
04	057	M	003	011	2	01	02C
04	057	Y	001	005	1	01	03C
04	057	Y	001	005	2	01	03C
04	057	Y	006	013	1	01	04C
04	057	Y	006	013	2	01	04C
04	057	Y	014	018	1	01	05C
04	057	Y	014	018	2	01	05C
04	057	Y	019	044	1	01	06C
04	057	Y	019	044	2	01	06C
04	057	Y	045	150	1	01	07C
04	057	Y	045	150	2	01	07C
04	058	M	000	002	1	01	01C
04	058	M	000	002	2	01	01C
04	058	M	003	011	1	01	02C
04	058	M	003	011	2	01	02C

04	058	Y	001	005	1	01	03C
04	058	Y	001	005	2	01	03C
04	058	Y	006	013	1	01	04C
04	058	Y	006	013	2	01	04C
04	058	Y	014	018	1	01	05C
04	058	Y	014	018	2	01	05C
04	058	Y	019	044	1	01	06C
04	058	Y	019	044	2	01	06C
04	058	Y	045	150	1	01	07C
04	058	Y	045	150	2	01	07C
04	059	M	000	002	1	01	01C
04	059	M	000	002	2	01	01C
04	059	M	003	011	1	01	02C
04	059	M	003	011	2	01	02C
04	059	Y	001	005	1	01	03C
04	059	Y	001	005	2	01	03C
04	059	Y	006	013	1	01	04C
04	059	Y	006	013	2	01	04C
04	059	Y	014	018	1	01	05C
04	059	Y	014	018	2	01	05C
04	059	Y	019	044	1	01	06C
04	059	Y	019	044	2	01	06C
04	059	Y	045	150	1	01	07C
04	059	Y	045	150	2	01	07C
04	060	M	000	002	1	01	01C
04	060	M	000	002	2	01	01C
04	060	M	003	011	1	01	02C
04	060	M	003	011	2	01	02C
04	060	Y	001	005	1	01	03C
04	060	Y	001	005	2	01	03C
04	060	Y	006	013	1	01	04C
04	060	Y	006	013	2	01	04C
04	060	Y	014	018	1	01	05C
04	060	Y	014	018	2	01	05C
04	060	Y	019	044	1	01	06C
04	060	Y	019	044	2	01	06C
04	060	Y	045	150	1	01	07C
04	060	Y	045	150	2	01	07C
04	061	M	000	002	1	01	01C
04	061	M	000	002	2	01	01C
04	061	M	003	011	1	01	02C
04	061	M	003	011	2	01	02C
04	061	Y	001	005	1	01	03C
04	061	Y	001	005	2	01	03C

04	061	Y	006	013	1	01	04C
04	061	Y	006	013	2	01	04C
04	061	Y	014	018	1	01	05C
04	061	Y	014	018	2	01	05C
04	061	Y	019	044	1	01	06C
04	061	Y	019	044	2	01	06C
04	061	Y	045	150	1	01	07C
04	061	Y	045	150	2	01	07C
04	078	M	000	002	1	01	01C
04	078	M	000	002	2	01	01C
04	078	M	003	011	1	01	02C
04	078	M	003	011	2	01	02C
04	078	Y	001	005	1	01	03C
04	078	Y	001	005	2	01	03C
04	078	Y	006	013	1	01	04C
04	078	Y	006	013	2	01	04C
04	078	Y	014	018	1	01	05C
04	078	Y	014	018	2	01	05C
04	078	Y	019	044	1	01	06C
04	078	Y	019	044	2	01	06C
04	078	Y	045	150	1	01	07C
04	078	Y	045	150	2	01	07C
04	081	M	000	002	1	01	01C
04	081	M	000	002	2	01	01C
04	081	M	003	011	1	01	02C
04	081	M	003	011	2	01	02C
04	081	Y	001	005	1	01	03C
04	081	Y	001	005	2	01	03C
04	081	Y	006	013	1	01	04C
04	081	Y	006	013	2	01	04C
04	081	Y	014	018	1	01	05C
04	081	Y	014	018	2	01	05C
04	081	Y	019	044	1	01	06C
04	081	Y	019	044	2	01	06C
04	081	Y	045	150	1	01	07C
04	081	Y	045	150	2	01	07C
04	083	M	000	002	1	01	01C
04	083	M	000	002	2	01	01C
04	083	M	003	011	1	01	02C
04	083	M	003	011	2	01	02C
04	083	Y	001	005	1	01	03C
04	083	Y	001	005	2	01	03C
04	083	Y	006	013	1	01	04C
04	083	Y	006	013	2	01	04C

04	083	Y	014	018	1	01	05C
04	083	Y	014	018	2	01	05C
04	083	Y	019	044	1	01	06C
04	083	Y	019	044	2	01	06C
04	083	Y	045	150	1	01	07C
04	083	Y	045	150	2	01	07C
04	088	M	000	002	1	01	01C
04	088	M	000	002	2	01	01C
04	088	M	003	011	1	01	02C
04	088	M	003	011	2	01	02C
04	088	Y	001	005	1	01	03C
04	088	Y	001	005	2	01	03C
04	088	Y	006	013	1	01	04C
04	088	Y	006	013	2	01	04C
04	088	Y	014	018	1	01	05C
04	088	Y	014	018	2	01	05C
04	088	Y	019	044	1	01	06C
04	088	Y	019	044	2	01	06C
04	088	Y	045	150	1	01	07C
04	088	Y	045	150	2	01	07C
04	125	M	000	002	1	01	01C
04	125	M	000	002	2	01	01C
04	125	M	003	011	1	01	02C
04	125	M	003	011	2	01	02C
04	125	Y	001	005	1	01	03C
04	125	Y	001	005	2	01	03C
04	125	Y	006	013	1	01	04C
04	125	Y	006	013	2	01	04C
04	125	Y	014	018	1	01	05C
04	125	Y	014	018	2	01	05C
04	125	Y	019	044	1	01	06C
04	125	Y	019	044	2	01	06C
04	125	Y	045	150	1	01	07C
04	125	Y	045	150	2	01	07C
04	133	M	000	002	1	01	01C
04	133	M	000	002	2	01	01C
04	133	M	003	011	1	01	02C
04	133	M	003	011	2	01	02C
04	133	Y	001	005	1	01	03C
04	133	Y	001	005	2	01	03C
04	133	Y	006	013	1	01	04C
04	133	Y	006	013	2	01	04C
04	133	Y	014	018	1	01	05C
04	133	Y	014	018	2	01	05C

