Statewide Management Organization

Systems Companion Guide

December 2014
Version 1.0

Statewide Management Organization (SMO) Systems Companion Guide

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

Change Control Table

Author of Change	Sections Changed	Description	Reason	Date
Kerri Capello/ Michael Carrone	Version 1.0	Version 1.0	Version 1.0	10/15/2014

Statewide Management Organization (SMO) Systems Companion Guide

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Overview

Introduction

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

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

DHH has designated the Office of Behavioral Health (DHH-OBH) for the oversight of the Louisiana Behavioral Health Partnership (LBHP). The mission of DHH-OBH is to promote recovery and resiliency in the community through services and supports that are preventive, accessible, comprehensive, and dynamic.

DHH-OBH serves adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness, as well as individuals of all ages with addictive disorders (AD). DHH-OBH is responsible for planning, developing, monitoring, and

evaluating public mental health (MH) and AD services for the citizens of the State.

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

DHH, based on Federal Guidelines, requires the SMO to report encounters for all Medicaid eligible adults and children. Reporting of these encounters must include all paid and denied encounters for services provided to Medicaid eligible adults and children who receive services under the SMO contract.

A list of services requiring reporting can be found under the Encounter Definition segment of this Section. The SMO will be required to submit encounters to the Fiscal Intermediary (FI) using HIPAA compliant Provider-to-Payer-to-Payer Coordination of Benefits (COB) 837I (Institutional) and 837P (Professional) transactions. DHH has provided as quick references in Appendix A Definitions of Terms and Appendix B Frequently Asked Questions.

Encounter Definition

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

- Mental Health Hospitals (free standing or distinct part psychiatric unit)
- Mental Health Clinics
- Community Mental Health Centers
- Physicians, Advance Practice Registered Nurses (APRN)
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage & Family Therapists
- Licensed Addiction Counselors
- Substance use and Alcohol use Centers
- Behavioral Health Rehabilitation Agencies or Providers
- Psychiatric Residential Treatment Facilities
- Therapeutic Group Homes
- Family Support Organizations
- Transition Coordination Agencies
- Respite Care Services Agencies
- Crisis Receiving Centers
- Behavioral Health Rehabilitation Provider Agencies
- Psychiatric Emergency Rooms

- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)
- HCBS 1915c Waiver Services for Children
- Pharmacy

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

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

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

Rate Setting

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

In full consideration of the Contract services rendered by the SMO, DHH agrees to pay the Contractor monthly payments based on the number of enrolled Members (Adult and Child) and other relevant cohort distinctions (age, eligibility category, etc.).

Non-Risk Reimbursement

Regulations allow Prepaid Inpatient Health Plans (PIHPs) to receive reimbursement under a non-risk arrangement that differs from the State Plan reimbursement methodology but does not use actuarially sound capitation rates. Paying a PIHP on a non-risk basis allows the State to pay the entity an administrative, per-member-per-month (PMPM) payment and then reimburse the SMO on an invoice basis for services rendered. The plan may not be at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the non-risk Upper Payment Limit (UPL), as defined at §42 CFR 447.362. Comprehensive non-risk contracts are PIHP contracts per §42 CFR 438.2.

The payments under non-risk contracts are not subject to the actuarial soundness requirements that are applied to risk contracts; however, federal financial participation (FFP) for payments under non-risk contracts is subject to a non-risk UPL amount, which is what FFS reimbursement would have paid for the services actually furnished through the PIHP, plus some administrative costs. This option allows the entity and the State to negotiate an alternative reimbursement schedule for payment that is less than or equal to the actual utilization priced at the FFS fee schedule but does not follow the FFS State Plan reimbursement methodology. Invoices not supported by submitted and accepted encounter data will not be reimbursed.

Quality Management and Improvement

The LBHP program operated by the SMO is a Medicaid program partially funded by CMS. The SMO is required to collect and report performance measures (PM) data that demonstrates adherence to clinical practice and/or improvement in patient outcomes. Measures as defined by DHH-OBH, include Health Care Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality (AHRQ) measures and/or other measures as outlined in the contract. DHH-OBH will use encounter data to evaluate the performance of the SMO and to audit the validity and accuracy of the reported measures.

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

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

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

Implementation Date

Within sixty (60) days of operation, the SMO's Systems shall be ready to submit encounter data to DHH's FI in a HIPAA compliant Provider-to-Payer-to-Payer COB format. If testing prior to contract go-live, the SMO will test with Molina using mock encounter data. If testing after contract go-live, the SMO will use real encounter data.

DHH-OBH Responsibilities

DHH-OBH is responsible for administering the Louisiana Behavioral Health Partnership Program. Administration includes data analysis, feedback to the SMO, ensuring data confidentiality, and the contents of this SMO Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

Name: Karen Stubbs, Health Plan Management	**Name:** Amanda Joyner, Fiscal Policy and Accountability
Telephone: 225-342-1435	**Telephone:** 225-342-2624
Fax: 225-342-8912	**Fax:** 225-342-8687
E-mail: Karen.Stubbs@LA.GOV	**Email:** Amanda.Joyner@LA.GOV

DHH-OBH is responsible for the oversight of the SMO Contract and SMO activities. DHH-OBH's responsibilities include coordination with Medicaid and Medicaid's FI on the development and production of the Systems Companion Guide, dissemination of the Systems Companion Guide to the SMO, the initiation and ongoing discussion of data quality improvement with the SMO, and facilitation of SMO training. DHH-OBH will notify the SMO of all updates and provide the SMO with the most current version of the Systems Companion Guide (as it is revised throughout the contract). DHH-OBH will also ensure the SMO's compliance with this guide.

DHH-OBH reserves the right to revise the SMO Systems Companion Guide at any time during the contract.

Fiscal Intermediary (FI) Responsibilities

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

The SMO will receive a listing of Medicaid eligible recipients at the beginning of each month and daily files for updates in a proprietary format. The SMO will also receive a capitation payment at the beginning of each month for each Medicaid eligible recipient enrolled with the SMO. Actuarially sound capitation rate ranges for Medicaid Recipients shall be set by DHH's actuarial Contractor, using the methodology described in the Overview of Rate Setting Methodology contained in the LBHP SMO Procurement Library.

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 999 Functional Acknowledgement. The TA1 report is

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

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

Proprietary Reports

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

These files include:

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

Statewide Management Organization (SMO) Responsibilities

The SMO is responsible for ensuring LBHP providers report accurate and complete encounter data.

The SMO must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by its providers. With regard to provider identification, the SMO is responsible for ensuring that the appropriate NPI, taxonomy, and 9-digit zip code are submitted in each transaction.

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

The SMO shall be able to transmit, receive and process data in HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as Virtual Private Network (VPN), that are in use at the start of the Systems readiness review activities.

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

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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) located on the CMS website. The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

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

The ASC X12 (837 IGs) contain most of the information needed by the SMO to complete this mapping. The SMO Systems Companion Guide contains the remaining information.

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

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

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

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

Transformed Medicaid Statistical Information System (T-MSIS)

Introduction

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

The SMO is expected to fully comply with T-MSIS system changes and testing.

The SMO is required to fully populate 837 data elements in accordance with the existing 5010 Implementation Guide and the SMO Systems Companion Guide.

Testing and Integration

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

Tier 1 Data Elements

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

Phase I

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

Phase II

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

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

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

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

Tier 2 Data Elements

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

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

NOTE: Testing for T-MSIS has been completed, and T-MSIS will move into production pending CMS approval.

Fiscal Intermediary (FI) Companion Guides and Billing Instructions

Molina, as DHH's FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 999 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

DHH Supplemental Instructions

DHH requires the SMO to submit the Provider-to-Payer-to-Payer COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2330B (Other Payer information) and 2430 (Service Line Adjudication Information). In the first set of COB loops, the SMO will be required to include information about the SMO provider claim adjudication. In the first set of COB data, the SMO shall place their unique DHH carrier code in loop 2330B, NM109. If there is Medicare TPL, the SMO shall place Medicare's unique DHH carrier code, 999999, in the second set of COB loops. The SMO shall provide DHH with any third-party payments, in subsequent COB loops, the SMO must include the DHH carrier code of the other payer in loop 2330B NM109. There can be only one single subsequent loop per unique payer.

SMO and Medicare Unique DHH Carrier Code Assignment

Plan Name: SMO	Assigned Carrier Code: 999996
Medicare	Assigned Carrier Code: 999999

Batch Submissions

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

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

Split Billing Claims

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

COB Model of 837 with TPL

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

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

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

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

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

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

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

Identifying Atypical Providers

A-typical providers may not be assigned an NPI. The SMO is to follow the instructions below when submitting any of the documents in **Appendix G**, as well as, encounters for this category of providers.

If a provider has a NPI, the SMO must send the NPI in Loop 2010AA NM109 (the typical place to send the Billing Provider's NPI in 837s). If the provider has a LA Medicaid Legacy Provider ID, send that number in Loop 2010BB REF*G2.

If the provider doesn't have a Legacy Provider ID, send the "Assigned Medicaid Provider ID" in Loop 2010BB REF*G2. This is in the same place in the 837 for either the Legacy Provider ID or the "Assigned Medicaid Provider ID" (the "Assigned Medicaid Provider ID" is the pseudo ID assigned by Molina when a provider is contracted with a Prepaid Plan and not enrolled in Legacy Medicaid).

File Splitting Criteria

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

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

BHT06

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

- Use a value of CH when the entire ST-SE envelop contains FFS Claims.
- Use a value of RP when the entire ST-SE envelope contains encounters. RP is used when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim.
- If the RP value is not used, either the entire batch of encounters will be rejected, or the batch will be processed as claims, which will result in the denial of every claim.

Accepting and Storing Encounters

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

SMO Internal Control Number (ICN)

The SMO ICN is to be populated in Line Item Control Number (LICN), Loop 2400 the REF *6R. Submitting the ICN in LICN allows unique Plan ICNs to be returned in 835s (and in SMO-W-010 reports) for each Molina ICN adjudicated. In previous versions of the Systems Companion Guide, the plan ICN was submitted in the Patient Control Number, and the same Plan ICN from Pat-Ctrl-No was returned for each Service-Line adjudicated.

Moving the Plan ICN from Patient Control Number (Pat-Ctrl-No) to LICN allows the Plans to send the Billing Provider's Pat-Ctrl-No in encounter records. Having the encounter records use the Billing Provider's Pat-Ctrl-No makes it easier for DHH and the auditors to match up Billing Provider claim records with their associated encounter records.

