Bayou Health Shared Plan

Systems Companion Guide

April 2014
Version 4.2

BAYOU HEALTH-S Systems Companion Guide

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	Sections Changed	Descriptions	Reason	DATE
Darlene White	2	Category II CPT Codes	Removal of language	7/20/2011
Darlene White	Appendix D	Claim Detail	Included PA	7/27/2011
Darlene White	1	Twenty-four (24) Month Claims History	Further clarification added	7/27/2011
Darlene White	1	Batch Submissions	Further clarification added	7/27/2011
Darlene White	2	Transaction Type	Update of Provider and Specialty Type Codes	7/27/2011
Darlene White	Appendix D	Claims Processing Flowchart	Added to provide further clarification	7/27/2011
Darlene White	Appendix E	Provider Directory/Network Provider and Subcontractor Registry	Updated Specialty Codes	7/27/2011
Darlene White	Appendix D Appendix H Appendix I	Claims File layout changes and other file layouts (820, PA/Precert, Provider, Diagnosis, CLIA)	Updated claim file layout and added new files layouts to Appendix D. Added Appendix H (common data elements) and Appendix I (LMMIS Claims Processing Edits)	9/1/2011 – 9/19/2011
Darlene White	Appendix D	Updated Provider Negotiated Rates File layout Added Appendix J – CCN TPL Discovery Web page screens	Due to an error Updates as requested by CCN-S organizations at Q&A meeting	9/26/2011

Darlene White	**Section 1** **Section 2** **Section 4** **Appendix D** **Appendix E** **Appendix H** **Appendix K**	**Section 1, information on BATCH SUBMISSIONS** **Section 2, information on ICN and Claims Adjustments Information** **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 to store procedure code** **Appendix E: Included Sample Provider Registry Edit Report** **Appendix H: added GSA to Region crosswalk** **Appendix K: added Scopes of Coverage**	**Claims submission and adjustments information** **Extract File layouts**	**10/10/2011 TO 10/12/2011**
Darlene White	**Appendix K**	**Administrative Fee Payments Crosswalk and Aid Category and Type Cases definitions**		**10/28/2011**
Darlene White	**Appendix D** **Appendix E** **Appendix I**	**Updated 820 File layout to correct RMR segment issue.** **Updated Provider Registry Edit Report with additional edit code values** **Updated Edit codes dispositions**		**11/29/2011**
Darlene White	**Appendix E**	**Changed Provider Registry File format: Provider Name (record position 45-74) is now a structured format.**		**12/6/2011**
Darlene White	**Appendix I**	**Updated Edit codes dispositions. The dispositions for the following edit codes were changed as shown:** **010-off,** **187-off,** **730-off,** **784-off,** **915-off,** **916-off.**		**12/7/2011**
Darlene White	**Appendix I**	**Updated Edit code disposition for 664: Set to E (EOB).**		**12/14/2011**

Darlene White	**Appendix D**	**Updated Claim Detail record layout.** **Updated Provider List record layout.**	**Added diagnosis code 2 and place of service to end of claims detail layout.** **Added pay-to address and TIN information to end of Provider List record layout.**	**01/06/2012 – 02/13/2012**
Darlene White	**Section 1 Overview** **Section 4 Files and Reports** **Appendix D** **Appendix I** **Appendix K**	**Section 1: Added note in Batch Submissions paragraph,** **Section 4: Updated frequency of Network Provider and Subcontractor Registry to semi-weekly** **Appendix D: Updated Claim Detail record layout (CCN-O-010, CCN-W-010).** **Appendix D: Updated 820 layout and added description of 820 adjustments process.** **Appendix D: Updated Provider Registry Edit Report (edit codes definitions) and added Provider Registry edit File layout** **Appendix D: Added entire section on Provider Registry Site File.** **Appendix I: turned edits status to O (off) on edit 078.** **Appendix K: Updated Recipient Type Case values table to add new codes 200 – 205.**	**Added note in Batch Submissions paragraph about dedicated dial-up lines for shared plans and BBS (claims submission to Molina). Also added a note about how plans may distribute claim types into submission files.** **Added new fields: Rx date, Rx days supply, Rx quantity, prescribing provider NPI and claim/encounter indicator to Claim Detail Record.** **On 820 format, changed definition of 2100B NM108, NM109 and RMR02. Added description (and example) of 820 adjustments records.**	**04/09/2012 – 04/23/2012**
Darlene White	**Appendix D**	**Modified Provider File layout to include Medicare-registered or other LLC NPI values,** **Modified 820 adjustments depiction to conform with HIPAA format:** **Removed DTM from void (ADX) set and added REF to adjustment set.**		**05/17/2012**

Darlene White		Updated occurrences of CCN to **BAYOU HEALTH, where applicable.**	**Waiver COA information is subject to change.**	
Darlene White	**Section 4** **Appendix D** **Appendix E** **Appendix K** **Appendix L** **Appendix M**	**p. 24-25, changed schedule of Provider Registry submission from semi-weekly to weekly.** **p. 64, changed CCN-O-010 and CCN-W-010 detail layout for Prescriber NPI (1171-1180) to BLANK value when not a pharmacy claim.** **p. 116-118, Registry File layout: added value X=Remove at position 610 and added new fields.** **Site File layout: added value X=Remove at position 371.** **p 185-189: Added HCBS Waiver COA information.** **p. 196, Shared Plan and FI Responsibility Chart** **Denied Claims Report Format**	**Added Chart** **Added Report Format**	**8/17/2012**
Darlene White	**Appendix D**	**Modified 820 layout to include 2 additional REF segments. Updated Prior Authorization File (FI to CCN) format to include Pharmacy PA (RxPA) information.**		**10/6/2012**
Darlene White		**Added PT=26 (pharmacy) to Provider Types table** Changed Provider Registry field NPPES Enumeration Date to Optional (O).		**10/22/2012**
Darlene White	**Appendix K**	**Changed from CCNS2 to CCNS1 all AC=03, TC=055 codes in the crosswalk; Added AC=03, TC=134 (LaCHIP Affordable Plan) to the crosswalk**		**12/12/2012**
Darlene White	**Section 6**	**Medicare Recovery Process**		**4/29/2013**
Darlene White	**Section 7**	**Medical Documentation**		**4/29/2013**
Darlene White	**Section 1**	**Update of information contained in the claims history**		**4/29-2/2013**
Darlene White	**Section 1**	**Timely Filing Guidelines**		**4/29/2013**

Darlene White	**Appendix L**	**Updated Shared Responsibility Chart**	**Removed second line of claims edit (6th line from bottom)**	**4/29/2013**
Darlene White	**Appendix D**	**TPL File Format**		**4/29/2013**
Deborah Davis	**Appendix D**	**ICD-10 File Layout**	**Modifications for :** *Edit Code Detail (CCN-O-010 and CCN-W-010) Prior Authorization File (FI to CCN) Diagnosis File for Pre-Admission Certification (FI to CCN)*	**4/9/2014**
Deborah Davis	**Section 7**	**Medical Documentation**	**Updated Transplant Related Diagnosis Codes**	**4/9/2014**
Deborah Davis	**Appendix M**	**Denied Claims Report Format**	**Template and instructions are now on makingmedicaidbetter. com website**	**4/9/2014**
Deborah Davis	**Section 4**	**Report format for Denied Claims Report**	**Template and instructions moved to the makingmedicaidbetter. com website**	**4/21/14**

Contents

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Overview

Introduction

Beginning December 2011, DHH will phase-in implementation of member enrollment services into Medicaid's Coordinated Care Network (CCN) Program, aka BAYOU HEALTH. Member enrollment into the BAYOU HEALTH Program will be phased in based on DHH's GSAs. Services will begin February 1, 2012 for GSA-A; April 1, 2012 for GSA-B; and June 1, 2012 for GSA-C.

A Shared Savings CCN (CCN) differs from the current CommunityCARE 2.0 program in that the CCN is a primary care case manager that provides enhanced primary care case management in addition to being the entity contracting with primary care providers (PCP) for PCP care management. The CCN will expand the current roles and responsibilities of the primary care providers through the establishment of patient-centered medical homes and create a formal and distinct network of primary care providers to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

DHH, or its FI, shall make monthly enhanced primary care case management fee payments to the CCN and lump sum savings payments to the CCN, if eligible. The enhanced primary care case management fee shall be based on the enrollee's Medicaid eligibility category as specified in the RFP and paid on a PMPM basis. The enhanced primary care case management rate schedule is provided in the CCN-S RFP in Appendix E – Mercer Certification, Rate Development Methodology and Rates). In order to be eligible to receive these payments, the CCN must enter into a Contract with DHH and remain in compliance with all provisions contained in the Contract.

In accordance with the requirements set forth in the Contract, the CCN shall specify the timeframe in which a provider has to submit a clean claim with the CCN. The CCN must accept and preprocess claims within two (2) business days of receipt. Preprocessed approved claims will be paid on a fee-for-service (FFS) basis by DHH. DHH shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

The CCN shall notify providers to file all claims directly to the CCN for services provided to CCN members. Claims submitted directly to DHH's FI for a CCN member will be denied. The CCN shall specify the timeframe in which a provider has to submit a clean claim with the CCN. The CCN must accept and preprocess claims within two (2) business days of receipt. The CCN shall preprocess all claims and submit claims for payment on a fee-for-service basis to the FI.

DHH Responsibilities

DHH is responsible for administering the state's Coordinated Care Network Program. Administration includes data analysis, production of feedback and comparative reports to CCNs, data confidentiality, and the contents of this CCN 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 CCN activities. DHH's claim responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with each CCN, and CCN training. DHH is responsible for reimbursing providers for services rendered to CCN enrollees. DHH will update the Systems Companion Guide on a periodic basis.

Fiscal Intermediary (FI) Responsibilities

Molina is under contract with DHH to provide Louisiana Medicaid Management Information System (LMMIS) services including the acceptance of electronic claim reporting from the CCNs. DHH's FI will be responsible for accepting, editing and storing CCN 837 claims data. The FI will also provide technical assistance to the CCNs 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 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

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

Proprietary Reports

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

Enrollment Broker Responsibilities

The Enrollment Broker shall make available to the CCN, 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.