04	133	Y	019	044	1	01	06C
04	133	Y	019	044	2	01	06C
04	133	Y	045	150	1	01	07C
04	133	Y	045	150	2	01	07C
06	007	Y	000	150	1	03	FLL
06	007	Y	000	150	2	03	FLL
06	013	Y	000	150	1	03	FLL
06	013	Y	000	150	2	03	FLL
06	014	Y	000	150	1	03	FLL
06	014	Y	000	150	2	03	FLL
06	030	Y	000	150	1	03	FLL
06	030	Y	000	150	2	03	FLL
06	078	M	000	002	1	01	01C
06	078	M	000	002	2	01	01C
06	078	M	003	011	1	01	02C
06	078	M	003	011	2	01	02C
06	078	Y	001	005	1	01	03C
06	078	Y	001	005	2	01	03C
06	078	Y	006	013	1	01	04C
06	078	Y	006	013	2	01	04C
06	078	Y	014	018	1	01	05C
06	078	Y	014	018	2	01	05C
06	078	Y	019	044	1	01	06C
06	078	Y	019	044	2	01	06C
08	029	M	000	002	1	01	01C
08	029	M	000	002	2	01	01C
08	029	M	003	011	1	01	02C
08	029	M	003	011	2	01	02C
08	029	Y	001	005	1	01	03C
08	029	Y	001	005	2	01	03C
08	029	Y	006	013	1	01	04C
08	029	Y	006	013	2	01	04C
08	029	Y	014	018	1	01	05C
08	029	Y	014	018	2	01	05C
08	029	Y	019	044	1	01	06C
08	029	Y	019	044	2	01	06C
08	031	Y	000	150	1	03	FLL
08	031	Y	000	150	2	03	FLL
08	078	M	000	002	1	01	01C
08	078	M	000	002	2	01	01C
08	078	M	003	011	1	01	02C
08	078	M	003	011	2	01	02C
08	078	Y	001	005	1	01	03C
08	078	Y	001	005	2	01	03C

08	078	Y	006	013	1	01	04C
08	078	Y	006	013	2	01	04C
08	078	Y	014	018	1	01	05C
08	078	Y	014	018	2	01	05C
13	001	M	000	002	1	02	01C
13	001	M	000	002	2	02	01C
13	001	M	003	011	1	02	02C
13	001	M	003	011	2	02	02C
13	001	Y	001	005	1	02	03C
13	001	Y	001	005	2	02	03C
13	001	Y	006	013	1	02	04C
13	001	Y	006	013	2	02	04C
13	001	Y	014	018	1	02	05M
13	001	Y	014	018	2	02	05F
13	001	Y	019	044	1	02	06M
13	001	Y	019	044	2	02	06F
13	001	Y	045	150	1	02	07M
13	001	Y	045	150	2	02	07F
13	009	M	000	002	1	02	01C
13	009	M	000	002	2	02	01C
13	009	M	003	011	1	02	02C
13	009	M	003	011	2	02	02C
13	009	Y	001	005	1	02	03C
13	009	Y	001	005	2	02	03C
13	009	Y	006	013	1	02	04C
13	009	Y	006	013	2	02	04C
13	009	Y	014	018	1	02	05M
13	009	Y	014	018	2	02	05F
13	009	Y	019	044	1	02	06M
13	009	Y	019	044	2	02	06F
13	009	Y	045	150	1	02	07M
13	009	Y	045	150	2	02	07F
13	071	M	000	002	1	02	01C
13	071	M	000	002	2	02	01C
13	071	M	003	011	1	02	02C
13	071	M	003	011	2	02	02C
13	071	Y	001	005	1	02	03C
13	071	Y	001	005	2	02	03C
13	071	Y	006	013	1	02	04C
13	071	Y	006	013	2	02	04C
13	071	Y	014	018	1	02	05M
13	071	Y	014	018	2	02	05F
13	071	Y	019	044	1	02	06M
13	071	Y	019	044	2	02	06F

13	071	Y	045	150	1	02	07M
13	071	Y	045	150	2	02	07F
13	085	M	000	002	1	02	01C
13	085	M	000	002	2	02	01C
13	085	M	003	011	1	02	02C
13	085	M	003	011	2	02	02C
13	085	Y	001	005	1	02	03C
13	085	Y	001	005	2	02	03C
13	085	Y	006	013	1	02	04C
13	085	Y	006	013	2	02	04C
13	085	Y	014	018	1	02	05M
13	085	Y	014	018	2	02	05F
13	085	Y	019	044	1	02	06M
13	085	Y	019	044	2	02	06F
13	085	Y	045	150	1	02	07M
13	085	Y	045	150	2	02	07F
22	007	Y	000	150	1	03	FLL
22	007	Y	000	150	2	03	FLL
22	013	Y	000	150	1	03	FLL
22	013	Y	000	150	2	03	FLL
22	014	Y	000	150	1	03	FLL
22	014	Y	000	150	2	03	FLL
22	032	Y	000	150	1	03	FLL
22	032	Y	000	150	2	03	FLL
22	033	Y	000	150	1	03	FLL
22	033	Y	000	150	2	03	FLL
22	035	Y	000	150	1	03	FLL
22	035	Y	000	150	2	03	FLL
22	078	M	000	002	1	01	01C
22	078	M	000	002	2	01	01C
22	078	M	003	011	1	01	02C
22	078	M	003	011	2	01	02C
22	078	Y	001	005	1	01	03C
22	078	Y	001	005	2	01	03C
22	078	Y	006	013	1	01	04C
22	078	Y	006	013	2	01	04C
22	078	Y	014	018	1	01	05C
22	078	Y	014	018	2	01	05C
22	078	Y	019	044	1	01	06C
22	078	Y	019	044	2	01	06C

Effective 7-1-2014, the following elements are applicable to HCBS Waiver:

01	018	Y	022	150	1	06	H02
01	018	Y	022	150	2	06	H02
01	019	Y	022	150	1	06	H01
01	019	Y	022	150	2	06	H01
01	026	Y	021	150	1	06	H01
01	026	Y	021	150	2	06	H01
01	027	Y	021	150	1	06	H02
01	027	Y	021	150	2	06	H02
01	043	Y	003	150	1	06	H01
01	043	Y	003	150	2	06	H01
01	070	Y	003	150	1	06	H02
01	070	Y	003	150	2	06	H02
01	082	Y	000	150	1	06	H01
01	082	Y	000	150	2	06	H01
01	093	Y	000	150	1	06	H02
01	093	Y	000	150	2	06	H02
01	117	Y	018	150	1	06	H01
01	117	Y	018	150	2	06	H01
01	118	Y	018	150	1	06	H02
01	118	Y	018	150	2	06	H02
01	119	Y	000	150	1	06	H01
01	119	Y	000	150	2	06	H01
01	149	Y	003	150	1	06	H02
01	149	Y	003	150	2	06	H02
01	150	Y	003	150	1	06	H01
01	150	Y	003	150	2	06	H01
01	153	Y	021	150	1	06	H01
01	153	Y	021	150	2	06	H01
01	154	Y	021	150	1	06	H02
01	154	Y	021	150	2	06	H02
02	018	Y	022	150	1	06	H02
02	018	Y	022	150	2	06	H02
02	019	Y	022	150	1	06	H01
02	019	Y	022	150	2	06	H01
02	026	Y	021	150	1	06	H01
02	026	Y	021	150	2	06	H01
02	027	Y	021	150	1	06	H02
02	027	Y	021	150	2	06	H02
02	043	Y	003	150	1	06	H01
02	043	Y	003	150	2	06	H01
02	070	Y	003	150	1	06	H02