The number that the SMO transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the SMO to use the value in this field as a key in the SMO's system to match the encounter to the information returned in the 835 transaction. The ICN shall be modified to contain a 4-digit prefix as follows:

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

Character 2: Claim paid/denied status. If the claim was paid by the SMO, this character position should have a 'P'. If the claim was denied by the SMO this character position should have a 'D'.

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

Billing Provider Patient Control Number

The Billing Provider Patient Control Number (PAT-Ctrl-No) is to be populated in Loop 2300 CLM01. The Mediciad FI will return both the Plan ICN and Billing Provider Patient Control Number in the 835 record and the proprietary file.

Financial Fields

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

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

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

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

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

Claim Received Date

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

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

Claim Paid Date

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

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

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

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

Professional Identifiers

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

Supplementation of CMS-1500 and UB-04

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

Category II CPT Codes

DHH requires the use of applicable Category II CPT Codes or HCPCS Level II G Codes for performance measurement. These codes will facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures. In conjunction with the Category II CPT Codes, the PQRI quality-data codes (QDCs) follow current rules for reporting other CPT and HCPCS codes.

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

- Date of service;
- Place of service;
- PQRI QDC(s), along with modifier (if appropriate);
- Diagnosis pointer;
- 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. This guidance is subject to change. Please note that the following tables contain DHH provider types and are outlined consistent with the services manual included in the SMO contract.

At present, the following provider types use 837I:

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

The following provider types use 837P:

Provider Type	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt - Infants & Toddlers (in-state only)
08	Case Mgmt - Elderly (in-state only)
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
22	Waiver Personal Care Attendant
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
27	Dentist and Dental Group
28	Optometrist and Optometrist Group

29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only) (for Waiver Services ONLY)
45	Case Mgmt - Contractor (in-state only)
46	Case Mgmt - HIV (in-state only)
47	Case Mgmt - CMI
48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
54	Ambulatory Surgical Center (in-state only)
61	Venereal Disease Clinic
62	Tuberculosis Clinic
65	Rehabilitation Center
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
70	LEA and School Board (EPSDT Health Services) (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic
75	Optical Supplier (in-state only)
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
83	Respite Care (Center Based)- Waiver (in-state only)

84	Substitute Family Care - Waiver (in-state only)
87	Rural Health Clinic (Independent) (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
95	American Indian / Native Alaskan "638" Facilities
97	Adult Residential Care
98	Supported Employment - Waiver (in-state only)
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehabilitation Provider Agency
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC).
AL	Community Choices Waiver Nursing
AM	Home Delivered Meals
AN	Caregiver Temporary Support

3

Encounter Edit Code(s) Disposition Logic

Introduction

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

Encounter Edits

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

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

Educational Edits

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

Deny – Repairable

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

A list of **Deny Edits – Repairable** can be found at the end of this section.

Deny – Not Repairable

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

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

System logic for some edits will be added to the guide upon update. The SMO may request in writing the system logic for edits not included in this Guide.

Encounter Correction Process

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

Resubmissions

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

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

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

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
001	INVALID CLAIM TYPE MODIFIER
002	INVALID PROVIDER NUMBER
003	INVALID RECIPIENT NUMBER
005	INVALID STATEMENT FROM DATE
006	INVALID STATMENT THRU DATE

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

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
012	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID REASON CODE
013	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
015	ACCIDENT INDICATOR MUST BE Y N SPACE
016	ACCIDENT INDICATOR NOT Y N OR SPACE
017	EPSDT INDICATOR NOT Y N OR SPACE
023	RECIPIENT NAME IS MISSING
024	BILLING PROVIDER NUMBER NOT NUMERIC
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC
028	INVALID MISSING PROCEDURE CODE
040	ADMISSION DATE MISSING OR INVALID
043	INVALID ATTENDING PHYSICIAN
045	PATIENT STATUS CODE INVALID OR MISSING
046	PATIENT STATUS DATE MISSING OR INVALID
047	PATIENT STATUS DATE GREATER THAN THRU DATE
055	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID
063	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
064	THE NET BILLED AMOUNT IS NOT NUMERIC
065	THE SIGNATURE INDICATOR MUST BE Y, N, OR BLANK
069	INVALID OCCURRENCE DATE
071	STATEMENT COVERS FROM DATE INVALID
072	STATEMENT COVERS THRU DATE INVALID
073	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
074	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
081	INVALID OR MISSING PATIENT STATUS DATE
082	INVALID PATIENT STATUS CODE
085	INVALID OR MISSING UNITS VISITS AND STUDIES
093	REVENUE CODE MISSING/INVALID
095	CONDITION CODE 40 FROM THROUGH NOT EQUAL
096	REVENUE CHARGE MISSING OR INVALID
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
101	INVALID EMERGENCY INDICATOR

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
114	INVALID OR MISSING HCPCS CODE
115	HCPCS CODE NOT ON FILE
120	QUANTITY INVALID/MISSING
127	NDC INVALID/MISSING
131	PRIMARY DIAGNOSIS NOT ON FILE
180	THE ADMISSION DATE WAS NOT A VALID DATE
183	SURGICAL PROCEDURE NOT ON FILE
186	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER
206	BILLING PROVIDER NOT ON FILE
211	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	RECIPIENT NOT ON FILE
260	ANESTHESIA BASE UNITS ARE NOT ON FILE
269	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD
273	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST
289	INVALID PROVIDER NUMBER WHEN DENY APPLIED
301	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY
307	SURGICAL PROCEDURE MISSING
309	DATE OF SURGERY MISSING
310	DATE OF SURGERY LESS THAN SERVICE FROM DATE
311	DATE OF SURGERY GREATER THAN SERVICE THRU DATE
376	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS
430	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT
444	MISSING/INVALID SERVICE PROVIDER
506	SUBMITTING PROVIDER IS NOT A CCN (SMO)
513	HCPCS REQUIRED
539	CLAIM REQUIRES DETAILED BILLING
702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
914	UNITS DO NOT MATCH DATES OF SERVICE/CLAIMCHECK
930	BILL ONE PROCEDURE PER LINE FOR EACH DATE OF SERVICE
931	DENIED PER THE TPL EOB INFORMATION
933	INVALID/MODIFIER/PROCEDURE CODE COMBINATION
946	SPLIT BILL FOR PARTIAL ELIGIBILITY.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
949	ANESTHESIA MINUTES INVALID OR MISSING
980	INVALID ADJUSTMENT REASON
983	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE

4

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from the SMO is treated as HIPAA-compliant transactions by DHH and its FI. As such, the SMO is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the SMO is requested to send real transmission data (NOTE: If the SMO is testing prior to contract go-live, the SMO will use mock encounter data in coordination with the Mediciad FI. Once the contract goes live, the SMO will use real encounter data). The FI does not define the number of encounters in the transmission; however, DHH will require a minimum set of encounters for each transaction type based on testing needs.

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

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

Test Process

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

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

Electronic Data Interchange (EDI)

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

- Upon request from the SMO, 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 SMO can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the potential submitter develops and tests application software to create EDI encounters.
- Molina requires the SMO to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
- When the submitter is ready to submit a file of test encounters, the test encounters shall be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and formats. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, additional test encounters will be submitted until an acceptable test run is completed.
  NOTE: This test submitter number (4509999) shall be used for submission of test encounters only.

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

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

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

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

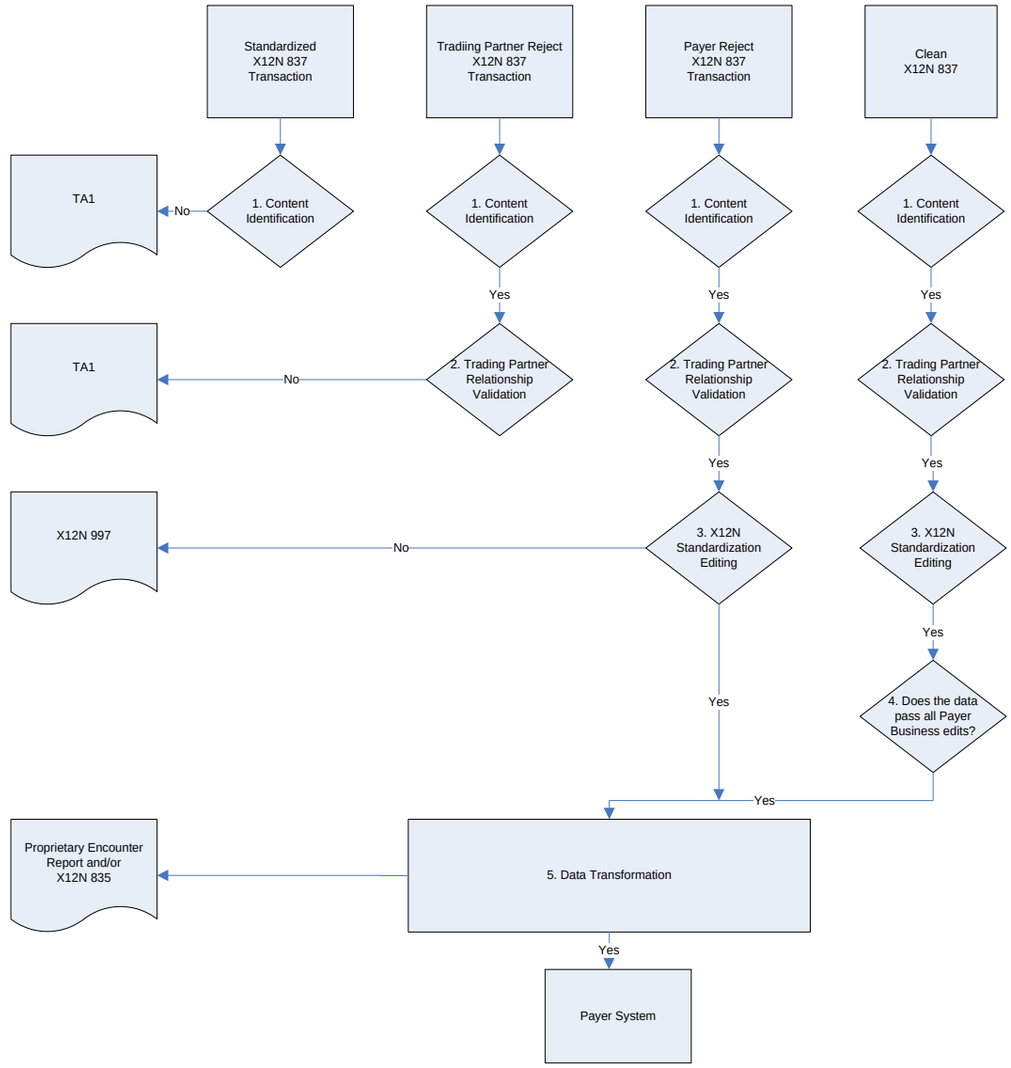
Timing

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

Editing and Validation Flow Diagram

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

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



Encounter Data Certification

The Federal Budget Balance Act (BBA) requires that when State payments to the SMO are based on data that is submitted by the SMO, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the SMO, which are used to create payments and/or develop/support capitated rates, must be certified by a completed signed Data Certification form, which is required to be submitted concurrently with each encounter submission. The data must be certified by one of the following individuals:

- SMO's Chief Executive Officer (CEO); or
- SMO's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

5

Data Management and Error Correction Process

Introduction

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

Rejection Criteria

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

Entire File

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

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

Once the transaction has passed interchange edits, it shall be subject to transaction set syntax errors. If the error occurs at the ST or SE level

segments, the entire transaction is rejected. These edits are reported on the ANSI ASC X12N 997.