CCN Responsibilities

It is the CCN's responsibility to ensure accurate and complete claims reporting from their providers.

The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts provider claims, verifies eligibility, validates prior authorization, preprocesses, and submits claims data to DHH's FI that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of the RFP and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

Claims Preprocessing

As it relates to the CCN Program, is the processing of all claims by a CCN for services provided to CCN members by Medicaid providers to verify service authorizations and ensure only clean claims are submitted to the FI for payment. Preprocessing will include, but not be limited to the following steps:

- Receipt of paper and EDI claims from providers
- Receipt of paper attachments necessary to substantiate a claim, if necessary
- Claims imaging, Image indexing, OCR and archiving
- Claims data capture
- Validation of eligibility
- Validation of prior authorization number
- Validation that visits do not exceed the number authorized or allowed by the CCN
- Generation of a claims internal control number (ICN)

Claims Submission

The CCN must accept and preprocess electronic claims within two (2) business days of receipt and paper claims within four (4) days of receipt. Preprocessed approved claims will be paid on a fee-for-service (FFS) basis by DHH. The ICN should reflect the Julian date that the claim was preprocessed.

Timely Filing Guidelines

Located in the Louisiana Medicaid Program General Information and Administration Manual, found at www.lamedicaid.com, Chapter 1 Section 1.4, is the Policy on Timely Filing. Specifically, we are addressing claims exceeding the initial timely filing limit, as Medicaid claims received after the initial one year timely filing limit (one year from the date of

service or date of retroactive certification) cannot be processed unless the provider is able to furnish documentation that verifies timely filing. The Shared Plan Responsibility Chart views this as both a Plan and Molina responsibility. Therefore, the following process shall be adhered to:

1. Requests from providers submitted to Shared Plans must include documentation as outlined in policy.
2. Shared Plans must review documentation to make a determination if the submission warrants an override of the edits (272 - Claim exceeds one year filing limit and 371 – Attachment requires review/filing limit) for Molina to adjudicate the claim.
3. If the Shared Plans approve the override, a PA Number, specifically "**987654321**" must be placed by the Shared Plan in the PA field. Use of this number in Molina's system will trigger the override, for adjudication. In instances where the claim requires prior authorization review by the plan, and if the review is approved, the plan should use the specific PA number above, rather than another one.
4. There is no need for the Shared Plans to submit documentation to Molina for these claims. The presence of the PA number signifies that the Plan has reviewed the documentation transmitted with the claim resubmission and confirmed that the claim was originally submitted timely.
5. Shared Plans need to build in a process to address claims received from a provider within 1-7 days of the 365 day limit. Given the Shared Plans 2 to 4 day preprocessing timeframe, it may be necessary to place the PA number on these claims, to avoid inappropriately forcing a 272 denial to occur within Molina's system based on their received date of the claim and their populating of a new ICN.

Twenty-four (24) Month Claims History

The 24 months claims historical file, which includes behavioral health, format is located in Appendix D under the heading Claim Detail (File CCN-W-010). This file will be sent for each recipient at the onset of enrollment into the CCN, and then on a weekly basis.

Batch Submissions

The BAYOU HEALTH Shared Plan may submit batch claims, up to 99 files per day. Batch encounters maximum recommended file size is 25 MB.

Using the Molina Bulletin Board System (BBS) to submit production claims; the Shared plans may use these DID (direct inward dial) phone numbers. Either number can be dialed and it will roll over to the other if not busy.

The new DIDs are 225-216-6410 and 225-216-6411.

Files should be sorted and separated in the following manner:

Transaction	Claim Type	Name	File Extension	Sample file name
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
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
837I	06	Home Health Bill Type 1st 2 digits of Bill Type=33	HOM	H4599999.HOM

834 Race/Ethnicity Codes

The Louisiana specific race/ethnicity codes have been mapped to the National 834 codes. CCNs are to pay particular attention to this section of the 834 Companion Guide, as you are required to crosswalk codes based on that instruction.

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Transaction Set Supplemental Instructions

Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. 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.

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 CCNs to complete this mapping.

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

In one rule, HHS is adopting X12 Version 5010 for HIPAA transactions. For Version 5010, the compliance date for all covered entities is January 1, 2012.

The ANSI ASC X12N 837 (Healthcare Claim Transactions – Institutional, Professional, and Dental) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12N National Implementation Guide. The ANSI ASC X12N Implementation Guides can be accessed at http://www.wpc-edi.com/content.

File Transfer

The CCN 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 a Virtual Private Network (VPN), that are in use at the start of the Systems Readiness Review activities.

Prior Authorization

The CCN-S prior authorization number is to be populated in loop 2300, PRIOR AUTHORIZATION OR REFERRAL NUMBER, REF02, data element 127. The prior authorization number may not exceed 16 digits and must be in a numeric format. A reference identification qualifier value of G1 is to be used in REF01, data element 128.

Internal Control Number

The CCN ICN is to be populated in loop 2400, Segment REF02 Qualifier 6R Data Element: Line item control number.

Molina Companion Guides and Billing Instructions

Molina, as DHH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 997 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.

Professional Identifiers

CCNs are required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each claim/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 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 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.

Transaction Type

The following tables provide guidance on the use of 837s. Please note that this guidance is subject to change.

The following provider types use 837I:

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

The following provider types use 837P:

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
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services (EarlySteps)
30	Chiropractor and Chiropractor Group

Provider Type	Description
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
46	Case Mgmt – HIV
51	Ambulance Transportation
57	OPH Public Health Registered Nurse
61	Venereal Disease Clinic
62	Tuberculosis Clinic
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
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
81	Case Mgmt - Ventilator Assisted Care Program
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan

Provider Type	Description
	"638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care
AS	OPH Public Health Clinic
AU	Public Health Registered Dietitian

The table below provides guidance on specialty and associated provider types. Please note that this guidance is subject to change. At present, DHH Provider Specialty and Provider Type Crosswalk:

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

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

Specialty	Description	Associated Provider Types
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
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

Specialty	Description	Associated Provider Types
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
1G	Pediatric Endocrinology	19,20
1T	Emergency Medicine	19,20
2E	Endocrinology and Metabolism	19,20
2H	Hematology	19,20
2J	Oncology	19,20
2I	Infectious Diseases	19,20
2M	Rheumatology	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
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38

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

Claim Adjustments Information

In order to establish claim adjustments or voids, please use the HIPAA 5010 Loop 2300 CLM (claim information) field CLM05-03 Claim Frequency Type Code. Louisiana Medicaid MMIS only accepts types ORIGINAL, CORRECTED, VOID. This is true for 837I and 837P transaction formats. The table below depicts the specific elements that should be addressed on an adjustment transaction.

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. Louisiana Medicaid MMIS only accepts types ORIGINAL, CORRECTED, VOID.
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 **Molina** adjudication system and printed on the remittance advice or included in the 835 (or included in the claims history file) for the previously submitted claim that is being adjusted by this claim.

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Repairable Denial Edit Codes and Descriptions

DHH has modified edits for claims processing. In order to ensure DHH has the most complete data for rate setting and data analysis, the provider and/or the CCN is to repair as many edit codes as possible. The table below represents the edit codes that must be corrected with assistance from the CCN.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES) EDIT DESCRIPTION
110	REBILL OB/ABORT D&C
161	HOSP-STAY-REQUIRES-PRECERT
187	PA-THRU-CLAIM-THRU-NOT-SAME
191	PROC-REQUIRES-PRIOR-AUTH
265	SURG REQUIRES PA-0
468	JUSTIFY EYEGLASSES
469	EYEWEAR DENIED
512	VNS REPROGRAMMING
538	REVIEW-DIAG-MED
621	RESUBMIT-WITH-REPORTS
627	SEND MED NECESSITY
664	1 PAYABLE/180 DAYS
770	PERTINENT HIST/REQ
786	UNKNOWN ABBREVATION
950	OPERATIVE-REQUESTED

Claim Correction Process

DHH's FI will submit remittance advices to the providers the day after they are produced by the MMIS adjudication cycle via the web. The CCNs are to assist providers with obtaining the required or missing information and resubmitting the claims in accordance with an approved quality assurance plan.

See Appendix I for a list of CCN-S program-specific edit codes with their dispositions.

4

Files and Reports

The following list of electronic files or reports are to be submitted by CCNs, DHH and the Enrollment Broker. The format and/or layout requirements for each file or report are located in either this Guide, the Quality Companion Guide, or on the makingmedicaidbetter.com website. As the following list may not be all inclusive, it is the CCNs responsibility to ensure that all required files or reports, as stated in the RFP, are submitted to DHH in a timely manner.

Unless otherwise specified, deadlines for submitting files and reports are as follows:

- Daily reports and files shall be submitted within one (1) business day following the due date;
- Weekly reports and files shall be submitted on the Wednesday following the reporting week;
- Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;
- Quarterly reports and files shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;
- Annual reports and files shall be submitted within thirty (30) calendar days following the twelfth (12th) month; and
- Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

Responsible Party	Receiving Party	File/Report Name	Frequency
DHH-FI	EB	New Enrollee File (to CCN via 834)	Daily
Enrollment Broker	CCN and DHH-FI	Member Linkage File (to CCN via 834)	Daily

Responsible Party	Receiving Party	File/Report Name	Frequency
Enrollment Broker	CCN and DHH-FI	Member Disenrollment File (to CCN via 834)	Daily
DHH-FI	CCN	CCN-S Monthly PMPM Reconciliation File (820 File)	Monthly
CCN	DHH-FI	Network Provider and Subcontractor Registry Master and Site Files	At Readiness Review and weekly thereafter
DHH-FI	CCN	Claims Historical Data & Immunization Data	Prior to Readiness Review and weekly thereafter
DHH-FI	CCN	Medicaid Prior Authorization and Pre-admission certification File	Weekly
DHH-FI	CCN	Medicaid Provider Enrollment File	Weekly
DHH-FI	CCN	Medicaid Provider Negotiated Rates File	Monthly
DHH-FI	CCN	Medicaid CLIA File	Yearly
DHH-FI	CCN	Medicaid Procedures that require PA	Monthly
DHH-FI	CCN	Medicaid Diagnoses that require Pre-Admission Certification (Precert)	Monthly
CCN	DHH-FI	Quality Profiles File	Quarterly
CCN	DHH	Denied Claims Report	Monthly

See Appendix D for format and layout descriptions of these files.