02	070	Y	003	150	2	06	H02
02	076	Y	000	018	1	06	H01
02	076	Y	000	018	2	06	H01
02	082	Y	000	150	1	06	H01
02	082	Y	000	150	2	06	H01
02	093	Y	000	150	1	06	H02
02	093	Y	000	150	2	06	H02
02	117	Y	018	150	1	06	H01
02	117	Y	018	150	2	06	H01
02	118	Y	018	150	1	06	H02
02	118	Y	018	150	2	06	H02
02	149	Y	003	150	1	06	H02
02	149	Y	003	150	2	06	H02
02	150	Y	003	150	1	06	H01
02	150	Y	003	150	2	06	H01
02	153	Y	021	150	1	06	H01
02	153	Y	021	150	2	06	H01
02	154	Y	021	150	1	06	H02
02	154	Y	021	150	2	06	H02
04	018	Y	022	150	1	06	H02
04	018	Y	022	150	2	06	H02
04	019	Y	022	150	1	06	H01
04	019	Y	022	150	2	06	H01
04	026	Y	021	150	1	06	H01
04	026	Y	021	150	2	06	H01
04	027	Y	021	150	1	06	H02
04	027	Y	021	150	2	06	H02
04	043	Y	003	150	1	06	H01
04	043	Y	003	150	2	06	H01
04	070	Y	003	150	1	06	H02
04	070	Y	003	150	2	06	H02
04	076	Y	000	018	1	06	H01
04	076	Y	000	018	2	06	H01
04	077	Y	000	018	1	06	H02
04	077	Y	000	018	2	06	H02
04	082	Y	000	150	1	06	H01
04	082	Y	000	150	2	06	H01
04	093	Y	000	150	1	06	H02
04	093	Y	000	150	2	06	H02
04	117	Y	018	150	1	06	H01
04	117	Y	018	150	2	06	H01
04	118	Y	018	150	1	06	H02
04	118	Y	018	150	2	06	H02
04	119	Y	000	150	1	06	H01

04	119	Y	000	150	2	06	H01
04	120	Y	000	150	1	06	H02
04	120	Y	000	150	2	06	H02
04	149	Y	003	150	1	06	H02
04	149	Y	003	150	2	06	H02
04	150	Y	003	150	1	06	H01
04	150	Y	003	150	2	06	H01
04	153	Y	021	150	1	06	H01
04	153	Y	021	150	2	06	H01
04	154	Y	021	150	1	06	H02
04	154	Y	021	150	2	06	H02
06	043	Y	003	150	1	06	H01
06	043	Y	003	150	2	06	H01
06	070	Y	003	150	1	06	H02
06	070	Y	003	150	2	06	H02
06	076	Y	000	018	1	06	H01
06	076	Y	000	018	2	06	H01
06	077	Y	000	018	1	06	H02
06	077	Y	000	018	2	06	H02
06	082	Y	000	150	1	06	H01
06	082	Y	000	150	2	06	H01
06	093	Y	000	150	1	06	H02
06	093	Y	000	150	2	06	H02
06	149	Y	003	150	1	06	H02
06	149	Y	003	150	2	06	H02
06	150	Y	003	150	1	06	H01
06	150	Y	003	150	2	06	H01
08	043	Y	003	150	1	06	H01
08	043	Y	003	150	2	06	H01
08	070	Y	003	150	1	06	H02
08	070	Y	003	150	2	06	H02
08	076	Y	000	018	1	06	H01
08	076	Y	000	018	2	06	H01
08	077	Y	000	018	1	06	H02
08	077	Y	000	018	2	06	H02
08	082	Y	000	150	1	06	H01
08	082	Y	000	150	2	06	H01
08	093	Y	000	150	1	06	H02
08	093	Y	000	150	2	06	H02
08	149	Y	003	150	1	06	H02
08	149	Y	003	150	2	06	H02
08	150	Y	003	150	1	06	H01
08	150	Y	003	150	2	06	H01
14	154	Y	021	150	1	06	H02

14	154	Y	021	150	2	06	H02
22	043	Y	003	150	1	06	H01
22	043	Y	003	150	2	06	H01
22	070	Y	003	150	1	06	H02
22	070	Y	003	150	2	06	H02
22	076	Y	000	018	1	06	H01
22	076	Y	000	018	2	06	H01
22	077	Y	000	018	1	06	H02
22	077	Y	000	018	2	06	H02
22	082	Y	000	150	1	06	H01
22	082	Y	000	150	2	06	H01
22	093	Y	000	150	1	06	H02
22	093	Y	000	150	2	06	H02
40	200	Y	000	021	1	06	H01
40	200	Y	000	021	2	06	H01

END OF TABLE.

Louisiana Medicaid Recipient Aid Category Codes

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

Louisiana Medicaid Recipient Type Case Codes

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	0
002	Deemed Eligible	0
003	SSI Conversion	0
004	SSI SNF	1
005	SSI/LTC	1
006	12 Months Continuous Eligibility	0
007	LACHIP Phase 1	0
008	PAP - Prohibited AFDC Provisions	0
009	LIFC - Unemployed Parent / CHAMP	0
010	SSI in ICF (II)- Medical	1
011	SSI Villa SNF	1
012	Presumptive Eligibility, Pregnant Woman	0
013	CHAMP Pregnant Woman (to 133% of FPIG)	0
014	CHAMP Child	0
015	LACHIP Phase 2	0
016	Deceased Recipient - LTC	0
017	Deceased Recipient - LTC (Not Auto)	0
018	ADHC (Adult Day Health Services Waiver)	0
019	SSI/ADHC	1
020	Regular MNP (Medically Needy Program)	0
021	Spend-Down MNP	0
022	LTC Spend-Down MNP (Income > Facility Fee)	0
023	SSI Transfer of Resource(s)/LTC	1
024	Transfer of Resource(s)/LTC	0
025	LTC Spend-Down MNP	0
026	SSI/EDA Waiver	1
027	EDA Waiver	0
028	Tuberculosis (TB)	0
029	Foster Care IV-E - Suspended SSI	0
030	Regular Foster Care Child	0
031	IV-E Foster Care	0
032	YAP (Young Adult Program)	0
033	OYD - V Category Child	0
034	MNP - Regular Foster Care	0
035	YAP/OYD	0
036	YAP (Young Adult Program)	0
037	OYD (Office of Youth Development)	0
038	OCS Child Under Age 18 (State Funded)	0
039	State Retirees	0