Claim

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

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

Service Line

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

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

Encounter Correction Process

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

Reports

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

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

[2] If requested by the SMO and prearranged with DHH

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

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

Electronic Notifications

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

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

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

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

Entire File

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

Claim

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

Service Line

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

This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter.

An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

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

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

Outstanding Issues

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

Dispute Resolution

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

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

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

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

6

Continuous Quality Improvement

Introduction

Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the SMO will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to assist DHH and the SMO in developing Encounter Quality Improvement Plans. Interim monitoring and follow-up on identified quality problem areas is an integral component of DHH's encounter process.

The Encounter Quality Improvement Plan is designed to provide DHH and the SMO with a comprehensive list of data quality issues present in the data for a given period of time. DHH will meet with the SMO as needed. The SMO meeting attendees are to include, but not be limited to the following staff: Claims, EDI Experts, and Clinical Quality Assurance Staff.

Prior to any meeting, the SMO is expected to have investigated any findings, and be prepared to explain the underlying reason(s) for the identified data quality issue(s). As data issues are discussed, the MCO must incorporate corrective action steps into a Quality Improvement Report. If issues are not resolved in a timely manner, DHH may request a Corrective Action Plan (CAP).

Minimum Standards

There are three components to encounter data quality assessment: Repairable Denials, Data Volume Assessment, and Children's Invoices Match Submitted Encounter Data.

Repairable Denials

Repairable denials must be for corrected and resubmitted in accordance with Section 20.10 of the RFP.

Data Volume Assessment

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

Children's Invoices Match Submitted Encounter Data

The invoices submitted by Magellan for Medicaid children's services must match the plan paid amount within the encounter data accepted by the MMIS. Payment for services will not be rendered for unsubstantiated invoices.

7

Adjustment Process and Void Process

Introduction

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

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

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

Line Adjustment Process

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

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

Molina ICN Format

The format of the Molina ICN is as follows:

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

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

8

Managed Care Behavioral Health Crossover Claims

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

The services include the following HCPCS:

S5110, H0038, H2014, S5150, H0045, H2017, S9485, H2011, H0036, H0039, H2033, H0018, T2048, S5145, H0001, H0004, H0005, H0011, H0012, H0015, H0019, H2034, H2036, H2013, H0049, and H0050.

In instances where a provider bills Medicare for any of the above HCPCS, the Medicaid FI will deny the claim with the 555 edit requesting the provider resubmit the claim to the SMO.

DHH's FI is responsible for submitting Weekly Crossover Files to the SMO using the HIPAA compliant 837 Format for Behavioral Health Crossover Claims processing. The FI sends three 837 files: inpatient 837I, outpatient 837I, and professional 837P. These are crossover claims that Molina denies with edit 133 because they are determined to be behavioral health services that are the SMO's responsibility.

Crossover Claims

Crossover claims are identified by Claim Type 14 or Claim Type 15. Below is the Chart that the FI uses to identify those Claim Types 14 and 15 that are sent to Magellan, with the following exclusions:

1. The FI processes all crossover claims for pure-QMB and pure-SLMB recipients.

2. The FI processes and zero-pays ($0) all CMHC crossover claims – PT 18.

Molina crossover claim criteria:

Claim Type	Provider Type	Provider. Speciality	Category Of Service	Description	Diagnostic Range	DOS
14	64			Mental Health Hospital, Free-standing		
14	69			Mental Health Hospital-Distinct Part Psych Unit		
14	60			Hospital	290-319	3/6/12
14			02	Inpatient MH Hospital		
14	96			PRTF		3/1/12
14			08	Outpt. Hosp.	290-319	
15	All Mental Health professionals		11	Mental Health Clinic		3/1/12
15	All Mental Health professionals		50	Psychology		3/1/12
15	All Mental Health professionals		74	Behavioral Management Services.		3/1/12
15	All Mental Health professionals		42	Rehab Chronically ill		3/1/12
15	All Mental Health professionals		67	Social Worker		3/1/12
15	12			MST		3/1/12
15	19	26, 27		D.O., psychiatry		3/1/12
15	20	26, 27		MD, psychiatry		3/1/12
15	31			psychology		3/1/12

15	73			Social Worker	290-319	3/1/12
15	74			MH Clinic		3/1/12
15	77			MH Rehab		3/1/12
15	78	26, 27		Nurse Practitioner, psychiatry		3/1/12
15	93	26, 27		Clinical nurse specialist, psychiatry		3/1/12
15	96			PRTF		3/1/12

Mental Health professional claims are payable by the SMO. They are identified as follows (with the exception of PT 18 CMHC):

Provider Type	Provider Specialty	Service Description	Specialty Description
12	Any, but usually 5M	MST	MST
19	26,27	Dr. Osteopathy (DO),and group	psychiatry
20	26, 27	Physician (MD) and group	psychiatry
31	95, 96	Psychologist	psychologist
31	6A	Psychologist	Psychologist - clinical
64	Any, usually 86	MH Hospital – free standing	Hospital and NH
69	Any, usually 86	Hospital – distinct part psych unit (DPPU)	Hospital and NH
73	Any, usually 73	Social worker	Social worker enrollment
74	Any, usually 70	Mental health clinic (MHC)	Clinic or other group practice
77	Any, usually 78	Mental health rehab (MHR)	Mental health rehab
78	26, 27	Nurse practitioner	psychiatry
93	26, 27	Clinical nurse specialist	psychiatry
96	Any, usually 9B	Psychiatric Residential Treatment Facility (PRTF)	PRTF

The following identifies those provider types that are associated with SMO-specific specialized BH providers. These providers are not usually enrolled by the FI.

53	Self Directed/Direct Support	In effect for CSoC

82	Personal Care Attendant –Waiver –(in-state only)	Also used for CSoC
AA	Assertive Community Treatment Team (ACT)	Effective 1/2012
AB	Prepaid Inpatient Health Plan (PIHP)	Effective 1/2012
AC	Family Support Organization	Effective 1/2012
AD	Transition Coordination (Skills Building)	Effective 1/2012
AE	Respite Care Service Agency	Effective 1/2012
AF	Crisis Receiving Center	Eff. 1/2012
AG	Behavioral Health Rehab provider Agency	Eff. 1/2012
AH	Licensed Marriage and Family Therapist (LMFT)	Eff. 1/2012
AJ	Licensed Addiction Counselors (LAC)	Eff. 1/2012
AK	Licensed Professional Counselors (LPC)	Eff. 1/2012

9

Medicare Recovery Process

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

The process takes the Fiscal Intermediary 2 weeks – the first week to identify the recipients who are retrospectively enrolled, and the second week to process the voids.

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

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

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

10

Department of Correction (DOC) PMPM Recoveries

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

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

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

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

11

Date of Death (DOD) PMPM Recoveries

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

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

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

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

.12

Medicaid Administrative Retroactive Enrollment Correction Process

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

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

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

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

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

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

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 (004010X098A1) file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and may not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc).
CAS Segment	Used to report claims or line level adjustments.
Centers for Medicare and Medicaid Services (CMS)	The agency within the U.S. Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under

	Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).
Claim	A request for payment for benefits received or services rendered.
Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under health plan rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim.
Clean claim	A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or use or a claim under review for medical necessity.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the SMO to Medicaid LBHP members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan and waivers as outlined in the contract's service definition manual.
CMS 1500	A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.
CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.
BAYOU HEALTH Network	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.
Coordination of Benefits (COB)	Refers to the activities involved in determining

	Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
CSoC	Coordinated System of Care
CSoC eligible	Children and youth eligible for the CSoC
Co-payment	Any cost sharing payment for which the Medicaid SMO member is responsible for in accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Corrective Action Plan (CAP)	A plan developed by the SMO that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a (SMO) are based on data that is submitted by the BH the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Denied claim	A claim for which no payment is made to the network provider by the SMO for any of several reasons, including but not limited to, the claim is for non-covered services, the provider or Member is ineligible, the claim is a duplicate of another transaction, or the claim

	has failed to pass a significant requirement (or edit) in the claims processing system.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
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.
Duplicate claim	A claim that is either a total or a partial duplicate of services previously paid.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal State Plan definition of "medical assistance". Note: 1915(c) waiver services for children are not covered under EPSDT.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter

	has denied. Other edit codes are informational only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.
Eligible	An individual qualified to receive services through the SMO, consistent with the eligibility requirements of DHH, DCFS, OJJ, DOE, and the local education agencies.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Encounter data	Records of medically-related services rendered by a provider to the SMO Member on a specified date of service. This data is inclusive of all services for which the SMO has any financial liability to a provider. Encounter data must be submitted for all at-risk claims processed by the SMO.
Enrollee	A Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in the SMO. This definition may also include a person who is qualified for Medicaid and whose application has been approved but who may or may not be receiving services.
Enrollment	The process conducted by DHH to enroll a Medicaid or CHIP eligible into the SMO.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired

	goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee for Service (FFS)	A method of provider reimbursement based on payments for specific services rendered to an enrollee.
File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI) for Medicaid	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.
Health Care Provider	A health care professional or entity that 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., SMO) 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.
ICD-9 or 10-CM codes (International Classification of Diseases, 9th Revision, Clinical Modification)	ICD-9-CM Codes currently used to identify diagnoses. The SMO shall move to ICD-10-CM as it becomes effective.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.

Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
Louisiana Behavioral Health Partnership	The behavioral health program managed by DHH-OBH that includes behavioral health services for a special target population of children eligible for the Coordinated System of Care (CSoC); adults with serious mental illness (SMI); and the child/adult population (e.g., the rest of the non-institutionalized Medicaid population). The benefit package for this third population includes inpatient psychiatric care, emergency room care, substance use services and care by psychiatrists for all adults and children. It also includes all EPSDT behavioral health care services for all Medicaid children. This population could be referred to as a traditional behavioral health "carve-out" program. DHH-OBH oversees the Behavioral Health Statewide Management Organization (SMO), the prepaid inpatient health plan (PIHP) that implements the 1) 1915(b) waiver; 2) the 1915(i) Adult Mental Health Rehabilitation services for the Severely Mentally Ill; and 3) the CSoC – 1915(c) SED Children's waiver. The mental health and substance use PIHP is at-risk for the provision of adult services including adults with limited mental health and substance use benefits, as well as children's services. Children are eligible under the PIHP for those State Plan services as well as all medically necessary EPSDT services. The SMO will also manage behavioral health services for Non-Medicaid eligible populations served by OBH, DCFS, and OJJ., and funded through state general funds and block grants, including services for individuals with co-occurring mental health and addictive conditions.
Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and

	rehabilitative services for all citizens in the state of Louisiana.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.
Medicaid Management Information System (LMMIS)	A mechanized claims processing and information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.
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)	The name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).
Medically Necessary Services	Health care services that are in accordance with generally accepted, evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have

	resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	Persons enrolled in the SMO.
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Network	As used in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a SMO to supply a range of behavioral health care services. The term "provider network" may also be used.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the SMO.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a SMO member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.
Primary Care Provider (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 SMO 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 SMO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Assessment and Performance Improvement Program (QAPI Program)	Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical

	record audits, performance measures, surveys, and related activities.
Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to the process where DHH assesses the SMO's ability to fulfill the requirements of the provider agreement. Such review may include, but is not limited to, review of proper licensure, operational protocols, SMO standards, and systems. The review may be completed as a desk review, on-site review, or combination, and may include interviews with pertinent personnel so that DHH can make an informed assessment of the SMO'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 SMO, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying "repairable edit code "code" to indicate that the encounter is repairable.
Representative	Any person who has been delegated the authority to obligate or act on behalf of

	another. Also known as the authorized representative.
Risk	The chance or possibility of loss. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Risk adjustment	A method for determining adjustments of the PMPM rate that accounts for variation in health risks among participating health plans when determining per capita prepaid payment. The SMO will not be risk adjusted.
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	This is not applicable for the SMO. The SMO will be statewide for the LBHP.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Shall	Denotes a mandatory requirement.
Should, May, Can	Denotes a preference but not a mandatory requirement.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Span of Control	Information systems and telecommunications capabilities that the SMO itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the

	Contract with DHH-OBH. The span of control also includes systems and telecommunications capabilities outsourced by the SMO
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Start-Up Date	The date SMO providers begin providing behavioral health services 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 SMO from the provider and/or switch vendor until the SMO hands-off a response to the provider and/or switch vendor.
System Availability	Measured within the SMO'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 HIPAA and how does it pertain to the SMO?

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

What is Molina and what is their role with the SMO?

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

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

There are three HIPAA-compliant 837 transactions — Institutional, Professional, and Dental services, and one (1) HIPAA NCPDP Transaction set for Pharmacy. The transactions the SMO will use will depend upon the type of service being reported. Further instructions can be found in Section 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What is a Trading Partner ID?

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

Why must the SMO submit encounter data?

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

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

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

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

Appendix C

Code Sets

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

When conducting 837 transactions, DHH requires the SMO to adhere to HIPAA standards governing Medical data code sets. Specifically, the SMO must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. The SMO is also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

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

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:

- Diseases;
- Injuries;
- Impairments;
- Other health problems and their manifestations; and
- Causes of injury, disease, impairment, or other health problems.

ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following

procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals (ICD-10 will be implemented October 1, 2015):

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

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

- Drugs; and
- Biologics.

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

The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:

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

In addition to the Category I codes described above, DHH requires that the SMO submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

The HCPCS, as maintained and distributed by 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.
- Other services, as applicable, in the manual outlined in the SMO contract

Appendix D

System Generated Reports

The overarching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH-OBH and the SMO with a basic accuracy and completeness assessment of each claim after each encounter cycle in order that preliminary corrections and repairs can be conducted and the encounter resubmitted to the FI. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the FI's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in summary and repairable edit codes reports and a summary report of the encounter data submitted. These edit codes are listed in Appendix D of this Guide. Those edit codes that assess encounters to be repairable for correction and resubmission by the SMO are found in Section 6 of this Guide.

The following reports are generated by the MMIS system and have been selected specifically to provide the SMO with useful information that, when compared with the 835 Remittance Advice for the specific encounter, will provide a complete explanation for the edit code. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These quality reports will also depict accuracy and completeness at a volume and utilization level.

ASC X12N 835

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

those that are repairable, are represented in the 835. TCNs are assigned by claim and can be located in the 835 specific to the encounter.

820 File (FI to SMO)

See below.

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					
		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.					
BPR=Financial Information					
Sample: BPR*I*950.00*C*NON******1726011595******20120209~					
	BPR	BPR01	Transaction Handling Code	I=Remittance Information Only	S
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON	S
		BPR05	Payment Format Code	NOT USED	S
		BPR06	(DFI) ID Number Qualifier	NOT USED	S
Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction. SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send.					
		BPR07	(DFI) Identification Number	NOT USED	S
		BPR08	Account Number Qualifier	NOT USED	S
		BPR09	Account Number		S
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	NOT USED	S
		BPR13	(DFI) Identification Number	NOT USED	S
		BRP14	Account Number Qualifier	NOT USED	S
		BPR15	Account Number		
		BPR16	EFT Effective Date	Expressed CCYYMMDD	
TRN=Reassociation Trace Number					
Sample: TRN*3*1123456789**~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		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*SMO Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	
		REF03	Description	'SMO 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

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	D
1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*SMO 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	

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
	2000B	ENT04	Identification Code	Individual Identifier - SSN	
2100B INDIVIDUAL NAME					
NM1=Policyholder Name					
Sample: NM1*QE*1*DOE*JOHN*Q***N*1234567890123~					
	2100B	NM101	Entity Identifier Code	"QE" - Policyholder (Recipient Name)	
	2100B	NM102	Policyholder	"1" - Person	
	2100B	NM103	Name Last	Individual Last Name	
	2100B	NM104	Name First	Individual First Name	
	2100B	NM105	Name Middle	Individual Middle Initial	
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Insurer's Unique ID number	
	2100B	NM109	Identification Code	Recipient ID	
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*AZ*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	
	2300B	RMR02	Reference Identification	Claim ICN	
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	
REF=Reference Information					
Sample: REF*ZZ*0101C~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	
	2300B	REF02	Reference Identification	Capitation Code	
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
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	

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

Statewide Management Organization (SMO) Systems Companion Guide

Appendix E

SMO Generated Reports

The over arching purpose of this set of reports is to supplement information that is reported through the encounter process. Once the encounter process has stabilized, DHH may use encounters as the basis for these reports.

Denied Claims Report

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

1. Lack of documentation to support Medical Necessity
2. Prior Authorization was not on file
3. Member has other insurance that must be billed first
4. Claim was submitted after the filing deadline
5. Service was not covered by the SMO

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

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

- Denial reason code including long description
- Claim type
- Missing documentation to support medical necessity
- Missing documentation of prior authorization (PA); e.g. no PA on file
- Date of service
- Date of receipt by SMO

- Primary diagnosis
- Secondary diagnosis (if applicable)
- Procedure/HCPCS code(s)
- Surgical procedure code(s) (if applicable)
- Revenue code(s) (if applicable)
- Primary insurance carrier (if applicable)
- Primary insurance coverage begin date (if applicable)

FQHC and RHC Quarterly Report

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

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

Appendix F

Encounter Edit Codes

In order for data to be useful, the data must meet minimum thresholds of data quality. One of the most basic tests of data quality is editing. All encounter data submitted to the MMIS are subject to edits. Edits may post at the line or at the header. If an encounter denies at the header the encounter must be corrected and resubmitted. Instructions for correcting line level denials are found in Section 7 of this Guide.

Encounter data edits can have one of the following dispositions:

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

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

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO SMO (SMO)
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
651	HOSPITAL CUTBACK APPLIED
701	CONSULT FOLLOW-UP VISITS NOT ALLOWED.
711	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY
790	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE
792	Bypass ClaimCheck edits
795	Bypass PAM edits
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
921	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS
947	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.
961	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK
962	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT
969	Integration Wizard Defined AUDIT-RESULT
977	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK
981	Integration Wizard Defined AUDIT-RESULT
029	SERVICE MORE THAN 12 MONTHS OLD
030	SERVICE THRU DATE TOO OLD
084	TREATMENT PLACE INVALID
108	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE
142	BILLING PROVIDER NPI MISSING/NOT ON FILE
143	SERVING PROVIDER NPI MISSING/NOT ON FILE
145	BILLING PROVIDER NPI MISMATCH

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (E) EDIT DESCRIPTION
146	SERVICING PROVIDER NPI MISMATCH
201	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
207	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
272	CLAIM EXCEEDS 1 YEAR FILING LIMIT
279	INVALID PLACE OF TREATMENT FOR PROF COMP
294	RECIPIENT NOT ON FILE RECYCLED 3 TIMES
295	RECIPIENT INELIGIBLE RECYCLED THREE TIMES
297	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.
330	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE
427	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH
546	Code added due to a REB of a current code only
550	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE
556	ATTENDING/SERVICING PROVIDER IS NOT LINKED TO SMO (SMO)
565	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.
584	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.
595	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)
596	Code added due to SPL claim
622	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
651	HOSPITAL CUTBACK APPLIED
701	CONSULT FOLLOW-UP VISITS NOT ALLOWED.
711	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV
715	FOUND DUPLICATE VISIT SAME DAY
727	EXCEEDS DAILY SERVICE MAXIMUM
730	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY
790	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE
792	Bypass ClaimCheck edits
795	Bypass PAM edits
851	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
855	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
863	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
918	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE
919	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN
921	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS
947	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.
961	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK
962	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK
964	Integration Wizard Defined AUDIT-RESULT
967	Integration Wizard Defined AUDIT-RESULT
969	Integration Wizard Defined AUDIT-RESULT
977	Integration Wizard Defined AUDIT-RESULT
978	CALCULATED PRICING IS ZERO/CALL HELP DESK
981	Integration Wizard Defined AUDIT-RESULT