The template and instructions for the Denied Claims Report can be found on makingmedicaidbetter.com website.

5

Transaction Testing and EDI Certification

Introduction

CCNs are required to undergo Trading Partner testing with the FI prior to electronic submission of claims data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, CCNs are requested to send real transmission data. The FI does not define the number of claims in the transmission; however, DHH will require a minimum set of claims for each transaction type based on testing needs.

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

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. Please refer to Appendix F for 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 claims 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 CCN, 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 CCN 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 claims.

- Molina requires CCNs 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 claims, the test claims should 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 claims will be submitted until an acceptable test run is completed. **This test submitter number (4509999) should be used for submission of test claims only!**

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

Once a CCN 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 claims into a preprocessor production run. The preprocessor generates an claims data file and one report. The Claims Transmittal Summary report, which lists whether a provider's batch of claims has been accepted or rejected, is generated for each submission. If a provider's claims are rejected, the provider number, dollar amount and number of claims are listed on the report.

CCNs 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 detail in Appendix F.

Timing

CCNs 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 located at:
www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm for specific instructions.

6

Medicare Recovery Process

Each quarter in a calendar year, Molina will run a Medicare Recovery Process. The basic concept of the process is that the search finds recipients who are retrospectively enrolled in Medicare (QMB, SLMB, Part A, B, etc.) and identifies any FFS Medicaid claims, including PMPM payment, and generates voids to 'recover' the payments.

The process takes Molina 2 weeks, the first week to identify the claims to be voided, and the 2nd week to process the voids. Each provider impacted by a claim recovery, receives the report (CP-0-12D) via the RA.

For Bayou Health Plan, Molina generates an 820 file, with the detail information regarding the voids for the past PMPM payments. 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

The Shared Plans actions when they receive the report and/or the 820 file, is to note that the recipients are identified as Medicare eligible and solicit the Enrollment Broker to send disenrollment information.

The report contains the following data elements:

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

7

Medical Documentation

During preprocessing, Shared Plans receive medical documentation from providers to make a medically necessary determination prior to electronic submission of clean claims to the FI. Instruction is listed below:

Prior Authorized Services

For claims that are prior authorized (as indicated on the fee schedule):

- The Health Plan shall identify these during preprocessing
- The claim and documentation shall be reviewed and the Health Plan shall verify the service provided is consistent with the service authorized and all necessary documentation has been provided.
- If the documentation was not submitted or is incomplete, the health plan shall deny the claim for lack of necessary documentation
- If verified as appropriate the plan shall forward the claim to Molina with the appropriate PA number and the ICN shall reflect that the documentation was received
    i. The documentation must be maintained by the plan and made available to DHH if requested.
    ii. The documentation is **not** forwarded to the FI

Consent Forms

For claims requiring a consent form (sterilization, abortion):

- The Health Plan shall identify these during preprocessing
- The documentation shall be reviewed and verified by the Health Plan
- If the required consent form was not submitted or is incomplete, the health plan shall deny the claim for submission of the necessary documentation.
- If verified as appropriate and complete the plan shall forward the claim to Molina and the ICN shall reflect that the consent form was received and verified by the plan.
    i. These forms must be maintained by the plan and made available to DHH if requested.
    ii. The consent form is **not** forwarded to the FI.

Manually Priced Services

For claims that require Manual Pricing (as indicated on the fee schedule)

- The Health Plan shall identify these during preprocessing
- If documentation was not submitted, the health plan shall deny the claim back to the provider requesting additional documentation as described in the Professional Services provider manual.
- If documentation is submitted with the claim, the shared plan shall forward the claim to Molina indicating in the ICN that the documentation was submitted.
    i. The health plan shall upload an electronic version of the corresponding documentation to Molina via the SFTP. (Jeff is developing a naming convention for document submission)
    ii. The documentation must be maintained by the plan and made available to DHH if requested.
- Molina will price according to the documentation submitted or if the documentation is insufficient, Molina will deny the claim with an explanation of denial and instructing the provider to resubmit the claim and needed documentation to the appropriate HEALTH PLAN.

Medical Review

For claims that require Medical Review (as indicated on the Fee Schedule)

- The Health Plan shall identify these during preprocessing
- If documentation was not submitted, the plan shall deny the claim back to the provider requesting additional documentation needed.
- If documentation is submitted with the claim, the plan shall conduct their own internal medical review to determine if the claim meets the plan's defined medical review criteria.
- If the documentation does not support the claim as medically appropriate, the plan shall deny the claim with an appropriate RA message.
- If Med Review determines the claim appropriate, the health plan shall forward the claim to Molina indicating in the ICN that the documentation was submitted and reviewed.
    i. These forms must be maintained by the plan and made available to DHH if requested.
    ii. The consent forms is **not** forwarded to the FI

DHH approved Transplants

For claims related to DHH Approved Transplants (prior to 2/1/12)

- The Health Plan shall identify these claims during preprocessing either by submission of a copy of the original DHH approval letter with the claim or by diagnosis code
- If the DHH Approval Letter is not submitted with the claim, the plan shall deny the claim back to the provider requesting the document.

- If the DHH Approval Letter is submitted with the claim, there is no secondary review needed by the Plan. The Plan however will need to place a PA number on the claim, and electronically submit the claim to Molina.
    i. These DHH Approval Letters must be maintained by the plan and made available to DHH if requested.
    ii. These Approval Letters are not be forwarded to the FI.

Transplant Related Diagnosis Codes

996.8 Complications of transplanted organ
996.80 Transplanted organ, unspecified
996.81 Kidney
996.82 Liver
996.83 Heart
996.84 Lung
996.85 Bone Marrow
996.86 Pancreas
996.87 Intestine
996.88 Organ Stem Cell
996.89 Other specified organ

S0092 Transplant From Live Non-Rel Donor
S0093 Transplant From Cadaver
S362 Heart Revascularization by Arterial Impl
S3955 Reimplantation of Aberrant Renal Vessel
S5281 Reimplantation of Pancreatic Tissue

V420 Kidney Transplant Status
V421 Heart Transplant Status
V422 Heart Valve Transplant
V423 Skin Transplant Status
V424 Bone Transplant Status
V4282 Stem Cell Transplant Status
V4283 Pancreas Transplant Status
V4284 Org/Tissue Repace Transplant –Intest
V4289 Organ-Tissue Transplant Nec
V429 Transplant Status Nos
V4587 Transplanted Organ Removal Status
V4983 Awaiting Organ Transplant Status
V5844 Aftercare Follow Organ Transplant

Medical Data Review Files

Below is the naming convention for the medical data review files which the Plan sends to the FI, and a couple of other guidelines:

- The file naming convention that should be followed for documentation files is:
  PPPPPPP-**NNNNNNNNNNNNNNNNNNN**-**DDDD**.pdf
  Where **PPPPPPP** is the Plan ID (which is 2162438 for UHC and 2162446 for CHS), **NNNNNNNNNNNNNNNNNNN** represents the plan's 20-digit claim ICN for which the document is associated, and **DDDD** represents a 3- or 4-character document descriptor that has one of the following values:.

  SURG = surgical notes
  LAB = lab notes
  PATH = pathology notes
  OFF = MD office notes
  ANES = Anesthesia notes
  RAD = radiology notes
  OTH = other service notes.

- File types should always be PDF.

- Plans should submit only one file type per ICN, when applicable. If a plan obtains 2 sets of surgical notes for a given service (claim), then the plan should combine those notes into a single SURG file, associated with the specific claim.

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.
997 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 997 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 CCNs, the contract signed by or on behalf of the CCN 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 CCN 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 CCN 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 CCN to Medicaid CCN 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 CCN 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 CCN are based on data that is submitted by the CCN, 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 claim 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 claims 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 CCN or other managed care program.
Enrollment	The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a CCN.
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 CCN.
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., CCN) performance.
HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care

	transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Implementation Date	The date DHH notifies the CCN 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 CCN 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 CCN 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 CCN 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 CCN to supply a range of primary and acute health care services. Also referred to as Provider Network.
Newborn	A live infant born to a CCN member.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the CCN.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a CCN 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 Case Management (PCCM)	A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.
Primary Care Provider (PCP)	An individual physician or other licensed nurse practitioner responsible for the

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

	service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which a CCN 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 CCN-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 CCN's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of CCN 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 CCN'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 CCN, 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 CCN, 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 CCN 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 CCN 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 CCN.
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Start-Up Date	The date CCN 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 CCN from the provider and/or switch vendor until the CCN hands-off a response to the provider and/or switch vendor.
System Unavailability	Measured within the CCN's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading

	partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level.
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 Molina and what is their role with CCNs?

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 should I use?

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services. The transactions CCNs will use will depend upon the type of service being reported.

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 CCNs 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 claim 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 claim.

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 claim data. You are assigned this ID prior to testing.

Appendix C

Code Sets

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

When conducting 837 transactions, DHH requires CCNs to adhere to HIPAA standards governing Medical data code sets. Specifically, CCNs 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. CCNs 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 CCNs to adopt the following standards, or their successor standards, for Medical 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 DHHS, 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 CCNs 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 Reports and Files

NOTE:
File types impacted by ICD-10 are:

- Edit Code Detail (CCN-0-010 and CCN-W-010)
- Prior Authorization File (FI to CCN)
- Diagnosis File for Pre Admission Certification (FI to CCN)

Claims Summary — Molina FILE (FI to CCN)

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

This report will serve as the high-level error report for the CCNs 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.