040	SLMB (Specified Low-Income Medicare Beneficiary)	0
041	OAA, ANB or DA (GERI HP-ICF(I) SSI-No)	0
042	OAA, ANB or DA (GERI HP-ICF(I) SSI Pay)	1
043	New Opportunities Waiver - SSI	1
044	OAA, ANB or DA (GERI HP-ICF(2) SSI-Pay)	1
045	SSI PCA Waiver	1
046	PCA Waiver	0
047	Illegal/Ineligible Aliens Emergency Services	0
048	QI-1 (Qualified Individual - 1)	0
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	0
050	PICKLE	0
051	LTC MNP/Transfer of Resources	0
052	Breast and/or Cervical Cancer	0
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	0
054	Reinstated Section 4913 Children	0
055	LACHIP Phase 3	0
056	Disabled Widow/Widower (DW/W)	0
057	BPL (Walker vs. Bayer)	0
058	Section 4913 Children	0
059	Disabled Adult Child	0
060	Early Widow/Widowers	0
061	SGA Disabled W/W/DS	0
062	SSI/Public ICF/DD	1
063	LTC Co-Insurance	0
064	SSI/Private ICF/DD	1
065	Private ICF/DD	0
066	AFDC- Private ICF DD - 3 Month Limit	0
067	AFDC or IV-E(1) Private ICF DD	0
068	SSI-M (Determination of disability for Medicaid Eligibility)	1
069	Roll-Down	0
070	New Opportunities Waiver, non-SSI	0
071	Transitional Medicaid	0
072	LAMI Psuedo Income	0
073	Recipient (65 Plus) Eligible SSI/Ven Pay Hospital	1
074	Description not available	0
075	TEFRA	0
076	SSI Children's Waiver - Louisiana Children's Choice	1
077	Children's Waiver - Louisiana Children's Choice	0
078	SSI (Supplemental Security Income)	1
079	Denied SSI Prior Period	0
080	Terminated SSI Prior Period	1
081	Former SSI	1
082	SSI DD Waiver	1
083	Acute Care Hospitals (LOS > 30 days)	0
084	LaCHIP Pregnant Woman Expansion (185-200%)	0
085	Grant Review	0
086	Forced Benefits	0
087	CHAMP Parents	0

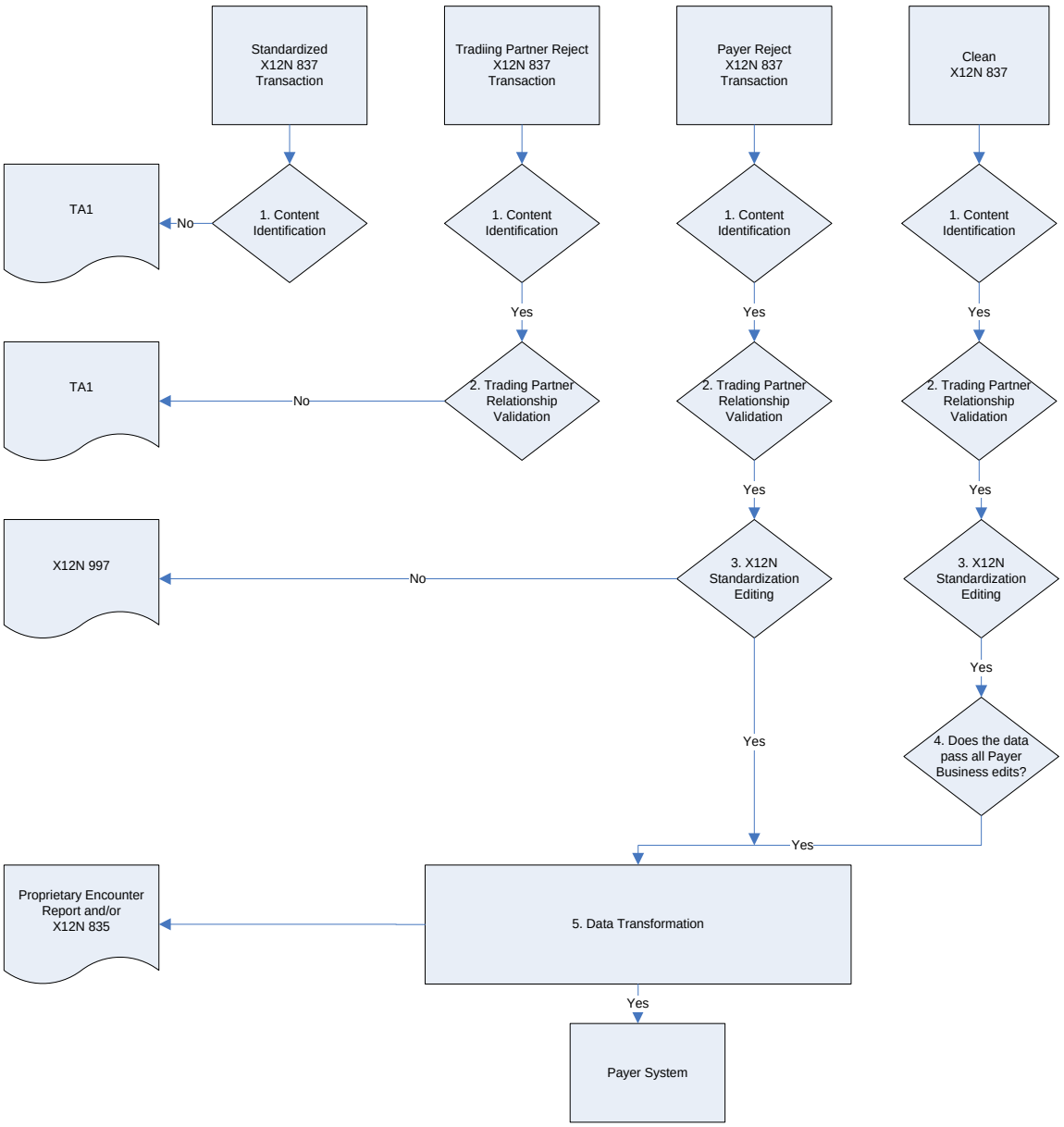
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	0
089	Recipient Eligible for Pay-Habitation and Other	0
090	LTC (Long Term Care)	0
091	A, B, D Recipient in Geriatric SNF; No SSI Pay	0
092	AFCD, GA, A, B, D in SNF; No AFDC Pay	0
093	DD Waiver	0
094	QDWI (Qualified Disabled/Working Individual)	0
095	QMB (Qualified Medicare Beneficiary)	0
097	Qualified Child Psychiatric	0
098	AFDC, GA, A, B, D ICF(2) No AFDC/Other Pay	0
099	Public ICF/DD	0
100	PACE SSI	1
101	PACE SSI-related	0
102	GNOCHC Adult Parent	0
103	GNOCHC Childless Adult	0
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	0
109	LaChoice, Childless Adults	0
110	LaChoice, Parents with Children	0
111	LHP, Childless Adults	0
112	LHP, Parents with Children	0
113	LHP, Children	0
115	Family Planning, Previous LAMOMS eligibility	0
116	Family Planning, New eligibility / Non LaMOM	0
117	Supports Waiver SSI	1
118	Supports Waiver	0
119	Residential Options Waiver - SSI	1
120	Residential Options Waiver - NON-SSI	0
121	SSI/LTC Excess Equity	1
122	LTC Excess Equity	0
123	LTC Spend Down MNP Excess Equity	0
124	LTC Spend Down MNP Excess Equity(Income over facility fee)	0
125	Disability Medicaid	0
127	LaChip Phase IV: Non-Citizen Pregnant Women Expansion	0
130	LTC Payment Denial/Late Admission Packet	0
131	SSI Payment Denial/Late Admission	1
132	Spendown Denial of Payment/Late Packet	0
133	Family Opportunity Program	0
134	LaCHIP Affordable Plan	0
136	Private ICF/DD Spendown Medically Needy Program	0
137	Public ICF/DD Spendown Medically Needy Program	0
138	Private ICF/DD Spendown MNP/Income Over Facility Fee	0
139	Public ICF/DD Spendown MNP/Income Over Facility Fee	0
140	SSI Private ICF/DD Transfer of Resources	1
141	Private ICF/DD Transfer of Resources	0
142	SSI Public ICF/DD Transfer of Resources	1
143	Public ICF/DD Transfer of Resources	0
144	Public ICF/DD MNP Transfer of Resources	0
145	Private ICF/DD MNP Transfer of Resources	0
146	Adult Residential Care/SSI	1
147	Adult Residential Care	0