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
642	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
673	EVAL AND MGT CODE PAID FOR THIS DOS
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
758	FOUND DUPLICATE SERVICE SAME DAY
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.
942	DENIED BY MEDICARE NOT COVERED BY MEDICAID
948	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	DATE OF DISCHARGE NOT COVERED

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
952	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
954	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE
972	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE
117	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS
210	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
219	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old
222	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)
231	NDC IS NOT ON THE PROCUDURE FORMULARY FILE
233	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN
234	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN
237	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN
293	RECYCLED RECIPIENT INELIGIBLE ON DOS
299	PROCEDURE/DRUG NOT COVERED BY MEDICAID
367	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY
508	WAIVER SVC NOT PAYABLE WHILE IP
528	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS
530	RECIPIENT WAS REIMBURSED FOR THIS SERVICE
631	EPSDT AGE OVER 21
642	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION
644	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
673	EVAL AND MGT CODE PAID FOR THIS DOS
689	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE
695	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
704	ER VISIT ON DATE OF INP HOS SERVICES
712	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS
716	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT
735	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS
746	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY
758	FOUND DUPLICATE SERVICE SAME DAY
791	BILLED CODE CONFLICTS WITH CODE ALREADY PAID
794	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV
797	DUPLICATE ADJUSTMENT RECORDS ENTERED
798	HISTORY RECORD ALREADY ADJUSTED
800	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES
813	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
814	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18
849	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER
898	EXACT DUPE SAME ICN - DROPPED
926	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.
942	DENIED BY MEDICARE NOT COVERED BY MEDICAID

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
948	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	DATE OF DISCHARGE NOT COVERED
952	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
954	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE
972	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE

The table below represents the edit codes that may be corrected by the SMO:

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[3] EDIT DESCRIPTION
001	INVALID CLAIM TYPE MODIFIER
002	INVALID PROVIDER NUMBER
003	INVALID RECIPIENT NUMBER
005	INVALID STATEMENT FROM DATE
006	INVALID STATMENT THRU DATE
007	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
012	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID REASON CODE
013	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN
015	ACCIDENT INDICATOR MUST BE Y N SPACE
016	ACCIDENT INDICATOR NOT Y N OR SPACE
017	EPSDT INDICATOR NOT Y N OR SPACE
023	RECIPIENT NAME IS MISSING
024	BILLING PROVIDER NUMBER NOT NUMERIC
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC
028	INVALID MISSING PROCEDURE CODE
040	ADMISSION DATE MISSING OR INVALID
043	INVALID ATTENDING PHYSICIAN
045	PATIENT STATUS CODE INVALID OR MISSING
046	PATIENT STATUS DATE MISSING OR INVALID
047	PATIENT STATUS DATE GREATER THAN THRU DATE
055	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID
063	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC

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

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[3] EDIT DESCRIPTION
064	THE NET BILLED AMOUNT IS NOT NUMERIC
065	THE SIGNATURE INDICATOR MUST BE Y, N, OR BLANK
069	INVALID OCCURRENCE DATE
071	STATEMENT COVERS FROM DATE INVALID
072	STATEMENT COVERS THRU DATE INVALID
073	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE
074	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU
081	INVALID OR MISSING PATIENT STATUS DATE
082	INVALID PATIENT STATUS CODE
085	INVALID OR MISSING UNITS VISITS AND STUDIES
093	REVENUE CODE MISSING/INVALID
095	CONDITION CODE 40 FROM THROUGH NOT EQUAL
096	REVENUE CHARGE MISSING OR INVALID
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
101	INVALID EMERGENCY INDICATOR
114	INVALID OR MISSING HCPCS CODE
115	HCPCS CODE NOT ON FILE
120	QUANTITY INVALID/MISSING
127	NDC INVALID/MISSING
131	PRIMARY DIAGNOSIS NOT ON FILE
180	THE ADMISSION DATE WAS NOT A VALID DATE
183	SURGICAL PROCEDURE NOT ON FILE
186	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER
206	BILLING PROVIDER NOT ON FILE
211	DATE OF SERVICE LESS THAN DATE OF BIRTH
215	RECIPIENT NOT ON FILE
260	ANESTHESIA BASE UNITS ARE NOT ON FILE
269	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD
273	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST
289	INVALID PROVIDER NUMBER WHEN DENY APPLIED
301	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY
307	SURGICAL PROCEDURE MISSING
309	DATE OF SURGERY MISSING

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE OR REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[3] EDIT DESCRIPTION
310	DATE OF SURGERY LESS THAN SERVICE FROM DATE
311	DATE OF SURGERY GREATER THAN SERVICE THRU DATE
376	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS
430	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT
444	MISSING/INVALID SERVICE PROVIDER
506	SUBMITTING PROVIDER IS NOT A CCN (SMO)
513	HCPCS REQUIRED
539	CLAIM REQUIRES DETAILED BILLING
702	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
796	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
799	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
914	UNITS DO NOT MATCH DATES OF SERVICE/CLAIMCHECK
930	BILL ONE PROCEDURE PER LINE FOR EACH DATE OF SERVICE
931	DENIED PER THE TPL EOB INFORMATION
933	INVALID/MODIFIER/PROCEDURE CODE COMBINATION
946	SPLIT BILL FOR PARTIAL ELIGIBILITY.
949	ANESTHESIA MINUTES INVALID OR MISSING
980	INVALID ADJUSTMENT REASON
983	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE

Appendix G

Provider Directory/Network Provider and Subcontractor Registry

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

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

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

Provider Registry File Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the SMO 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	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				zeroes, be sure to include them.	
21	Delimiter		1	Character, use the ^ character value	
22	Entity Type code	1=Individual, 2=Organization	1		R
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the Legal Business Name for Organizations. If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-27th characters=last name, 28-30th positions=suffix. If names do not fit in these positions, please truncate the end of the item so that it fits in the		30	Character	R

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

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Taxonomy Code 3	blank.			
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 SMO Companion Guide for list of applicable provider types and specialties.	R
401	Delimiter		1	Character, use the ^ character value	
402-409	Provider Enumeration Date	NPPES enumeration date.	8	Numeric, format YYYYMMDD	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if	8	Numeric, format YYYYMMDD	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		not appropriate.			
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	M=Male, F=Female, N=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	Y=Yes, panel is open. N=No, panel is not open.	1	Character	R for PCPs; otherwise optional.
579	Delimiter		1	Character, use the ^ character value	
580	Language Indicator 1 (this is the primary language indicator)	1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	
582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
583	Delimiter		1	Character, use the ^ character value	
584	Language	0=no other	1	Character	O

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	0=no age restrictions 1=adult only 2=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of patients that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with SMO	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of SMO enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This	R for PCPs; otherwise

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				number represents the maximum number of enrollees in other plans (not SMO) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	optional.
609	Delimiter		1	Character, use the ^ character value	
610	SMO Enrollment Indicator	N=New enrollment C=Change to existing enrollment D=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	SMO Enrollment Indicator Effective Date	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	0=no restrictions 1=family members only	1		R for PCPs; otherwise optional.
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in SMO 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 SMO Companion Guide	2		O
628	Delimiter		1	Character, use the ^	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in SMO Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	SMO Contract Name or Number	This should represent the contract name/number that is established between the SMO and the Provider	30	Character	R
662	Delimiter		1	Character, use the ^ character value	
663-670	SMO Contract Begin Date	Date that the contract between the SMO and the provider started	8	Numeric date value in the form YYYYMMDD	R
671	Delimiter		1	Character, use the ^ character value	
672-679	SMO Contract Term Date	Date that the contract between the SMO and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the SMO 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	2	2-digit parish code value. See the SMO Companion Guide.	O

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				character value	
696-697	Provider Parish served – 6th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
698	Delimiter		1	Character, use the ^ character value	
699-700	Provider Parish served – 7th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO 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 SMO Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves.	2	2-digit parish code value. See the SMO Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Use only if necessary; otherwise enter 00.			
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO Companion Guide.	O
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the SMO 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 SMO Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that	2	2-digit parish code value. See the SMO	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.		Companion Guide.	
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 SMO 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 SMO Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726-749	Spaces	End of record filler	24	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

The SMO is required to populate the provider type codes to a DHH valid provider type code as shown in the list below:

Provider Type and Description

Please note: Rows shaded in green are specific to SMO provider registry.

Provider Type	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver (in-state only)
04	Pediatric Day Health Care (PDHC) facility
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)
07	Case Mgmt - Infants & Toddlers (in-state only)
08	Case Mgmt - Elderly (in-state only)
09	Hospice Services (in-state only)
10	Comprehensive Community Support Services
11	Shared Living - Waiver (in-state only)
12	Multi-Systemic Therapy (in-state only)
13	Pre-Vocational Habilitation (in-state only)
14	Adult Day Habilitation - Waiver (in-state only)
15	Environmental Accessibility Adaptation - Waiver (in-state only)
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
18	Community Mental Health Center (in-state only)
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) (in-state only)
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy (out-of-state for crossovers only)
27	Dentist and Dental Group
28	Optometrist and Optometrist Group
29	EarlySteps and EarlySteps Group (in-state only)
30	Chiropractor and Chiropractor Group
31	Medical or Licensed Psychologist
32	Podiatrist and Podiatrist Group
33	Prescribing Only Provider
34	Audiologist
35	Physical Therapist

Provider Type	Description
36	Not assigned
37	Occupational Therapist
38	School-Based Health Center (in-state only)
39	Speech/Language Therapist
40	DME Provider (out-of-state for crossovers only)
41	Registered Dietician
42	Non-Emergency Medical Transportation (in-state only)
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)
44	Home Health Agency (in-state only)
45	Case Mgmt - Contractor (in-state only)
46	Case Mgmt - HIV (in-state only)
47	Case Mgmt - CMI
48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
53	Direct Care Worker
54	Ambulatory Surgical Center (in-state only)
55	Emergency Access Hospital
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 (in-state only)
66	KIDMED Screening Clinic (in-state only)
67	Prenatal Health Care Clinic
68	Substance use and Alcohol use Center
69	Hospital - Distinct Part Psychiatric Unit (in-state only)
70	LEA and School Board (EPSDT Health Services) (in-state only)
71	Family Planning Clinic
72	Federally Qualified Health Center (in-state only)
73	Licensed Clinical Social Worker (LCSW)
74	Mental Health Clinic

Provider Type	Description
75	Optical Supplier (in-state only)
76	Hemodialysis Center (in-state only)
77	Mental Health Rehabilitation (in-state only)
78	Nurse Practitioner and Nurse Practitioner Group
79	Rural Health Clinic (Provider Based) (in-state only)
80	Nursing Facility (in-state only)
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver (in-state only)
83	Respite Care (Center Based)- Waiver (in-state only)
84	Substitute Family Care - Waiver (in-state only)
85	ADHC Home and Community Based Services - Waiver (in-state only)
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent) (in-state only)
88	ICF/DD - Group Home (in-state only)
89	Supervised Independent Living - Waiver (in-state only)
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 (in-state only)
99	Greater New Orleans Community Health Connection (in-state only)
AA	Assertive Community Treatment Team (ACT)
AB	Prepaid Inpatient Health Plan (PIHP)
AC	Family Support Organization
AD	Transition Coordination (Skills Building)
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehabilitation Provider Agency
AH	Licensed Marriage & Family Therapist (LMFT)
AJ	Licensed Addiction Counselors (LAC)
AK	Licensed Professional Counselors (LPC).
AL	Community Choices Waiver Nursing

Provider Type	Description
AM	Home Delivered Meals
AN	Caregiver Temporary Support

Below are the DHH provider specialty, subspecialties and types.