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	8	Numeric, format YYYYMMDD

Column(s)	Item	Notes	Length	Format
		Molina.		
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 detail portion of the file is sorted by this number	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency	2	Numeric

Column(s)	Item	Notes	Length	Format
		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		
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.

Claim 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 CCNs 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

Column(s)	Item	Notes	Length	Format
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
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		8	Numeric

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

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

Claim Detail — Molina file (FI to CCN)

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

This report lists claim detail as adjudicated in the MMIS for the initial 24 month recipient history. This report will be distributed as a delimitated text file and is a detailed listing by header and line item of edits applied to the claims data. Claims history includes behavioral health claims/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

Column(s)	Item	Notes	Length	Format
		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 ^

Column(s)	Item	Notes	Length	Format
				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

Column(s)	Item	Notes	Length	Format
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 CCN on claim	14	Numeric with decimal point, left zero-fill.
243	Delimiter		1	Uses the ^ character value.
244-248	Procedure Code	As submitted by CCN 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 CCN 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 1	ICD-9-CM diag code, if available (this represents the primary diagnosis)	5	Character, does not include the decimal.

Column(s)	Item	Notes	Length	Format
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 H
338	Delimiter		1	Uses the ^ character value.
339-340	Category of Service		2	See Category of Service values in Appendix H
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		2	See Provider Type

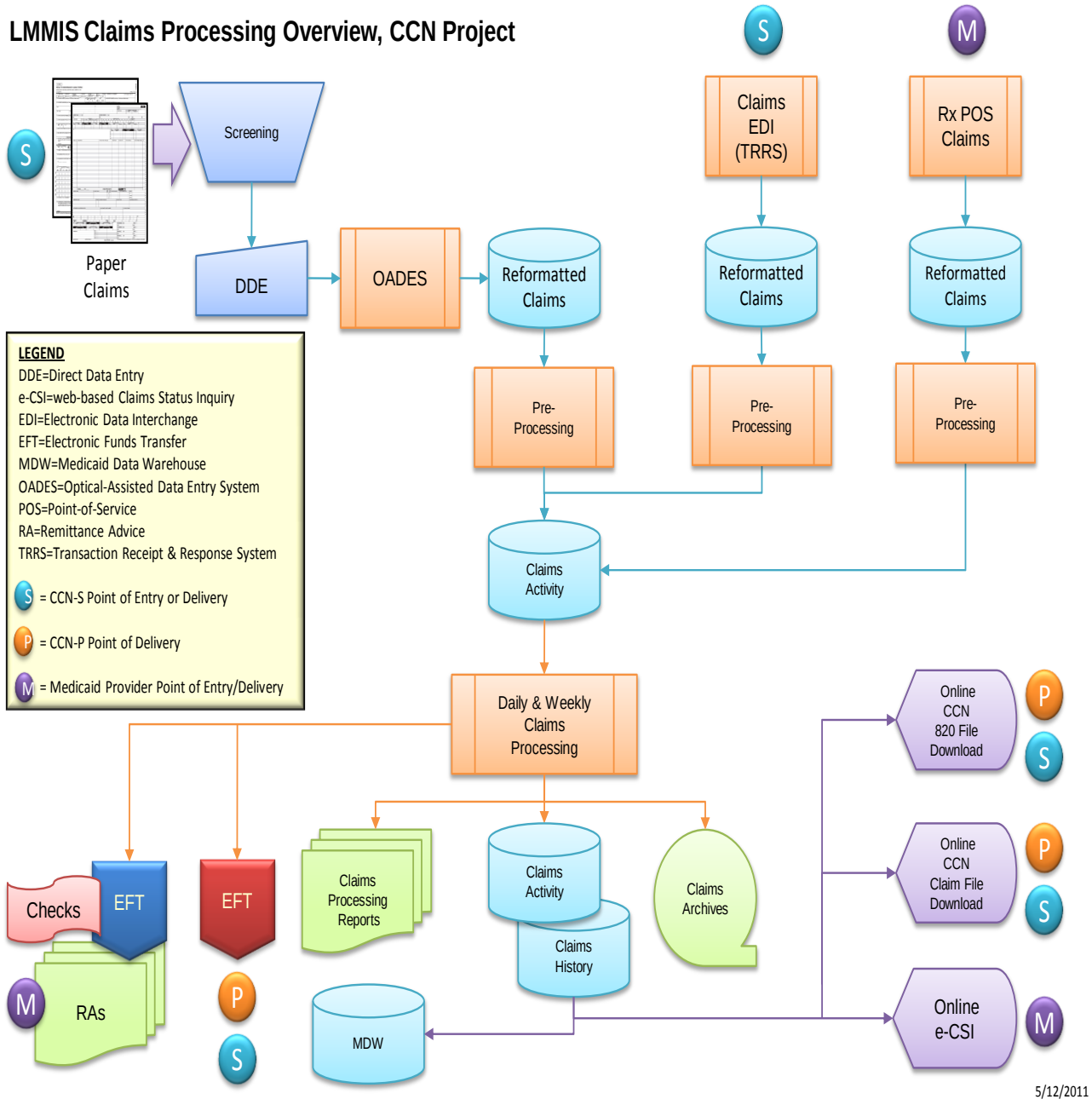
Column(s)	Item	Notes	Length	Format
	Type			values in Appendix H
366	Delimiter		1	Uses the ^ character value.
367-368	Servicing/ Attending Provider Type		2	See Provider Type values in Appendix H
369	Delimiter		1	Uses the ^ character value.
370	Claim Status		1	Numeric: 1=Paid Original 2=Adjustment/Void 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

Column(s)	Item	Notes	Length	Format
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 (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;	8	Numeric, YYYYMMDD

Column(s)	Item	Notes	Length	Format
		otherwise, will have 0 value		
1153	Delimiter		1	Uses the ^ character value.
1154-1157	Rx Days Supply	Only populated on Pharmacy claims; otherwise, will have 0 value	4	Numeric, left fill with zero.
1158	Delimiter		1	Uses the ^ character value.
1159-1169	Rx Quantity	Only populated on Pharmacy claims; otherwise, will have 0 value	11	Numeric with decimal point, left zero-fill.
1170	Delimiter		1	Uses the ^ character value.
1171-1180	Prescribing Provider NPI	Only populated on Pharmacy claims; otherwise, will have blank value	10	Numeric
1181	Delimiter		1	Uses the ^ character value.
1182	ICD Indicator	Used to identify whether ICD-9 or ICD-10 CM codes were submitted on claim/encounter	118	0=ICD-10 9=ICD-9
1183	Delimiter		1	Uses the ^ character
1184-1190	ICD-10-CM primary		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	ICD10-CM		7	Will contain spaces if only ICD-9 code is submitted. If ICD-10 code was submitted, it will not contain the period.
1199	Delimiter		1	Uses the ^ character

Column(s)	Item	Notes	Length	Format
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.

Claims Processing Flowchart



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 H
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix H
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment		8	Numeric, date

Column(s)	Item	Notes	Length	Format
	Effective End Date			value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-123	Provider Street Address (Servicing)		30	
124	Delimiter		1	Uses the ^ character value
125-154	Provider City (Servicing)		30	
155	Delimiter		1	Uses the ^ character value
156-157	Provider State	USPS abbreviation	2	
158	Delimiter		1	Uses the ^ character value
159-168	Provider Phone		10	Numeric
169	Delimiter		1	Uses the ^ character value
170-171	Provider Parish		2	See parish code values in Appendix H
172	Delimiter		1	Uses the ^ character value
173-181	Provider Zip Code		9	Numeric
182	Delimiter		1	Uses the ^ character value
183	Urban-Rural Indicator (applicable to hospitals only)		1	Character: 0=not applicable 1=urban 2=rural 3=sole community hospital
184	Delimiter		1	Uses the ^ character value
185-214	Provider Street Address (Pay-To)		30	
215	Delimiter		1	Uses the ^ character value
216-245	Provider City (Pay-To)		30	
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 ^

Column(s)	Item	Notes	Length	Format
				character value
260	Tax ID number (TIN) or SSN		9	Numeric, left fill with zeros
269	Delimiter		1	Uses the ^ character value
270	Medicare-registered or other LLC NPI number First occurrence		10	Numeric if present, otherwise spaces
280	Delimiter		1	
281	Medicare-registered or other LLC NPI number 2nd occurrence		10	Numeric if present, otherwise spaces
291	Delimiter		1	
292	Medicare-registered or other LLC NPI number 3rd occurrence		10	Numeric if present, otherwise spaces
302	Delimiter		1	
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

Column(s)	Item	Notes	Length	Format
379	Delimiter		1	
380	Medicare-registered or other LLC NPI number 11th occurrence		10	Numeric if present, otherwise spaces
390	Delimiter		1	
391	Medicare-registered or other LLC NPI number 12th occurrence		10	Numeric if present, otherwise spaces
401	Delimiter		1	
402	Medicare-registered or other LLC NPI number 13th occurrence		10	Numeric if present, otherwise spaces
412	Delimiter		1	
413	Medicare-registered or other LLC NPI number 14th occurrence		10	Numeric if present, otherwise spaces
423	Delimiter		1	
424	Medicare-registered or other LLC NPI number 15th occurrence		10	Numeric if present, otherwise spaces
434	Delimiter		1	
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 H
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix H
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-101	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 H.
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 Number Including Check Digits (9 digits)	S

Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. 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)	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=Reassociation Trace Number					
Sample: TRN*3*1123456789**~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace	S

				Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	
		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	D

				CCYYMMDD-CCYYMMDD	
1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*CCN-S of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	
	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	Administrative Fee Code (CCNS1 or CCNS2)	
	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, a value from 00 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) – a 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 Case Type (aka Type Case) – a 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 because it is not HIPAA-compliant for ADX)
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 this line to conform with HIPAA)
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 (Precert) 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		5	ICD-9-CM