148	Youth Aging Out of Foster Care (Chaffee Option)	0
149	New Opportunities Waiver Fund	0
150	SSI New Opportunities Waiver Fund	1
151	ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	0
152	ELE School Lunch (Express Lane Eligibility -School Lunch)	0
153	SSI - Community Choices Waiver	1
154	Community Choices Waiver	0
155	HCBS MNP Spend down	0
178	Disabled Adults authorized for special hurricane Katrina assistance	0
200	CsoC-SED MEDICAID CHILD -MEDS TC and sgmt TC 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
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 Spenddown (Adult)	

Appendix M

Editing and Validation Diagram

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



Data Certification[3]

[3] CFR 42 § 438.604 - Data that must be certified; CFR § 438.606 - Source, content, and timing of certification.

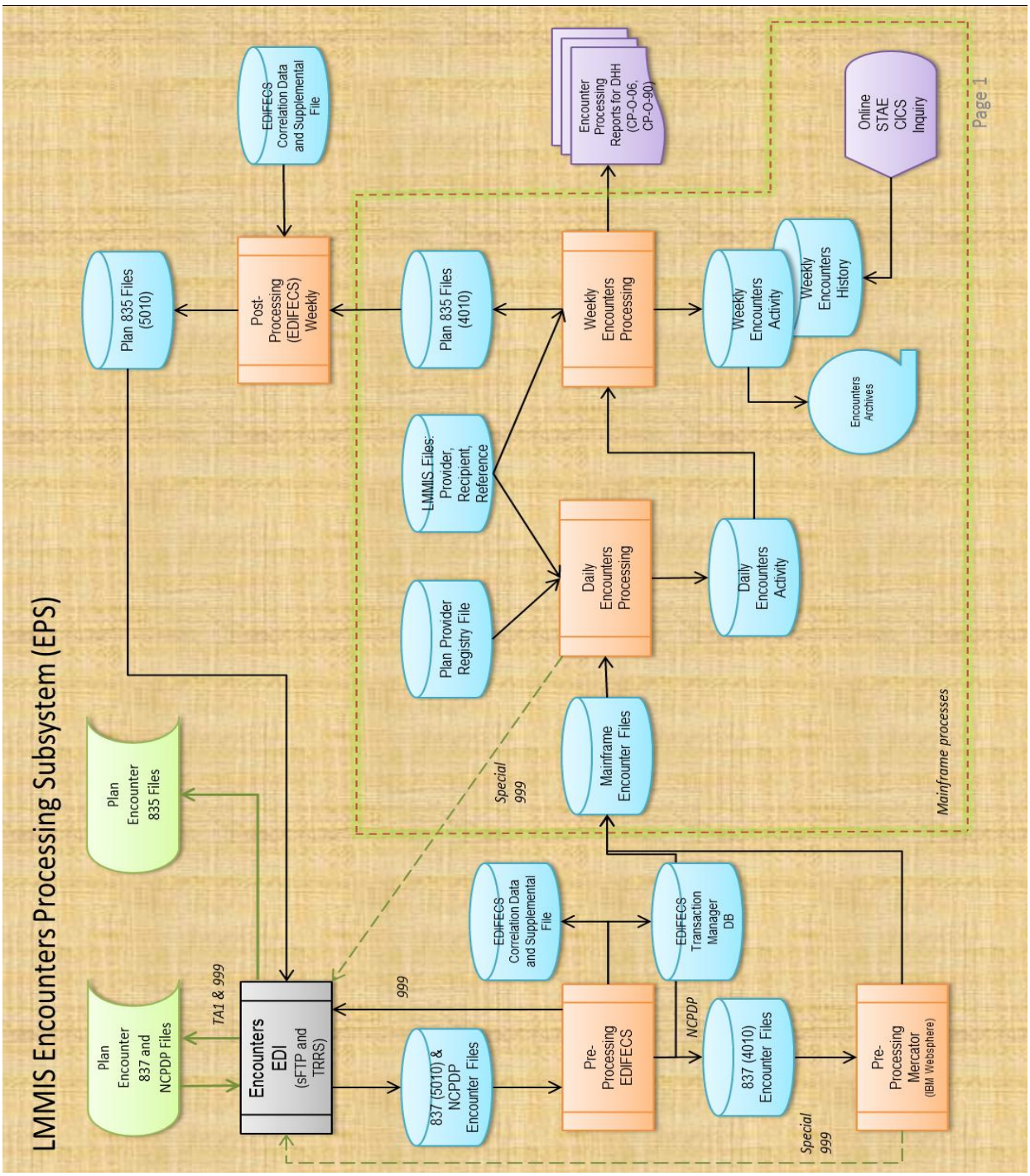
Appendix N

Pharmacy Encounter Batch Guide

The Batch Pharmacy Companion Guide has been created as a supplement to this System Companion Guide; and must be utilized as such for instructions on submitting NCPDP Files as well as making corrections to the encounter data edits that are set to a Deny - Repairable disposition. The Guide can be found on the makingmedicaidbetter website.