Provider Specialty, Subspecialty and Type

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
00	All Specialties	1		n/a
01	General Practice	1		19,20
02	General Surgery	1		19, 20, 93
03	Allergy	1		19,20
04	Otology, Laryngology, Rhinology	1		19,20
05	Anesthesiology	1		19, 20, 91
06	Cardiovascular Disease	1		19,20
07	Dermatology	1		19,20
08	Family Practice	1		19, 20, 78
09	Gynecology (DO only)	1		19
10	Gastroenterology	1		19,20
11	Not in Use	n/a		n/a
12	Manipulative Therapy (DO only)	1		19
13	Neurology	1		19,20
14	Neurological Surgery	1		19,20
15	Obstetrics (DO only)	1		19
16	OB/GYN	1		19, 20, 78, 90
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1		19
18	Ophthalmology	1		20
19	Orthodontist	1		19,20
20	Orthopedic Surgery	1		19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	1		19
22	Pathology	1		20
23	Peripheral Vascular Disease or Surgery (DO only)	1		19
24	Plastic Surgery	1		19,20
25	Physical Medicine Rehabilitation	1		19,20
26	Psychiatry	1		19, 20, 93

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
27	Psychiatry; Neurology (DO only)	1		19
28	Proctology	1		19,20
29	Pulmonary Diseases	1		19,20
30	Radiology	1		19,20
31	Roentgenology, Radiology (DO only)	1		19
32	Radiation Therapy (DO only)	1		19
33	Thoracic Surgery	1		19,20
34	Urology	1		19,20
35	Chiropractor	1		30,35
36	Pre-Vocational Habilitation	1		13
37	Pediatrics	1		19, 20, 78
38	Geriatrics	1		19,20
39	Nephrology	1		19,20
40	Hand Surgery	1		19,20
41	Internal Medicine	1		19,20
42	Federally Qualified Health Centers	1		72
43	Not in Use	n/a		n/a
44	Public Health/EPSDT	1		66,70
45	NEMT - Non-profit	1		42
46	NEMT - Profit	1		42
47	NEMT - F+F	1		42
48	Podiatry - Surgical Chiropody	1		20, 32
49	Miscellaneous (Admin. Medicine)	1		20
50	Day Habilitation	1		14
51	Med Supply / Certified Orthotist	1		40
52	Med Supply / Certified Prosthetist	1		40
53	Med Supply / Certified Prosthetist Orthotist	1		40
54	Med Supply / Not Included in 51, 52, 53	1		40
55	Indiv Certified Orthotist	1		40
56	Indiv Certified Protherist	1		40
57	Indiv Certified Protherist - Orthotist	1		40
58	Indiv Not Included in 55, 56, 57	1		40
59	Ambulance Service Supplier, Private	1		51
60	Public Health or Welfare Agencies & Clinics	1		61, 62, 66, 67

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
61	Voluntary Health or Charitable Agencies	1		unknown
62	Psychologist Crossovers only	1		29, 31
63	Portable X-Ray Supplier (Billing Independently)	1		25
64	Audiologist (Billing Independently)	1		29,34
65	Indiv Physical Therapist	1		29,35
66	Dentist, DDS, DMS	1		27
67	Oral Surgeon - Dental	1		27
68	Pedodontist	1		27
69	Independent Laboratory (Billing Independently)	1		23
70	Clinic or Other Group Practice	1		19, 20, 68, 74, 76, 91, 38
71	Speech Therapy	1		29
72	Diagnostic Laboratory	1		23
73	Social Worker Enrollment	1		73
74	Occupational Therapy	1		29,37
75	Other Medical Care	1		65
76	Adult Day Care	1		85
77	Habilitation	1		85
78	Mental Health Rehab	1		77
79	Nurse Practitioner	1		78
80	Environmental Modifications	1		15
81	Case Management	1		07, 08, 43, 46, 81
82	Personal Care Attendant	1		82
83	Respite Care	1		83
84	Substitute Family Care	1		84
85	Extended Care Hospital	1		60
86	Hospitals and Nursing Homes	1		55, 59, 60, 64, 69, 80, 88
87	All Other	1		26,40,44, 60
88	Optician / Optometrist	1		28,75
89	Supervised Independent Living	1		89
90	Personal Emergency Response Sys (Waiver)	1		16
91	Assistive Devices	1		17
92	Prescribing Only Providers	1		33

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
93	Hospice Service for Dual Elig.	1		09
94	Rural Health Clinic	1		79,87
95	Psychologist (PBS Program Only)	1		31
96	Psychologist (PBS Program and X-Overs)	1		31
97	Family Planning Clinic	1		71
98	Supported Employment	1		98
99	Provider Pending Enrollment	1		n/a
1A	Adolescent Medicine	2	37	19,20
1B	Diagnostic Lab Immunology	2	37	19,20
1C	Neonatal Perinatal Medicine	2	37	19,20
1D	Pediatric Cardiology	2	37	19,20
1E	Pediatric Critical Care Medicine	2	37	19,20
1F	Pediatric Emergency Medicine	2	37	19,20
1G	Pediatric Endocrinology	2	37	19,20
1H	Pediatric Gastroenterology	2	37	19,20
1I	Pediatric Hematology - Oncology	2	37	19,20
1J	Pediatric Infectious Disease	2	37	19,20
1K	Pediatric Nephrology	2	37	19,20
1L	Pediatric Pulmonology	2	37	19,20
1M	Pediatric Rheumatology	2	37	19,20
1N	Pediatric Sports Medicine	2	37	19,20
1P	Pediatric Surgery	2	37	19,20
1S	BRG - Med School	2		19,20
1T	Emergency Medicine	1		19,20
1Z	Pediatric Day Health Care	1		04
2A	Cardiac Electrophysiology	2	41	19,20
2B	Cardiovascular Disease	2	41	19,20
2C	Critical Care Medicine	2	41	19,20
2D	Diagnostic Laboratory Immunology	2	41	19,20
2E	Endocrinology & Metabolism	2	41	19,20
2F	Gastroenterology	2	41	19,20
2G	Geriatric Medicine	2	41	19,20
2H	Hematology	2	41	19,20
2I	Infectious Disease	2	41	19,20
2J	Medical Oncology	2	41	19,20
2K	Nephrology	2	41	19,20

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
2L	Pulmonary Disease	2	41	19,20
2M	Rheumatology	2	41	19,20
2N	Surgery - Critical Care	2	41	19,20
2P	Surgery - General Vascular	2	41	19,20
2Q	Nuclear Medicine	1		19,20
2R	Physician Assistant	1		94
2S	LSU Medical Center New Orleans	2		19,20
2T	American Indian / Native Alaskan	2		95
2Y	OPH Genetic Disease Program	1		40
3A	Critical Care Medicine	2	16	19,20
3B	Gynecologic oncology	2	16	19,20
3C	Maternal & Fetal Medicine	2	16	19,20
3D	Community Choices Waiver - Respiratory Therapy	2	87, 75	44, 65
3E	Community Choices Waiver - PT and OT	2	87, 75	44, 66
3F	Community Choices Waiver - PT and S/L T	2	87, 75	44, 67
3G	Community Choices Waiver - PT and RT	2	87, 75	44, 68
3H	Community Choices Waiver - OT and S/L T	2	87, 75	44, 69
3J	Community Choices Waiver - OT and RT	2	87, 75	44, 70
3K	Community Choices Waiver - S/L T and RT	2	87, 75	44, 71
3L	Community Choices Waiver - PT, OT & S/L T	2	87, 75	44, 72
3M	Community Choices Waiver - PT, OT & RT	2	87, 75	44, 73
3N	Community Choices Waiver - PT, S/L T & RT	2	87, 75	44, 74
3Q	Community Choices Waiver - OT, S/L T & RT	2	87, 75	44, 75
3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2	87, 75	44, 76
3S	LSU Medical Center Shreveport	2		19,20
3U	Community Choices Waiver – Assistive Devices – Home Health	2		
4A	Home and Community-Based Services	1		01,02

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
4B	NOW RN	1		06
4C	NOW LPN	1		06
4D	NOW Psychologist	1		06
4E	NOW Social Worker	1		06
4R	Registered Dietician	1		41
4S	Ochsner Med School	2		19,20
4W	Waiver Services	1		42
4X	Waiver-Only Transportation	1		42
5A	PCS-LTC	1		24
5B	PCS-EPSDT	1		24
5C	PAS	1		24
5D	PCS-LTC, PCS-EPSDT	1		24
5E	PCS-LTC, PAS	1		24
5F	PCS-EPSDT, PAS	1		24
5G	OCS-LTC, PCS-EPSDT, PAS	1		24
5H	Community Mental Health Center			18
5I	Statewide Management Organization (SMO)	1		AB
5J	Youth Support	1		AC
5K	Family Support	1		AC
5L	Both Youth and Family Support	1		AC
5M	Multi-Systemic Therapy			12
5N	Substance use and Alcohol use Center	1		68
5P	PACE	1		50
5S	Tulane Med School	2		19,20
5U	Individual	1		AD
5V	Agency/Business	1		AD
5W	Community Choices Waiver - Personal Assistance Service	2	87	44
5X	Therapeutic Group Homes	1		96
5Y	PRCS Addiction Disorder	1		