Column(s)	Item	Notes	Length	Format
	Diagnosis Code (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 Precert Type	1=PA 2=Precert	1	Character
114	Delimiter		1	Uses the ^ character value
115-116	PA Type Or Precert Type	**Precert**: 03=Inpatient Acute **PA**: 04=Waiver 05=Rehab 06=HH 07=Air EMT 09=DME 10=Dental 11=Dental 14=EPSDT-PCS 16=PDHC 35=ROW 40=RUM 50=LT-PCS 60=Early Steps CM 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 PA transactions). For RxPA transactions, this field will contain the Therapeutic Class.	GEN ICU NICU REHAB PICU CCU TU=Telemetry LT=LTAC	5	Character
126	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				character value
127-136	PA Line Amount Used	For an approved PA or Precert line item, this field contains any amount used as a result of claims processing. For RxPA transactions, the first 6 digits of this field contain the HICL.	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-10 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	Dlimiter		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 (Precert) 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 H 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 H 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

Denied Claim Report (CCN to DHH)

On a monthly basis, DHH is interested in analyzing claims denied for the following reasons:

Denial Reason Code 1 - Lack of documentation to support Medical Necessity
Denial Reason Code 2 - Prior Authorization denied
Denial Reason Code 3 - Member has other insurance that must be billed first
Denial Reason Code 4 Claim was submitted after the timely filing deadline
Denial Reason Code 5 -Service was not covered
Denial Reason Code 6 - Other

The report shall be submitted monthly to the Plan Manager in an Excel Spreadsheet. The report shall include:

- Recipient ID
- Billing Provider NPI
- Servicing Provider NPI
- Plan Internal control number (ICN) for the claim
- Denial reason Code (as shown above 1-6)
- Claim type (DHH 2 digit code)
- Date of service
- Provider billed amount
- Date of receipt by the Health Plan
- Date Denied
- Primary diagnosis
- Secondary diagnosis (if applicable)
- CPT Procedure /HCPCS code(s)
- ICD-9 Surgical procedure code(s) (if applicable)
- Revenue code(s) (if applicable)
- Primary insurance carrier (TPL), if applicable

Note: Inpatient claims should be reported as a document item, while outpatient, home Health, rehab and professional claims should be reported based on each detail line item.

DHH requires Shared Plans to submit information on **all** claims denied during their pre-processing. The file format for this report can be found on makingmedicaidbetter.com website.

TPL File (FI to CCN)

On a weekly basis, the FI will submit a TPL file to all Plans. This file is placed on the Plan's FTP site. The file contains TPL information for all Medicaid members, and is not specific to a Plan's enrollment. The file format contains the following information:

```
01  EB-OTHER-INS-DETAIL.
    05  OTHER-INS-RECIP-ID-CURR        PIC X(13).
    05  OTHER-INS-RECIP-ID-ORIG        PIC X(13).
    05  OTHER-INS-TYPE                 PIC X(02).
    88  PRIVATE-TPL                    VALUE 'PR'.
    88  MEDICARE-PART-A                VALUE 'MA'.
    88  MEDICARE-PART-B                VALUE 'MB'.
    88  LAHIPP                         VALUE 'LH'.
```

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

Appendix E

Provider Directory/Network Provider and Subcontractor Registry

Shared Savings BAYOU HEALTH Plans (Plans) are required to contract with an adequate network of Primary Care Providers (PCPs) to ensure member access to primary care 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 PCPs. All contract providers in shared savings plans are required to be enrolled in Louisiana Medicaid. The Plans are required to provide DHH with a listing of all contracted providers.

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

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

Many of the data elements are publicly available from NPPES through the Freedom of Information Act (FOIA).. Any providers no longer taking patients must be clearly identified. Under the FOIA, CMS allowed disclosure of NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry became operational on September 4th and CMS posted the downloadable file on September 12th, 2007. The complete listing of data elements and file specifications are detailed in this Appendix.

It is the 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.(cst) 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
44	Home Health Agency
46	Case Mgmt - HIV

Provider Type	Description
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
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist

Provider Type	Description
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
18	Ophthalmology	20
19	Orthodontist	19,20
20	Orthopedic Surgery	19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	19

Provider Specialty	Description	Associated Provider Types
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 Chiropody	20,32
49	Miscellaneous (Admin. Medicine)	20
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified	40

Provider Specialty	Description	Associated Provider Types
	Prosthetist Orthotist	
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
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

Provider Specialty	Description	Associated Provider Types
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
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	38

Provider Specialty	Description	Associated Provider Types
	20 hrs week	
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 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	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				leading zeroes, be sure to use them.	
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the Legal Business Name for Organizations.		30	Character If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-30th characters=last name, If names do not fit in these positions, please truncate the end of the item so that it fits in the positions. **DO NOT include suffixes or titles in the last name see columns 761-765 Provider Suffix and 767-776 Provider Title**	R
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character	

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	(Telephone Number)				
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business Mailing Address (Fax Number)	Do not enter dashes or parentheses.	10	Numeric	O
215	Delimiter		1	Character, use the ^ character value	
216-245	Provider Business Location Address (First line address)	No P.O. Box here, please use a physical address.	30	Character	R
246	Delimiter		1	Character, use the ^ character value	
247-276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
					hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separate record.
366	Delimiter		1	Character, use the ^ character value	
367-376	Healthcare Provider Taxonomy Code 2	Use if necessary; otherwise leave blank.	10	Character	O
377	Delimiter		1	Character, use the ^ character value	
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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	O
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
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	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	**Y**=Yes, panel is open. **N**=No, panel is	1	Character	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		not open.			
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 patients	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 plan.** It should be left all zeroes if the	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				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	
612-619	CCN Enrollment Indicator Effective	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Date				
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 Number	This should represent the contract name/number that is established between the CCN and the Provider	30	Character	R, but you may enter 0s or spaces to indicator a non-contracted network provider.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
686	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
687-688	Provider Parish served – 3rd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
689	Delimiter		1	Character, use the ^ character value	
690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if	2	2-digit parish code value. See the Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		necessary; otherwise enter 00.			
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 the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider	Parish code	2	2-digit parish	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Parish served – 10th	value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.		code value. See the Companion Guide.	
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
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;	2	2-digit parish code value. See the Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		otherwise enter 00.			
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the 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 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	1	Numeric, value 0,1,2 or 3.	R

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
780	End of record delimiter		1	Character, use the ^ character value	

Provider Registry Edit Report (sample)

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


CCN ID: NNNNNNN - PROVIDER NAME FROM LMMIS PROVIDER FILE


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


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

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018=(R) Missing/Invalid BAYOU HEALTH Contract termination date
019=(R) Missing provider parish (at least 1 must be submitted)
020=(R) Invalid provider parish value (for a submitted value)
021=(R) Duplicate NPI records found. Only first one in the file is accepted
022=(R) Medicaid Provider ID (Other Provider Identifier) is not found on MMIS Provider File
023=(R) Missing/Invalid NPPES Enum Date
024=(R) Missing/Invalid Provider License Data
025=(A) NPI not found on LMMIS Provider Enrollment File
026=(R) BAYOU HEALTH provider not found on LMMIS Provider Enrollment File
027=(R) Unable to assign a Medicaid provider... too many collisions
028=(R) Enrollment Ind=N (new), but provider already exists on registry
029=(R) Enrollment Ind=C or D, but provider does not exist on registry
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 Maximus.

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	014 . (014 is not a

							Provider ID. It is the check-digit number. Check-digit provider numbers begin with 1 or 2, not with 00 or 01.	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 same address, based on columns 11, 13, 15, and 17.**	003, 013, 021
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-		011, 012

						state or '99' if out-of-state.		
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	^

Appendix F

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 claim data for storage in the MMIS claims history file. The plan consists of three (3) tiers of testing, which are outlined in detail below.

The 835 Companion Guide is located on the Molina Provider Web site, www.lamedicaid.com, at URL: http://www.lamedicaid.com/provweb1/HIPAABilling/HIPAAindex.htm

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each CCN must enroll with EDI to receive a Trading Partner ID in order to submit electronic claim data. In most cases, the CCNs 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 CCNs 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 should not be considered when determining whether a CCN has passed or failed the EDIFECS portion of testing.

EDI must certify each CCN prior to the MMIS receipt of claims via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 997 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 5010A (Addenda) format, not in the 4010 format. This phase of testing was designed to do the following:

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

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

Testing Tier II

Once each CCN has successfully passed more than 50% of their claim data claims through the preprocessors, Molina will process the claims through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the CCNs via IDEX. Each CCN is required to examine the returned 835s and compare them to the claim data claims (837s) they submitted to insure all claims that were submitted are accounted for in the data collection. Molina will send the new edit code reports to the CCNs 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 claim data claim in order to assist them with their research. Molina is available to answer any questions that any CCN may have concerning the edit codes.

Testing Tier III

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

Appendix G

Websites

The following websites are provided as references for useful information not only for CCN 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.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. Links available to CCN-S entities on the FI Provider Web site are:

Website Address	Website Contents
	• 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.cms.gov	This is the **CMS home page**.
http://www.wedi.org/snip/	This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will

Website Address	Website Contents
	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, claims, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.

Appendix H

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	Childrens' Choice Waiver
44	EPSDT - Personal Care Services

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

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	Indiv 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, Pre-paid)	
5R	CCN-S (Coordinated Care Network, Shared Savings)	1
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 is comprised of Regions 1 and 9
GSA - B is comprised of Regions 2, 3, and 4
GSA - C 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 I

Louisiana MMIS Claims Processing Edits

This list of edits is not complete, but demonstrates the edit dispositions as researched by DHH, Mercer and Molina.
Standard edits, such as recipient eligibility on DOS and provider enrollment on DOS still apply.

The following list of edits was updated on 11/29/2011 as a result of a meeting with DHH and Molina SMEs that occurred on 11/18/2011. This list is subject to change.

CCN Status values:
P=Pend, D=Deny, E=Educational, O=Off, T=Test (error is not set).