Appendix O

LMMIS Encounter Processing Flow Chart



Appendix P

Encounter Data Certification Form

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

Please Type or Print Clearly

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

BAYOU Health DATA Certification Statement

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

I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable Federal and State laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the Bayou Health Plan contract.

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

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

Medicaid Management Information System (MMIS) Edit Logic

DHH has provided system logic for the following edit categories along with their "long" description:

Educational

813 – Exact Duplicate Error: Identical Physician Claims
815 – Exact Duplicate Error: Identical Rehab Services Claim

Deny – Repairable Under Limited Circumstances

258 – Difference Between Service Dates and Quantity

Deny Repairable

120 – Quantity Invalid or Missing
130 – All Providers 9999999 To Be Deny (invalid NPI/Taxonomy)
796 – Original/Adjustment Billing Provider Number Different
799 – No History Record on File for this Adjustment

Deny – Not Repairable

The following denials are Exact Duplicate Error(s) for Identical Claim:

794 – Inpatient Hospital Service Paid for Same Date of Service to Same Attending
801 – Inpatient Hospital Claims
805 – Outpatient Hospital Claims
822 – Home Health Claims
828 – Ambulance Claims
833 – Non-Ambulance Claims
837 – Durable Equipment Claims

The following denials are Exact Duplicate Errors for Services that are not payable on the same date(s) of service:

806 – Outpatient Service and Rehab Service
807 – Outpatient Serviced and Home Health Service
808 – Outpatient Service and Ambulance Service
810 – Outpatient Service and Durable Equipment Service
816 – Rehab Service and Home Health Service
817 – Rehab Service and Ambulance Service
818 – Rehab Service and Non-Ambulance Service
819 – Rehab Service and Durable Equipment Service
823 – Home Health Service and Ambulance Service
830 – Ambulance Service and Durable Equipment Service
849 – Already Paid Same Attending Provider Different Billing Provider

Below is the logic for Edits 813 and 815 which are Educational and do not require correction(s):

Edit 813

MMIS Error Code Value:	813
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Physician claims (A-CLAIM-TYP is '04') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Physician claim (HIST-CLAIM-TYPE is '04'). This edit condition requires that billing provider (A-BILL-PROV-NO) matches the billing provider on the historical claim, however when the following services (A-PROC) are billed the servicing provider (A-PROV) must be matched against the servicing provider on this prior claim (HIST-SERV-PROV): • '00098', '10000' through '79999', '90000' through '99999', or 'W3340' when the following modifiers (A-TOOTH-PROC-MOD) are used: '24', '25', 'AB', 'AC', 'AD', 'AE', or 'AH'. • '00099' through '02000' when the historical procedure (HIST-PROCEDURE) is '00098', '10000' through '79999', '90000' through '99999', or 'W3340' with the following modifiers (HIST-PROC-MOD) are used: '24', '25', 'AB', 'AC', 'AD', 'AE', or 'AH'. • 00099' through '02000' when the historical procedure is (HIST-PROCEDURE) is '00099' through '02000'. This edit condition requires that the services performed exactly match the services on the prior claim (A-PROC equals HIST-PROCEDURE), except for hospital evaluations and consultations. In these cases, initial hospital evaluations and hospital consultations (A-PROC is '99221' through '99234' or '99251' through '99255') performed when any prior similar service was performed (HIST-PROCEDURE is '99221 through '99234' or '99251' through '99255') will generate this error. The type of service on these claims must also match (A-TOS equals HIST-TYPE-SERVICE), with the following exceptions: • Surgical services (A-PROC is '10000' through '69999' and HIST-PROCEDURE is '10000' through '69999') when the type of service on either claim is '03' or '07'. • An assistant surgeon modifier is applied to any modifier field on either the current or the historical claim (A-TOOTH-PROC-MOD, A-PROC-MOD2, A-PROC-MOD3, A-PROC-MOD4, HIST-PROC-MOD, HIST-PROC-MOD2, HIST-PROC-MOD3, or HIST-PROC-MOD4 is equal to '80' or '81').	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Edit 815

MMIS Error Code Value:	815
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Rehabilitation services claims (A-CLAIM-TYP is '05') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Rehabilitation services claim (HIST-CLAIM-TYPE is '05') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE and A-TOOTH-PROC-MOD equals HIST-PROC-MOD).	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Below is the logic for Edit 258. This edit is Repairable under limited circumstances ONLY.

Edit 258

MMIS Error Code Value:	258
Program Alias:	SPANNING-DATES-QUANT-DIFF
Full Description:	DIFFERENCE BETWEEN SERVICE DATES AND QUANT
Adjudicated In:	LAM2D060 (Daily Encounter edit)
Claim Outcome:	DENY
Conditions:	
Physician claims (CLAIM TYPE is '04') where the span in dates of service (DOS-Through minus DOS-From) does not match the units billed on the claim.	
Bypass Conditions:	
• Bypassed when a single date of service is on the claim (DOS-From equals DOS-Through).	

Below is the logic for Edits 120, 130, 796, and 799. These Edits are Repairable.

Edit 120

MMIS Error Code Value:	120
Program Alias:	METRIC-QTY-ERR in LAM2D030 and LAM2P320 QTY-INVALID-MISSING in LAM2D060
Full Description:	QUANTITY INVALID/MISSING
Adjudicated In:	LAM2CI05 LAM2D030 LAM2R045 LAM2D060 LAM2P320 LAM2P350
Claim Outcome:	PEND for Medical Review. If the operator cannot sight-verify/correct the data, then the claim status will be updated to DENY.