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
5Z	Therapeutic Group Home Disorder	1		96
6A	Psychologist -Clinical	1		31
6B	Psychologist-Counseling	1		31
6C	Psychologist - School	1		31
6D	Psychologist - Developmental	1		31
6E	Psychologist - Non-Declared	1		31
6F	Psychologist - All Other	1		31
6H	LaPOP	1		01
6N	Endodontist	1		27
6P	Periodontist	1		27
6S	E Jefferson Fam Practice Ctr - Residency Program	2		19,20
6T	Community Choices Waiver - Physical Therapy	2	65, 87, 75	35, 44, 65
7A	SBHC - NP - Part Time - less than 20 hrs week	1		38
7B	SBHC - NP - Full Time - 20 or more hrs week	1		38
7C	SBHC - MD - Part Time - less than 20 hrs week	1		38
7D	SBHC - MD - Full Time - 20 or more hrs week	1		38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	1		38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	1		38
7G	Community Choices Waiver - Speech/Language Therapy	2	71, 87, 75	39, 44, 65
7H	Community Choices Waiver - Occupational Therapy	2	74, 87, 75	37, 44, 65
7M	Retail Convenience Clinics	2	70	19,20,78
7N	Urgent Care Clinics	2	70	19,20,79
7S	Leonard J Chabert Medical Center - Houma	2		19,20
8A	EDA & DD services	2	82	82, AH
8B	EDA services	2	82	82
8C	DD services	2	82	82
8D	Community Choices Waiver - Caregiver Temporary Support	1	82, 83	82, 83

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types
8E	CSoC/Behavioral Health	1, 2		AB, AC, AD, AE, AF, AG, AH, AJ, AK, 82, 31, 68, 70, 73, 83, 53
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	2	8D	AN
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	2	8D	AN
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	2	8D	AN
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	2	8D	AN
8K	ADHC HCBS	1		AL
8L	Hospital-based PRTF	1		96
8M	Community Choices Waiver - Home-Delivered Meals	1		AM
8N	Community Choices Waiver - Nursing	2		44, 78
8P	Other specialization (other than Addiction Disorder)	1		96
8Q	Community Choices Waiver - EAA Assessor, Inspector, Approver	2		15
9B	Psychiatric Residential Treatment Facility	1		96
9D	Residential Care	1		97
9E	Children's Choice Waiver	1		03
9L	RHC/FQHC OPH Certified SBHC	1		72
9P	GNOCHC - Greater New Orleans Community Health Connection	1		99
9Q	PT 21 - EDI Independent Billing Company	2		21
9U	Medicare Advantage Plans	1		21
9V	OCDD - Point of Entry	1		21
9W	OAAS - Point of Entry	1		21
9X	OAD	1		21
9Y	Juvenile Court/Drug Treatment Center	1		21
9Z	Other Contract with a State Agency	1		21

Appendix H

Test Plan

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

Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each SMO must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. The SMO 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 SMO to be able to both transmit and receive.

The second step performed concurrently with the enrollment, is EDIFECS testing. A partnership exists between EDIFECS and Molina Electronic Data Interchange (EDI) Services, Inc. to assist in compliance testing and tracking submitter test files prior to submission through the Molina Electronic Data Interchange (EDI). Certain errors will occur while testing with EDIFECS that shall not be considered when determining whether a SMO has passed or failed the EDIFECS portion of testing.

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

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;

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

Once EDIFECS testing is complete, the SMO is certified that the X12 transaction is properly formatted to submit to the MMIS. The encounter claims data from the SMO is identified by the value 'RP' being present in X12 field TX-TYPE-CODE field. The SMO must ensure that their Medicaid IDs are in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'. If line item SMO paid amount is submitted, they also need to populate the 'Other Payer Primary Identifier' in loop 2430 segment SVD with their Medicaid provider number. These fields are used in the MMIS pre-processors to indicate that the amount in the accompanying prior paid field is the SMO's paid amount and not TPL or any other COB amount. For more details, please refer to the Molina Electronic Data Interchange (EDI) Services, Inc. *Submitter Testing Report* for the DHH.

Testing Tier II

Once the SMO has successfully passed more than 50% of their encounter data claims through the pre-processors, Molina will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction to be retrieved by the SMO via IDEX. Each SMO is required to examine the returned 835s and compare them to the encounter data claims (837s) they submitted to ensure all claims that were submitted are accounted for in the data collection. Molina will send the new edit code reports to the SMO and DHH for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. Molina is available to answer any questions that any SMO may have concerning the edit codes.

Testing Tier III

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

Appendix I

Websites

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

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

Website Address	Website Contents
	resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.
http://www.x12.org	This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.

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

Statewide Management Organization (SMO) Systems Companion Guide

Appendix K

SMO Data Exchange Document

File Exchange with LBHP/CSoC SMO

(as amended from LIFTs 7063, 6666, 9553)

Platforms: Mainframe, Client-Server

Level: 3

Version 3.10

Date: 11-20-2014

Louisiana Medicaid

Requirements and High-Level Design (RAHD)
and
Detailed Specifications Document (DSD)
for
LIFT 7980
File Exchange with LBHP/CSoC SMO

(as amended from LIFTs 7063, 6666, 9553)

Platforms: Mainframe, Client-Server

Level: 3

Version: 3.10
Date: 11/20/2014

Project Information:

Document Title	Louisiana MMIS RAHD/DSD – **File Exchange with LBHP/CSoC SMO**
Author	Jeff Raymond Molina
To Be Approved By	DHH Subject Matter Expert (s): Darrell Montgomery DHH Project Core Team Member (s): George Bucher
Comments	Revisions will be noted below and identified as version number N.N, with an increase in the version number decimal position for each subsequent revision.
RAHD-DSD Template:	10/26/06

REVISION HISTORY

Rev	Section	Type	Date	Author	Remarks
3.3	ALL	Draft	12/19/2011	J. Raymond	First version of the deliverable submitted to DHH for review.
3.4	2.5.2.12 2.5.4.2	Draft	01/19/2012 – 01/25/2012	J. Raymond	Updated version showing added type case code on LTC eligibility file: **EB-LTC-DATA. Added field:** **LTC-OTHER-TYPE-CASE** **PIC X(3).** Added Section 2.5.4.2 Provider Registry Edit Report
3.5	2.5.1 2.5.5.1 2.6.1	Final	04/17/2012	J. Raymond	Added CB-EMC-CODE to EB-CLAIM-BASE in order to distinguish between claims and encounters.
3.6	2.5.2	Final	04/04/2013	J. Lavigne	Added 2.5.2 WEEKLY DECOMPRESSED PHARMACY FILL
3.7	2.5.5.1	Final	07/16/2014	J. Lavigne	Added Magellan Weekly Encounter Feeds information.
3.8	2.5.1.1	Final	09/19/2014	J. Lavigne	Updated to remove the CB-CC-LINK-IND field that was replaced by the CB-EMC-CODE field at the end of Claims-Base table (2.5.1.1)
3.9	2.5.3.12	Final	11/19/14	T. Tate	Updated the Recipient LTC Data for the record layout in section 2.5.3.12 per request.
3.10	C.18	Final	11/20/14	T. Tate	Updated the Preferred Language Indicator with new code and languages.

Table of Contents

1.0 REQUIREMENTS AND HIGH-LEVEL DESIGN (RAHD)

1.1 Overview of Processing Requirements

(This is the text of LIFT Description)

We are requesting that Molina staff work to identify, define, develop and implement standard file extracts for the following primary LMMIS data sources:

1. Recipient data and available eligibility information;
2. Provider data, including available enrollment information;
3. Claims-based data;
4. Available Hospice information;
5. Available TPL information.

Once established in a production environment, these file extracts should be executed upon a mutually accepted and feasible schedule (between DHH, Molina and the SMO).

1.2 SFP and Proposal References/LIFT

LIFTs 7980

SFP References

Not applicable

Proposal References

Not applicable

1.3 General Requirements

1.3.1 Molina CONSIDERATIONS

1) Molina will create Recipient, Provider, and Site file extracts to be sent periodically to the SMO based on the schedule in Appendix B of this document.

   a) Only updated records will be sent Monday through Thursday.

   b) Files will only be created for days where the state is open for business. On state holidays, there will be no files generated.

   c) Weekly files will be generated each Sunday evening which will contain a full listing of all recipient, provider, and site information.

2) Molina will create Claims file extracts to be sent weekly for claims processed, except for Long-Term Care and Crossover claims.

1.3.2 SMO CONSIDERATIONS

1) SMO will provide access to a secure FTP server at their location.

2) A non-expiring login id and password will be provided to Molina.

3) SMO will maintain the FTP server and allow space to store all files to be sent to their location.

1.4 Online Requirements (Screens/Pages)

1.4.1 There are no online requirements for this LIFT.

1.5 Reporting Requirements

1.5.1 There are no reporting requirements for this LIFT.

1.6 Subsystems/Applications Impacted

1.6.1 MAINFRAME SUBSYSTEMS (BOLD ALL THAT APPLY):

Claims	EPSDT	Financial Adjustments	**MARS**	PA/Pre-cert
POS	Provider	Recipient	Reference	SURS
TDUR	CC/KM	**Other: FTP**		

1.6.2 WEB/CLIENT SERVER APPLICATIONS (BOLD ALL THAT APPLY):

Coinserve	**DED -Data Element**	e-CCR – Web-Based	e-CDI – Web-Based	e-CSI – Web-Based

	Dictionary	Community Care Reports	Clinical Data Inquiry	Claims Status Inquiry
e-PA - Web-Based Prior Authorization	e-RA – Web-Based PCP Referral Auth	FDW – Financial Data Warehouse	InTERnet	InTRAnet
LaHIPP	Mailing Labels	MDW – Medicaid Data Warehouse	MSIS – Medical Statistical Info Set	OADES – Optical Assisted Data Entry System
OFT – Online Financial Transactions	Online Zip+4	PBP – Peer-Based Profiling	PETS – Provider Enrollment Tracking System	PRIMS – Pharmaceutical Rebate Info Mgmt System
Recip Reimbursement	REVS/MEVS/ eMEVS – Eligibility Verification	RxPA – Pharmacy Prior Authorization	SPT – System Project Tracking	Sys Doc
TPL Recovery	TRRS – EDI Transaction Receipt and Response System	Other: Med Vendor		

1.7 Operations Impacted

(Bold all that apply and note the operational impacts below):

Adjustments	Data Prep / Entry	Edit Reso	EDI	Files Maintenance
LTC – Long Term Care	Med Review	PA/Precert	PBM – Pharmacy Benefit Management	Prod Control/CO
Prov Enrollment	Prov Relations/Fld	SURS	Other:	