Edit Code	Short Description	Long Description	CCNS Status
010	**INV PRIOR AUTH DATE**	**PRIOR AUTHORIZATION DATE NOT NUMERIC**	**O**
076	INVALID-DME-PA-AMOUNT	INVALID DME PA AMOUNT (PRIOR AUTHORIZATION AMOUNT NOT NUMERIC)	P
078	RESUB W/ DOCUMENTS	RESUB W/ DOCUMNTS CALL 800-473-2783 (Transplants)	O
106	BILL PRV NOT PCP	BILLING PROVIDER NOT PCP OR SERVICE NOT AUTHOR BY PCP	D
110	REBILL OB/ABORT D&C	REBILL OB OR ABORTION D & C CPT CODE WITH REPORTS	O
147	REF/PCP NPI NO MATCH	REFERRING/PCP NPI MISMATCH	E
160	PRECERT-NOT-ON-FILE	PRECERT NUMBER NOT ON FILE	O
161	HOSP-STAY-REQUIRES-PRECERT	HOSPITAL STAY REQUIRES PRECERTIFICATION	D

162	PRECERT-NOT-APPROVED	PRECERT NOT APPROVED	O
163	CLAIM-DOS-NOT-PRECERT-COVERED	CLAIM DATE OF SERVICE NOT PRECERT COVERED	O
164	CLAIM > PRECERT LOS	CLAIM EXCEEDS PRECERT AUTHORIZED DAYS	O
165	SURG-REQUIRES-PRECERT	SURGERY REQUIRES PRECERT	O
166	PRECERT-RECIP-NOT-MATCHED	CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRECERT FILE	O
167	PRECERT-PROV-NOT-MATCHED	CLAIM PROVIDER ID DOES NOT MATCH ID ON PRECERT FILE	O
168	PRECRT SURG DATE ERR	CLAIM SURGERY DATE DOES NOT MATCH DATE ON PRECERT FILE	O
169	CUTBACK-TO-PRECERT-DAYS	DAYS CUTBACK TO PRECERT APPROVED DAYS	O
170	PRECERT-PEND-REVIEW	PRECERT PEND REVIEW	O
171	PRECERT-NOF-RESUBMIT	NO HOSPITAL PRECERT ON FILE; RESUBIT WITH DOCUMENTATION	O
172	CLM/PA DTE MUST MTCH	CLAIM DATES MUST MATCH PRIOR AUTHORIZATION DATES	O
187	**PA-THRU-CLAIM-THRU-NOT-SAME**	**CLAIM THRU DOS MUST = PA 30 DAY THRU PERIOD**	**O**
189	**PUT PA# IN BLOCK 23**	**CORRECT PA# MUST BE IN BLOCK 23 ON CLAIM**	O
190	PA-NOT-ON-FILE	PA NUMBER NOT ON FILE	O
191	PROC-REQUIRES-PRIOR-AUTH	PROCEDURE REQUIRES PRIOR AUTHORIZATION	D
192	PA-NOT-APPROVED	PA HAS NOT BEEN APPROVED	O
193	CLAIM-DATE-NOT-PA-COVERED	DATE ON CLAIM NOT COVERED BY PA	O
194	PA-ALREADY-CONSUMED	CLAIM EXCEEDS PRIOR AUTHORIZED LIMITS	O
195	PA-TOTAL-NOT-SPANNED	MUST HAVE SPANNING DOS IF BILLING FOR TOTAL AUTHORIZATION AMOUNT	D
196	PA-RECIP-ID-NOT-MATCHED	CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRIOR AUTHORIZATION FILE	O
197	PA-PROV-NOT-MATCHED	PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID	O
198	PA-PROC-NOT-MATCHED	PA PROCEDURE NOT SAME AS CLAIM PROCEDURE	O

203	PROVIDER ON REVIEW	PROVIDER ON REVIEW	P
214	PROV-ALLOW-ONE-PROC	PROVIDER ALLOWED 1 SERVICE PER RECIPIENT PER DAY	D
227	POSSIBLE-707	POSSIBLE 707 PEND (CLAIM IN PROCESS)	O
228	POSSIBLE-713	POSSIBLE 713 PEND (CLAIM IN PROCESS)	O
229	POSSIBLE-714	POSSIBLE 714 PEND (CLAIM IN PROCESS)	O
237	P/F PROV SPEC RESTRT	P/F PROVIDER SPECIALTY RESTRICTION	P
246	STAND-BY-CHGS	PROLONGED ATTENDANCE BILLED; PENDED FOR REVIEW	O
249	SURG-REQ-REVIEW	SURGERY REQUIRES REVIEW FOR ATTACHMENTS	E
250	DIAG-REQ-REVIEW	DIAGNOSIS/PROCEDURE REQUIRES REVIEW	E
251	DENIED-DUE-TO-DIAG	PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS	D
259	ANESTH-UNITS-REQ-REVIEW	ANESTHESIA UNITS/MINUTES REQUIRE MEDICAL REVIEW	O
260	ANESTHESIA-UNITS-NOF	ANESTHESIA BASE UNITS ARE NOT ON FILE	P
263	PROCEDURE-AGE-RESTRT	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD	O
264	PA-01 REQUIRES REVIE	PA-01 FORM REQUIRES REVIEW FOR VALIDITY	O
265	SURG REQUIRES PA-0	SURGERY DONE AS IP REQUIRES VALID PA-01 FORM	D
280	MANUAL-PRICE-PEND	MANUAL PRICING REQUIRED/HARD COPY BILL	P
284	MANUAL-PRICE-GR-BILLED	MANUAL PRICE EXCEEDS BILLED CHARGES	P
285	PAYMENT-GR-BILL-CHARGE	PAYMENT EXCEEDS BILLED CHARGES/REQUIRES REVIEW	P
320	REF-ASSIST-MISS-REF1	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 1	O
323	REF-ASSIST-MISS-REF2	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 2	O
324	REF-ASSIST-MISS-REF3	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 3	O

331	ABORTION JUST	DOES NOT MEET PROGRAM CRITERIA FOR ABORTION	E
332	STERILIZATION < 21	STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21	D
333	AUTH MINOR UNM MO	FOUND NO DOCUMENT/OVERRIDE CODE MINOR UNM MOTHER/UNBORN	O
334	CONSENT 30/180 DAYS	CONSENT MUST BE AT LEAST 30 DAYS BUT NO MORE THAN 180 DAYS	O
335	SERVICE LIMIT REVIEW	ATTACHMENT REVIEW SERVICE LIMITS	O
336	ABORTION-REQUIRES-REVIEW	ABORTION REQUIRES REVIEW	O
337	STERILIZATION-REQUIRES-REVIEW	STERILIZATION OFS FORM 96 REQUIRES REVIEW	O
338	HYSTERECTOMY-REQUIRES-REVIEW	HYSTERECTOMY REQUIRES REVIEW	O
347	EXCEEDS MAX 23 DAYS	EXCEEDS MAXIMUM MONTHLY DAYS	D
368	REASON-REF-MISS-REF1	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 1	O
390	SERV MAX 1 PER MO	SERVICE EXCEEDS MAXIMUM ALLOWABLE OF 1 PER MONTH	D
399	REASON-REF-MISS-REF2	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 2	O
400	REFER-PHYS-REQD	REFERRING/ATTENDING PHYSICIAN REQUIRED	O
402	NO-SERV-EXCEEDS-MAX	NUMBER OF SERVICES EXCEEDS STATE MAX/ CUTBACK APPLIED	E/D
403	MULTIPLE SURGERY	MULTIPLE SURGERY - PENDED FOR MANUAL PRICING	O
406	EXCEEDS TREATMENTS	EXCEEDS 3 CHIRO TREATMENTS SAME DAY	D
410	REASON-REF-MISS-REF3	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 3	O
411	REF-NAME-MISS-REF1	REFERRED TO NAME IS MISSING AND REQUIRED FOR REFERRAL 1	O
412	REF-NAME-MISS-REF2	REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #2	O
413	DME-REQUIRES-PRIOR-AUTH	DME REQUIRES PRIOR AUTHORIZATION	O
414	REF-NAME-MISS-REF3	REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #3	O

415	PA AMOUNT GR LEVEL3	PRIOR AUTHORIZED AMOUNT GREATER THAN LEVEL 3 CHARGE	O
416	REF-PHONE-MISS-REF1	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #1	O
417	REF-PHONE-MISS-REF2	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #2	O
418	REF-PHONE-MISS-REF3	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #3	O
419	OFS REV PA DT GT DOS	OFS TO REVIEW-PA DATE GREATER THAN SERVICE DATE	O
422	ONE H.HLTH NURSE/DAY	ONLY ONE HOME HEALTH NURSE VISIT ALLOWED PER DAY	O
423	ONE H.HLTH AIDE/DAY	ONLY ONE HOME HEALTH AIDE VISIT ALLOWED PER DAY	O
468	JUSTIFY EYEGLASSES	SEND DOCUMENTATION FOR MORE THAN 3 EYEGLASSES PER YEAR	O
469	EYEWEAR DENIED	LIMITATION MET - SUBMIT JUSTIFICATION FOR ADD'L EYEWEAR	E
470	SUBMIT-ANESTH-DOC	ATTACH ANESTHESIA RECORD AND DOCUMENT MEDICAL NECESSITY	O
477	JUSTIFY OVER 1/A/YR	SEND DOC TO JUSTIFY OVER ONE PROCEDURE PER YEAR	O
478	SONOGRAM-AND REPORTS	SEND WRITTEN SONOGRAM RESULTS WITH OP PATH AND HISTORY	E
488	ONLY-1ST DIAG,VS PD	KELOID TREATMENT-ONLY FIRST DIAGNOSTIC VISIT IS PAID	E
496	DOC MEDICA NECESSITY	SUBMIT DOCUMENTATION TO WARRANT MEDICAL NECESSITY	O
510	ALLOW 1 PER 7 YEARS	ONLY 1 OF THESE PROCS IN 7 YEARS PER RECIP/PROVIDER	D
512	VNS REPROGRAMMING	SUBMIT MEDICAL DOCUMENTATION TO JUSTIFY REPROGRAMMING	O
533	EXCEEDS MAX ER REVS	EXCEEDS MAXIMUM ER REVENUE CODES PER VISIT	O
534	PA-APRVD-PROC-DELETED	PRIOR AUTHORIZATION APPROVED PRIOR TO DELETION OF PROCEDURE CODE	O
538	REVIEW-DIAG-MED	REVIEW DIAGNOSIS AND/OR ATTACHMENT FOR MEDICAL NECESSITY	D
542	UNITS EXCEED DAILY MAX	UNITS EXCEED MAXIMUM ALLOWED DAILY LIMIT	D