Conditions:

LAM2D030, LAM2R045 and LAM2P320
Pharmacy claims (A-CLAIM-TYP is '12') with a missing or invalid dispensed amount (PH-QUANTITY is not greater than 0).
LAM2D060
The actual units on a dispensed drug is missing or invalid (OP-NDC-UNITS or PR-NDC-UNITS is blank or non-numeric) on an Outpatient, Physician, Rehabilitation Services, Home Health, or DME claims (A-CLAIM-TYP is '03', '04', '05', '06', or '09').
LAM2P350
1. Claims for drugs that are orally administered as a liquid (F526-DRUG-DISP-UNIT is '1' and F526-DRUG-RTE-ADMIN is '1') has are not dispensed with a whole number (fractional component of PH-QUANTITY is not zeroes).
2. The drug indicated on the claim has an EOB 120 indicator (F526-EOB120-IND), and the amount dispensed is not in even units based on the established package size for that drug (PH-QUANTITY is not divided into a whole number by F526-DRUG-PACKAGE-SIZE).
3. Claims for Norelgestromin patches (A-NDC is '00062192015') that are dispensed with an inappropriate number of days supply based on the amount dispensed. The following combinations are deemed appropriate:
• 3 units (PH-QUANTITY is 3): 28 to 30 days (PH-RX-DAYS-SUPPLY is greater than 27 and less than 31);
• 6 units (PH-QUANTITY is 6): 56 to 60 days (PH-RX-DAYS-SUPPLY is greater than 55 and less than 61); or

• 9 units (PH-QUANTITY is 9): 84 to 90 days (PH-RX-DAYS-SUPPLY is greater than 83 and less than 91).
This edit condition is effective for claims serviced on or after August 1, 2006 (A-FROM-DATE is greater than 20060731).
4. Claims for Norelgestromin patches (A-NDC is '00062192001') that are dispensed in any amount other than 1 unit (PH-QUANTITY is 1) with a 7 day supply (PH-RX-DAYS-SUPPLY is 7). This edit condition is effective for claims serviced on or after August 1, 2006 (A-FROM-DATE is greater than 20060731).

Bypass Conditions:
None.

Edit 130

MMIS Error Code Value:	130
Program Alias:	DENY-PROV-9999999
Full Description:	ALL PROVIDERS 9999999 TO BE DENY.
Adjudicated In:	LAM2D060
Claim Outcome:	DENY
Conditions:	
1. Servicing or Billing Provider ID is '9999999' (A-PROV-NO or A-BILL-PROV-NO is '9999999'). 2. The billing provider ID is not found on the Provider Master file (F400), and A-ICN-MEDIA is '1', then A-BILL-PROV-NO will be set to '9999999' and this error will be generated.	
Bypass Conditions:	
None.	

Edit 796

MMIS Error Code Value:	796
Program Alias:	n/a
Full Description:	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
Adjudicated In:	LAM2W180 LAM2W185
Claim Outcome:	DENY
Conditions:	
Each adjustment or void claim is queried against the claims history file, using the original recipient ID (A-RECIP-ORIG), the claim type (A-CLAIM-TYP) and the former ICN (A-FORMER-ICN) indicated on the claim. This error code is returned when a matching history record is found, but they have been billed by different providers (A-BILL-PROV-NO does not match H-BILL-PROV-NO).	
Bypass Conditions:	
None.	

Edit 799

MMIS Error Code Value:	799
Program Alias:	n/a
Full Description:	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
Adjudicated In:	LAM2W180 LAM2W185
Claim Outcome:	DENY
Conditions:	
Each adjustment or void claim is queried against the claims history file, using the original recipient ID (A-RECIP-ORIG), the claim type (A-CLAIM-TYP) and the former ICN (A-FORMER-ICN) indicated on the claim. This error code is returned if a matching record is not found.	
Bypass Conditions: None	

Below is the logic for Edits 794, 801, 805, 822, 828, 833, 837, 806, 807, 808, 810, 816, 817, 818, 819, 823, 830, and 849. These edits are Not Repairable.

Edit 794

MMIS Error Code Value:	794
Program Alias:	INPT SER PD SAME ATT
Full Description:	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
Claim Outcome:	DENY
Conditions:	
A duplicate professional encounter is identified where the same servicing provider is present on a previously accepted encounter for an adult recipient (age is greater than 20) for a hospital visit or consultation (CPT is '99221' through '99233' or '99251' through '99255') for the same DOS.	
Bypass Conditions: None	

Edit 801

MMIS Error Code Value:	801
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Hospital claims (A-CLAIM-TYP is '01') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service on a prior Inpatient Hospital claim (HIST-CLAIM-TYPE is '01') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO).	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Edit 805

MMIS Error Code Value:	805
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Outpatient claims (A-CLAIM-TYP is '03') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service on a prior Outpatient claim (HIST-CLAIM-TYPE is '03') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES matches HIST-BILL-AMT) and type of service (A-TOS matches HIST-TYPE-SERVICE). The services on the claim must also match; the criteria used for this match depends on Outpatient claim as follows: • Laboratory services (A-PROC is 'HR300' through 'HR319') when the HCPC code on the claim matches the HCPC code on the prior claim (OP-HCPC-CODE equals HIST-HCPC-CODE).	

Edit 822

MMIS Error Code Value:	822
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Home Health claims (A-CLAIM-TYP is '06') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Home Health claim (HIST-CLAIM-TYPE is '06') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT).	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Edit 828

MMIS Error Code Value:	828
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Emergency Transportation claims (A-CLAIM-TYP is '07') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Emergency Transportation claim (HIST-CLAIM-TYPE is '07') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE).	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Edit 833

MMIS Error Code Value:	833
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Non-Emergency Transportation claims (A-CLAIM-TYP is '08') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Non-Emergency Transportation claim (HIST-CLAIM-TYPE is '08') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE).	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Edit 837

MMIS Error Code Value:	837
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
DME claims (A-CLAIM-TYP is '09') where the date of services (A-FROM-DATE, A-THRU-DATE) match the	
dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior DME claim (HIST-CLAIM-TYPE is '09') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, PR-NDC equals HIST-PR-NDC, A-TOS equal HIST-TYPE-SERVICE).	
Bypass Conditions:	
• Void or Credit adjustment claims (A-CLAIM-TYP-MOD is '3' or '4', A-ICN equals HIST-ICN). • Debit adjustment claims (A-CLAIM-TYP-MOD is '2', A-FORMER-ICN equals HIST-ICN).	

Edit 806

MMIS Error Code Value:	806
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Outpatient claims (A-CLAIM-TYP is '03') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service on a prior Rehabilitation claim (HIST-CLAIM-TYPE is '05') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES), for the same services (OP-HCPC-CODE matches HIST-HCPC-CODE, A-TOS matches HIST-TYPE-SERVICE). 2. Rehabilitation service claims (A-CLAIM-TYPE is '05') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service on a prior Outpatient claim (HIST-CLAIM-TYPE is '03') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO) with the same billed amount (A-BILLED-CHARGES matches HIST-BILL-AMT), for the same services (A-TOOTH-PROC-MOD equals HIST-PROC-MOD).	
Bypass Conditions:	
None.	