564	MAX EXCEEDS LIFETIME	MAXIMUM SERVICES EXCEEDED-LIFETIME/CLAIMCHECK	D
565	MAX SERVICE SAME DAY	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK	D
597	PA/CLM MOD NOT SAME	PA MODIFIER DOES NOT MATCH CLAIM MODIFIER	D
599	SONOS NOT JUST	DOCUMENTATION DOES NOT JUSTIFY ADDITIONAL SONOGRAMS	O
616	ONE PANEL/PREGNANCY	ONLY ONE PRENATAL LAB PANEL PER PREGNANCY	D
620	PAN & IND CODE/ PANE	ONE URINALYSIS PER PREGNANCY PAYABLE	D
621	RESUBMIT-WITH-REPORTS	RESUBMIT WITH OPERATIVE AND PATHOLOGY REPORTS AND HISTORY	O
623	EXCEEDS ONE PER YEAR	SEND DOCUMENTAION TO JUSTIFY MORE THAN ONE PER YEAR	O
625	MED NEC INSUFFICIENT	DOCUMENTATION OF MEDICAL NECESSITY INSUFFICIENT	D
627	SEND MED NECESSITY	SEND PROOF OF MEDICAL NECESSITY AND EPSDT REFERRAL	O
628	NEED EPSDT & MED NEC	NEED EPSDT REFERRAL AND PROOF OF MEDICAL NECESSITY	O
640	EXCEEDS MAX,PHYS,YRS	EXCEEDS MAXIMUM ALLOWED BY SAME PHYSICIAN W/I 3 YEARS	E
641	EXCEEDS MAX/HOSPITAL	EXCEEDS MAXIMUM ALLOWED PER HOSPITALIZATION	E
642	1 CONSLT/PHYS/HOSP	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION	E
643	EXCEEDS DAY MAX VISI	EXCEEDS DAILY MAXIMUM ALLOWED VISITS	E
646	EXCEEDS DAY MAX VISI	EXCEEDS DAILY MAXIMUM VISITS PER PROVIDER/SPECIALTY	E
664	1 PAYABLE/180 DAYS	ONLY ONE (1) PAYABLE PER 180 DAYS	E
696	PROBLEM CODE PD 2YRS	PROBLEM ORIENTED CODE PAID WITHIN 2 YEARS	O
709	STERILIZATION-REVIEW	STERILIZATION CONSENT FORM INCORRECT/ILLEGIBLE	O
712	INITIAL HOSP INPT PD	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS	D
715	2ND. VISIT SAME DAY	FOUND DUPLICATE VISIT SAME DAY	O

726	MULTIPLE SURGERY	MULTIPLE SURGERY-PENDED FOR REVIEW	O
727	EXCEEDS DAILY MAX	EXCEEDS DAILY SERVICE MAXIMUM	E
730	**1 INP HSP VST PER DA**	**ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY**	**O**
734	EXCEEDS-MAX-UNITS-AL	RECIPIENT HAS EXCEEDED MAXIMUM ALLOWED SERVICES PER 6MO	E
739	EXCEEDS-MAX-UNITS-AL	RECIPIENT HAS EXCEEDED MAXIMUM ALLOWED SERVICES PER YR	E
742	ALLOW 1 PER 5 YEARS	ONLY 1 OF THESE PROCS ALLOWED IN 5 YEARS PER RECIP/PROV	D
743	PREG EXCEEDED	MAX PER PREGNANCY EXCEEDED	O
745	1/PREG-158A NEEDED	ONE ALLOWED/PREG.;158-A NEEDED FOR UNUSUAL SITUATIONS	O
748	1 DEL.ALLOW. 6MTH.SP	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN	D
751	HYSTERECTOMY-REVIEW	HYSTERECTOMY REQUIRED ACKNOWLEDGEMENT OR PROOF PREVIOUSLY STERILE	O
752	TL NEEDS OFS 96	STERILIZATION REQUIRES OFS FORM 96.	O
754	RVW READMIT/DSCHG DX	PEND FOR REVIEW OF READMIT/DISCHARGE DIAGNOSIS	E
756	DOC/READMIT SAME DAY	RESUBMIT WITH DOCUMENTATION OF DISC/READMIT SAME DATE	E
761	SEND DATED OP REPORT	SEND DATED OPERATIVE REPORT FOR DATE BILLED	O
762	SEND DATED NOTES	SEND SPECIFIC DATED NOTES FOR EACH DATE BILLED	O
769	REFERRED TO P.A.	TO BE REVIEWED BY PRIOR AUTHORIZATION;DO NOT RESUBMIT	O
770	PERTINENT HIST/REQ	RESUBMIT WITH PERTINENT HISTORY	O
771	SEND L & D RECORDS	RESUBMIT WITH LABOR AND DELIVERY RECORDS	O

778	CIRCLE UNLISTED DESC	CIRCLE UNLISTED CODE DESCRIPTION IN-OPERATIVE REPORT	O
782	SEND DATED NOTES	EXCEEDS SONOGRAMS/PREGNANCY IN 270 DAYS	O
783	EXCEEDS SONOS/270DAY	JUSTIFY ADDITIONAL SONOGRAMS W PERTINENT DATED NOTES	E
784	**EXCEEDS MO LIMIT**	**EXCEEDS MONTHLY LIMIT**	**O**
785	SERV REV/CHIRO CNSLT	SERVICE LIMIT REVIEW BY CHIROPRACTIC CONSULTANT	O
786	UNKNOWN ABBREVATION	RESUBMIT WITH ABBREVATION LEGEND	O
900	LIFETIME LIMITS-ONE	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED	O
901	UNITS WERE CUTBACK	SERVICE LIMITS EXCEEDED - PARTIAL/FULL CUTBACK APPLIED	E
904	SVC BEYOND TIME LIM	SERVICE PERFORMED BEYOND REQUIRED TIME SPECIFICATIONS	O
906	EXCEEDS MAX ALLOWED	EXCEEDS MAMIMUM ALLOWED	E
907	PHY/CLINIC OVER MAX	PHYSICIAN/CLINIC VISITS EXCEEDS ANNUAL MAXIMUM	E
908	HH VISITS OVER 50	HOME HEALTH VISITS EXCEEDS ANNUAL MAXIMUM ALLOWED (50)	D
911	HOSP DAYS OVER MAX	HOSPITAL DAYS EXCEED ANNUAL MAXIMUM ALLOWED	O
913	PHY/HOSP VIS OVER MX	PHYSICIAN HOSPITAL VISITS EXCEED ANNUAL MAXIMUM	O
915	**EMERG OP OVER 3**	**EMERGENCY OUTPATIENT VISITS EXCEED ANNUAL MAXIMUM (3)**	**O**
916	**NON-EMER OP OVER 12**	**NON-EMERGENCY OUTPATIENT VISITS EXCEED MAXIMUM (12)**	**O**
917	OVER LIFETIME LIMIT	LIFETIME LIMITS FOR THIS SERVICE HAVE BEEN EXCEEDED	D
923	CHIROP E&M VISIT MAX	CHIROPRACTIC E & M VISIT MAX REACHED	D
950	OPERATIVE-REQUESTED	ATTACH BOTH OPERATIVE AND HISTORY REPORT	O

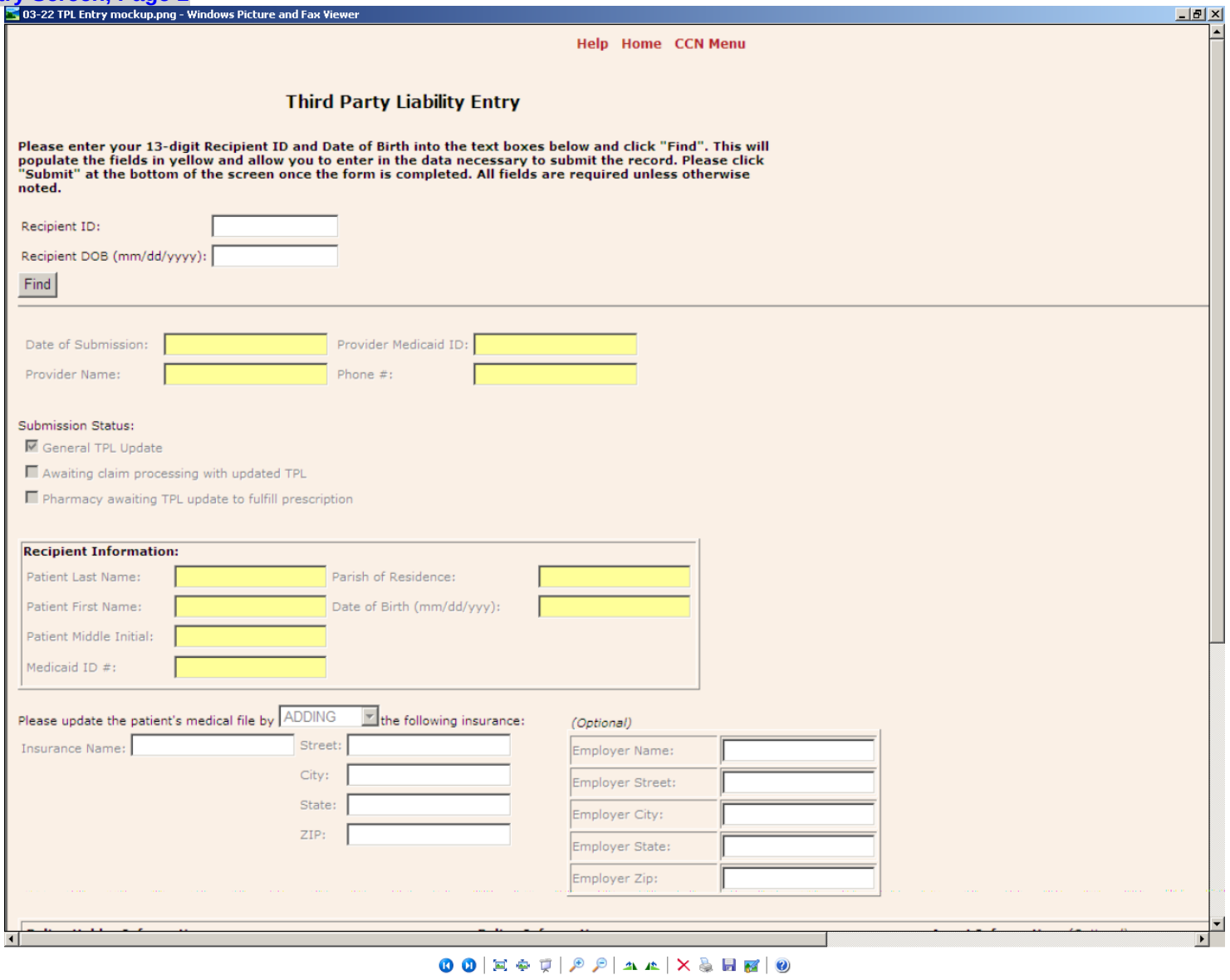
957	PROC/DIAG NO MED NEC	PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY	E
960	NEED-AUTH-AND-REPORT	ATTACH BHSF AUTHORIZATION LETTER AND OPERATIVE REPORT	E

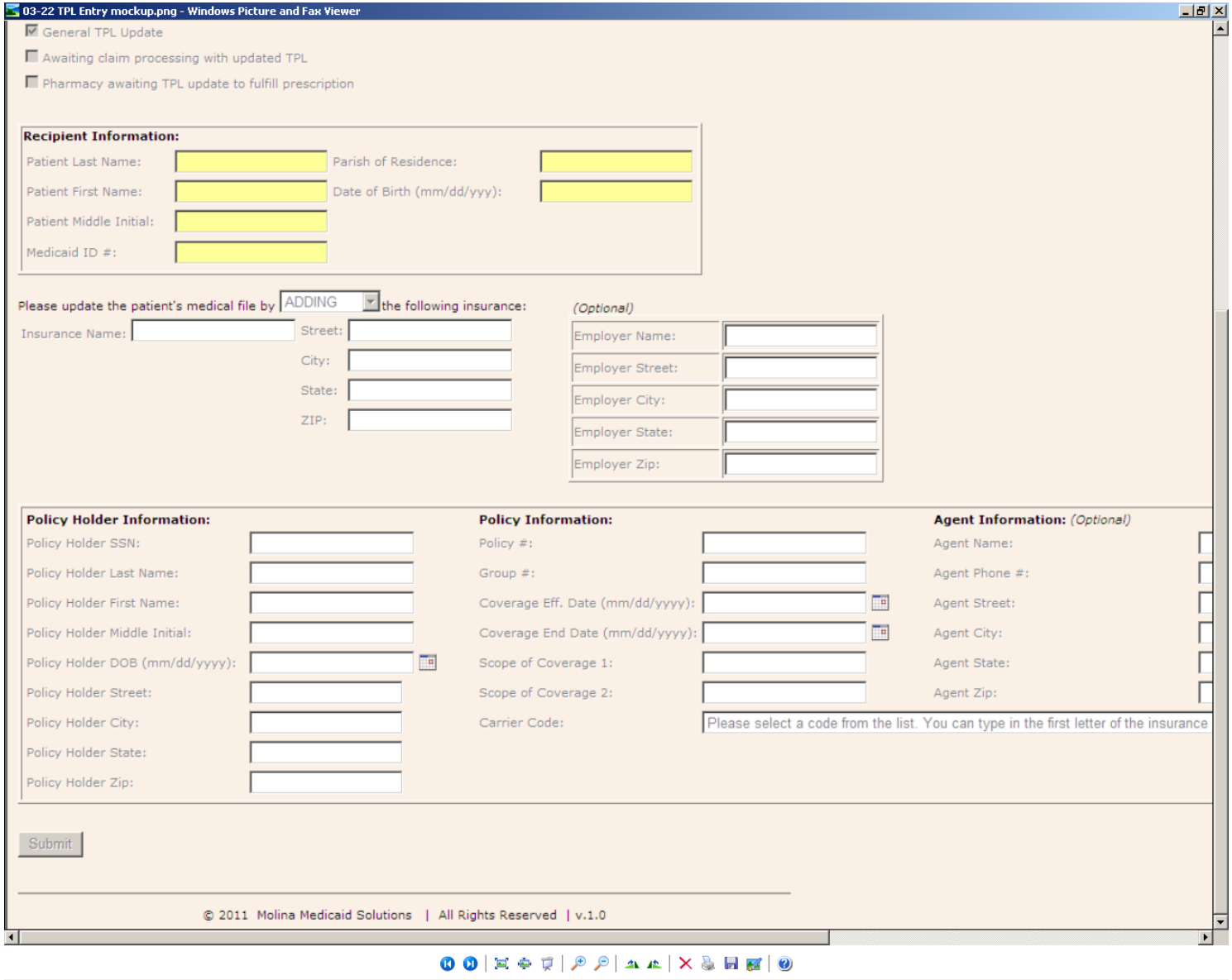
Appendix J

CCN TPL Discovery Web Application

The following web page screens depict the web application available to Bayou Health Plans to identify and report to DHH the TPL information for Medicaid recipients who are linked. Complete instructions are contained in the Bayou Health Applications User Manual, which is available at www.lamedicaid.com .

TPL Entry Screen, Page 1





TPL Entry Screen, Page 2

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 K

Administrative Fee Payments Crosswalk

CCN-S (Shared) Administrative Fee Payment Codes

Publication Date: 12/12/2012

SUBJECT TO CHANGE

CCNS1 Family and Children

CCNS2 SSI/Foster Care

Aid Category	Type Case	Age Type (M=months, Y=years)	Start Age	End Age (inclusive)	Sex (1=M, 2=F)	CCNS Code
01	001	M	000	002	1	CCNS2
01	001	M	000	002	2	CCNS2
01	001	M	003	011	1	CCNS2
01	001	M	003	011	2	CCNS2
01	001	Y	001	005	1	CCNS2
01	001	Y	001	005	2	CCNS2
01	001	Y	006	013	1	CCNS2
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01	003	M	003	011	1	CCNS2
01	003	M	003	011	2	CCNS2
01	003	Y	001	005	1	CCNS2
01	003	Y	001	005	2	CCNS2

01	003	Y	006	013	1	CCNS2
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01	059	Y	006	013	2	CCNS2
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HCBS Waiver Eligibles:

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06	082	Y	000	150	2	CCNS2
06	093	Y	000	150	1	CCNS2
06	093	Y	000	150	2	CCNS2
06	149	Y	003	150	1	CCNS2

06	149	Y	003	150	2	CCNS2
06	150	Y	003	150	1	CCNS2
06	150	Y	003	150	2	CCNS2
08	043	Y	003	150	1	CCNS2
08	043	Y	003	150	2	CCNS2
08	070	Y	003	150	1	CCNS2
08	070	Y	003	150	2	CCNS2
08	076	Y	000	018	1	CCNS2
08	076	Y	000	018	2	CCNS2
08	077	Y	000	018	1	CCNS2
08	077	Y	000	018	2	CCNS2
08	082	Y	000	150	1	CCNS2
08	082	Y	000	150	2	CCNS2
08	093	Y	000	150	1	CCNS2
08	093	Y	000	150	2	CCNS2
08	149	Y	003	150	1	CCNS2
08	149	Y	003	150	2	CCNS2
08	150	Y	003	150	1	CCNS2
08	150	Y	003	150	2	CCNS2
14	154	Y	021	150	1	CCNS2
14	154	Y	021	150	2	CCNS2
22	043	Y	003	150	1	CCNS2
22	043	Y	003	150	2	CCNS2
22	070	Y	003	150	1	CCNS2
22	070	Y	003	150	2	CCNS2
22	076	Y	000	018	1	CCNS2
22	076	Y	000	018	2	CCNS2
22	077	Y	000	018	1	CCNS2
22	077	Y	000	018	2	CCNS2
22	082	Y	000	150	1	CCNS2
22	082	Y	000	150	2	CCNS2
22	093	Y	000	150	1	CCNS2
22	093	Y	000	150	2	CCNS2
40	200	Y	000	021	1	CCNS2
40	200	Y	000	021	2	CCNS2

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 L

Shared Plan and FI Responsibility Chart

Function	Responsible Party	
	Shared Plan	Fiscal Intermediary
Claim Routing	X	
Fraud and Abuse Editing	X	
Member Selection	X	
Claims imaging, Image indexing, OCR and archiving	X	
Provider Selection	X	
Assignment of Plan ICN	X	
Rejection of non-clean claims	X	
Authorization matching and verification	X	
Claim editing:		
Duplicate Claims	X	X
Validation of NPI/Taxonomy	X	X
Medicaid Provider ID		X
NCCI edits		X
Member Eligibility	X	X
Timely Filing	X	X
Combination editing (ex. age, gender, etc.)	X	X
TPL denials		X
Non-covered services	X	X
Benefit limits	X	
Lack of documentation to support medical necessity	X	
Maximum units/frequency	X	
837 File generation	X	
837 File submission	X	
Receipt of 837 file & loading of claims to platform		X
Generation of 999 file		X
Process 999 acknowledgement file	X	
Member Liability (copays, coinsurance & deductible)		X
Application of Pricing		X
Coordination of benefits		X

Reimbursement/Payment policies		X
Generation of Provider RAs	X	X
Generation of Payment to Provider		X
Generation of 835 to Plan		X
Generation of 835 to Provider		X
Generation of Notice to Provider on Denials	X	

Appendix M

Denied Claims Report Format

The template and instructions for the Denied Claims Report can be found on www.makingmedicaidbetter.com.