Edit 807

MMIS Error Code Value:	807
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Outpatient claims (A-CLAIM-TYP is '03') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service on a prior Home Health claim (HIST-CLAIM-TYPE is '06') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES), for the same services (OP-HCPC-CODE matches HIST-HCPC-CODE, A-TOS matches HIST-TYPE-SERVICE). 2. Home Health claims (A-CLAIM-TYP is '06') where the dates of service (A-FROM-DATE, A-THRU-DATE) overlap the dates of service on a prior Outpatient claim (HIST-CLAIM-TYPE is '03') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES), for the same services (A-TOS matches HIST-TYPE-SERVICE).	
Bypass Conditions: None	

Edit 808

MMIS Error Code Value:	808
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Outpatient claims (A-CLAIM-TYP is '03') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service on a prior Emergency Transportation claim (HIST-CLAIM-TYPE is '07') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES), for the same services (OP-HCPC-CODE matches HIST-HCPC-CODE, A-TOS matches HIST-TYPE-SERVICE). 2. Emergency Transportation claims (A-CLAIM-TYP is '07') where the dates of service (A-FROM-DATE, A-THRU-DATE) overlap the date of service on a prior Outpatient claim (HIST-CLAIM-TYPE is '03') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES equals HIST-BILL-AMT) for the same services (A-TOS equals HIST-TYPE-SERVICE).	
Bypass Conditions:	
None.	

Edit 810

MMIS Error Code Value:	810
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUIPMENT
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Outpatient claims (A-CLAIM-TYP is '03') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service on a prior Durable Medical Equipment claim (HIST-CLAIM-TYPE is '09') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES), for the same services (OP-HCPC-CODE matches HIST-HCPC-CODE, A-TOS matches HIST-TYPE-SERVICE). 2. DME claims (A-CLAIM-TYP is '09') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service on a prior Outpatient claim (HIST-CLAIM-TYPE is '03') by the same billing provider (A-BILL-PROV-NO matches HIST-BILL-PROV-NO), with the same billed amount (A-BILLED-CHARGES), for the same services (OP-HCPC-CODE matches HIST-HCPC-CODE, A-TOS matches HIST-TYPE-SERVICE). **Bypass Conditions:** None.	

Edit 816

MMIS Error Code Value:	816
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Rehabilitation services claims (A-CLAIM-TYP is '05') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Home Health claim (HIST-CLAIM-TYPE is '06') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO). 2. Home Health claims (A-CLAIM-TYP is '06') where the dates of service (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Rehabilitation services claim (HIST-CLAIM-TYPE is '05') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) with the same billed charges (A-BILLED-CHARGES equals HIST-BILL-AMT), for the same services (A-PROC equals HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD and A-TOS equals HIST-TYPE-SERVICE).	
Bypass Conditions:	
None.	

Edit 817

MMIS Error Code Value:	817
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Rehabilitation services claims (A-CLAIM-TYP is '05') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Emergency Transportation services claim (HIST-CLAIM-TYPE is '07') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT). 2. Emergency Transportation services claims (A-CLAIM-TYP is '07') where the dates of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Rehabilitation services claim (HIST-CLAIM-TYPE is '05') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT).	
Bypass Conditions:	
None.	

Edit 818

MMIS Error Code Value:	818
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANCE
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Rehabilitation services claims (A-CLAIM-TYP is '05') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Non-Emergency Transportation services claim (HIST-CLAIM-TYPE is '08') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT). 2. Non-Emergency Transportation claims (A-CLAIM-TYP is '08') where the dates of service (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Rehabilitation services claims (HIST-CLAIM-TYPE is '05') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT).	
Bypass Conditions:	
None.	

Edit 819

MMIS Error Code Value:	819
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE EQUIP
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Rehabilitation services claims (A-CLAIM-TYP is '05') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Durable Medical Equipment services claim (HIST-CLAIM-TYPE is '09') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT). 2. DME claims (A-CLAIM-TYP is '09') where the date of services (A-FROM-DATE, A-THRU-DATE) match the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Rehabilitation services claim (HIST-CLAIM-TYPE is '05') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT). **Bypass Conditions:** None.	

Edit 823

MMIS Error Code Value:	823
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Home Health claims (A-CLAIM-TYP is '06') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Emergency Transportation claim (HIST-CLAIM-TYPE is '07') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT). 2. Emergency Transportation services claims (A-CLAIM-TYP is '07') where the dates of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Home Health claim (HIST-CLAIM-TYPE is '06') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT).	
Bypass Conditions:	
None.	

Edit 830

MMIS Error Code Value:	830
Program Alias:	n/a
Full Description:	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
1. Emergency Transportation claims (A-CLAIM-TYP is '07') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior DME claim (HIST-CLAIM-TYPE is '09') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT). 2. DME claims (A-CLAIM-TYP is '09') where the date of services (A-FROM-DATE, A-THRU-DATE) overlap the dates of service (HIST-FROM-DATE, HIST-TO-DATE) on a prior Emergency Transportation claim (HIST-CLAIM-TYPE is '07') for the same billing provider (A-BILL-PROV-NO equals HIST-BILL-PROV-NO) for the same service (A-PROC is equal to HIST-PROCEDURE, A-TOOTH-PROC-MOD equals HIST-PROC-MOD, A-TOS equal HIST-TYPE-SERVICE) with the same charges billed (A-BILLED-CHARGES equals HIST-BILL-AMT).	
Bypass Conditions:	
None.	

Edit 849

MMIS Error Code Value:	849
Program Alias:	n/a
Full Description:	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
Adjudicated In:	LAM2W200
Claim Outcome:	DENY
Conditions:	
Error Code 813 (EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS) is assigned to a claim that has identical service dates, servicing provider, and service as a historical claim (A-FROM-DATE equals HIST-FROM-DATE, A-THRU-DATE equals HIST-TO-DATE, A-PROV-NO equals HIST-SERV-PROV, A-TOS equals HIST-TYPE-SERVICE, A-PROC equals HIST-PROCEDURE and A-TOOTH-PROC-MOD equals HIST-PROC-MOD), although the billing providers on both claims is different (A-BILL-PROV-NO is not equal to HIST-BILL-PROV-NO).	
Bypass Conditions:	
Anesthesia services bypass this edit (A-TOS is ‘01’).	

END OF DOCUMENT