1.8 Operational Requirements

1.8.1 Molina production control will generate files and monitor FTP process after nightly updates.

1.9 Provider/DHH/ Molina Training Requirements

1.9.1 None identified.

1.10 High-Level Design

Molina will create 4 extract processes, one for Recipient, Provider, Provider-Site and Claims respectively. The claims extract will be run weekly and create a series of several extract files. These files are as follows:

Claims – Generated Weekly – (Join Key – Date-of-Payment and Sequence Number)

1) Claim Header – Information common amongst all claim types, such as Individual Claim Number (ICN), Provider ID, Recipient ID, Date of service, etc…
2) Error Codes – Up to 10 Error codes, Error Sequence, and Error Indicator associated with claim
3) EOB Codes – Up to 10 EOB codes and EOB Sequences associated with claim
4) Diagnosis File – Up to 6 diagnosis codes with an indicator identifying primary, secondary, …
5) Surgical Dx – Up to 6 surgical diagnosis codes associate with UB04 and 837I claims.
6) Hospital Header – Claim information specific to hospital inpatient claims, such as admit-date, attending physician, patient-status, etc…
7) Hospital Revenue – Revenue code, units, revenue-charge, and non-revenue-charge
8) Outpatient Detail – Claim information specific to hospital outpatient claims, such as revenue code, HCPC or NDC when available. (Home Health services will also be included in this format)
9) Professional Detail – HCPC/Procedure Code, units, referring provider, treatment place…
10) Dental Detail – Contains dental specific information, such as ADA code, surfaces with modifiers, treatment place, referring agency.
11) Pharmacy Detail – Contains pharmacy specific information, such as NDC, Prescribing physician, Rx-Date, Metric Quantity, Days Supply, etc …
12) EPSDT Detail – Procedure Code, Last Screening Date, Screening Code, Immunization Indicator, up to 6 suspected conditions.
13) EPSDT Suspect Conditions – Under Care, Offsite, and In-house indicators.
14) EPSDT Referrals – Appointment date, referred to provider-site, Name, Phone,

Recipients – (Join Key Recipient-ID)

1) Recipient Header – Contains information that appears once per recipient, such as Name, Current ID, Original ID, Birthday, etc…
2) Lock-In Table – Contains information for recipients that are restricted by DHH to specific providers and/or pharmacist such as, Date range of Lock-In, Pharmacist, Provider, Lock-In Code.
3) Recipient Eligibility Table – Contains information regarding a recipient's period of eligibility, such as: Approval-code, Type-Case, Aid-Category, Money-Code, Begin-Date, End-Date, MEDS-ID, last activity-date.
4) Recipient LTC-Waiver Table – Contains information identifying waiver or LTC facility, with the begin and end dates.
5) Recipient TPL Detail – Contains information about any Private TPL and/or Medicare Part-A, Part-B insurance associated with the recipient.
6) Recipient CCN Data – Contains information about any linkages to either CCN-P, CCN-S, or PACE MCO plans relevant for the recipient.
7) Recipient Hospice Data – Contains information about hospice enrollment.

Providers – (Join Key -- Provider-ID)

1) Provider Header – Contains information that appears once per provider, such as Name, NPI, Type, Specialty, Parish, etc…
2) Provider Enrollment – Up to 3 records per provider with the Begin-Date, End-Date, and Cancellation Reason associated with provider's enrollment within the Medicaid system.
3) Provider-Member-Of Table – Up to 20 records per provider identifying under which other provider ids the provider may be associated, the begin date, the end date, and cancellation code. Primarily used to identify under which group the provider may perform services, as in a physician can be a member of several hospitals and clinics.
4) Provider-Members Table – Up to 1500 records per provider identifying which other provider ids may be associated with the facility. Primarily used to identify providers, such as hospitals where there are numerous other providers working at the facility.

1.11 Assumptions, Constraints, and Open Items

1.11.1 ASSUMPTIONS

1.11.1.1 Molina will extract information that is stored in the LMMIS files. Addresses and phone numbers have been validated, except where noted by other values in the files.

1.11.2 CONSTRAINTS

1.11.1.2 None noted.

1.11.3 OPEN ITEMS

1.11.3.1 Comprehensive Data Dictionary to be developed.

STATUS: COMPLETE. See Section 2.6 and Appendix C

1.11.3.2 Devise schedule of FTP transfers for daily, weekly, monthly files.

STATUS: COMPLETE. See Appendix B.

1.12 Referenced Documents

LIFT 7980.

2.0 DETAILED SYSTEMS DESIGN (DSD)

2.1 Process Description/Flowcharts/Specifications

The changes needed to LMMIS Core infrastructure include the following LMMIS subsystems/applications:

2.1.1 RECIPIENT SUBSYSTEM

2.1.1a No changes are necessary.

2.1.2 PROVIDER SUBSYSTEM

2.1.2a No changes are necessary.

2.1.3 PRIOR AUTHORIZATION and PRECERT SUBSYSTEMS

2.1.3a No changes are necessary.

2.1.4 REFERENCE SUBSYSTEM

2.1.4a No changes are necessary.

2.1.5 CLAIMS PROCESSING (CP) SUBSYSTEM

2.1.5a No changes are necessary..

2.1.6 BACK-END SUBSYSTEMS and MARS/MDW

2.1.6a SURS (J-SURS)

No modifications will be necessary.

2.1.6c MSIS

No changes are necessary.

2.1.6c MARS/MDW Reporting

File extract process described in this document.

2.1.7 OTHER SUBSYSTEMS

2.1.7a No specific subsystems will be impacted.

2.2 Online Screens/Pages Layouts

2.2.1 No modifications are necessary.

2.3 Forms Changes

2.3.1 No modifications will be necessary.

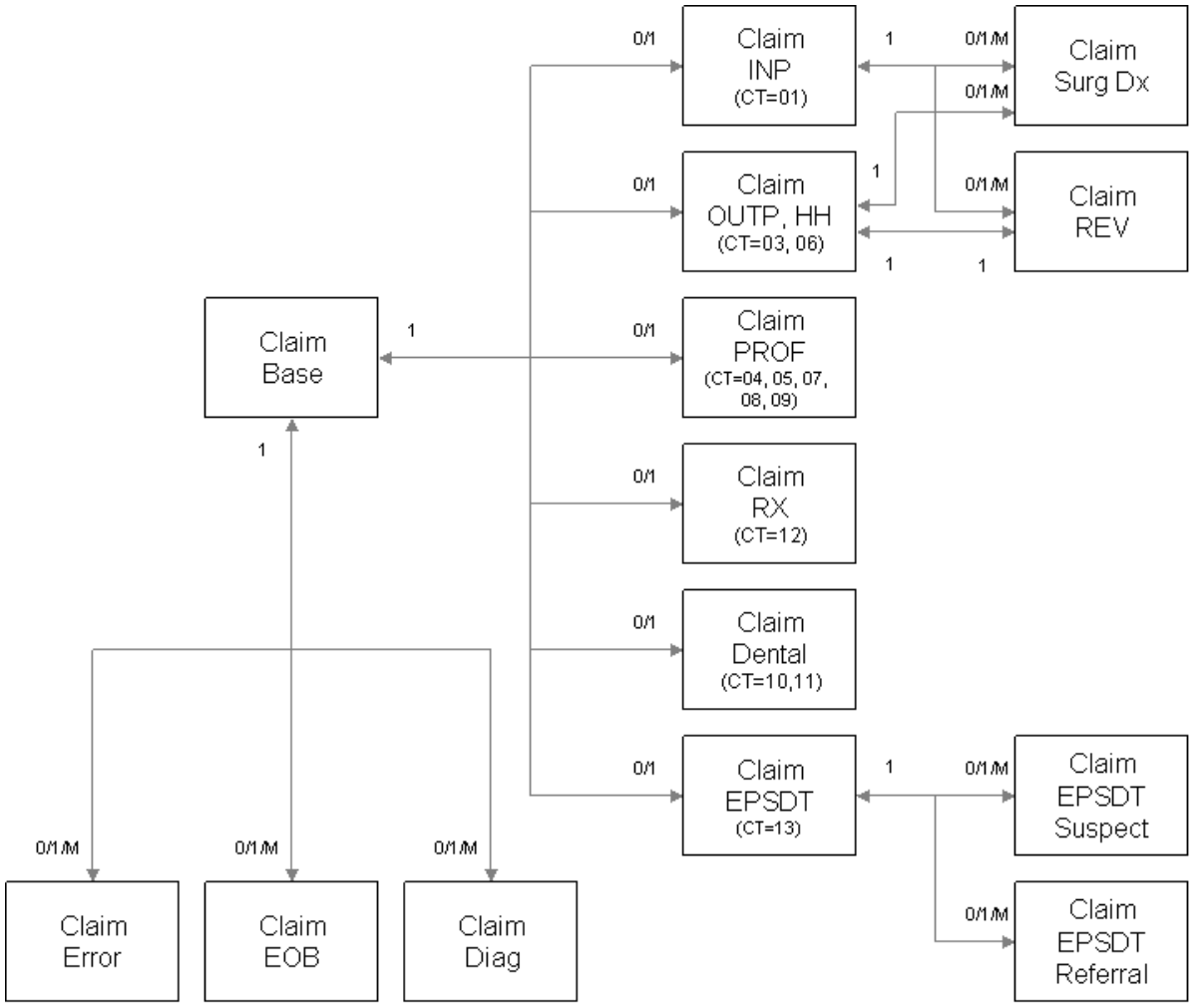
2.4 Reports/layouts

2.4.1 No Reports are to be generated.

2.5 File Definitions/Entity Relationship Diagram, Schema

2.5.1 CLAIM FILES. Sent by Molina to the SMO according to the schedule in Appendix B.

The following diagram, 2.5-A, depicts the file extract schema for claims data.



Join criteria on all tables: Checkwrite+ClaimID

2.5.1.1 Claim Base

NOTE: SMO will receive ALL claim types and we will send one (1) year of claims history, initially, at the beginning of the project.

```
01  EB-CLAIM-BASE.
    05  CB-CHECKWRITE-DATE              PIC 9(08).
    05  CB-CLAIMID                      PIC 9(08).
    05  CB-ICN                          PIC 9(13).
    05  CB-CLAIM-TYPE                   PIC 9(02).
    05  CB-CLAIM-MOD                    PIC 9(01).
    05  CB-CLAIM-STATUS                 PIC 9(01).
    05  CB-SVC-PROV                     PIC 9(07).
    05  CB-SVC-CHK-DGT                  PIC 9(07).
    05  CB-SVC-NPI                      PIC X(10).
    05  CB-BILL-PROV                    PIC 9(07).
    05  CB-BILL-CHK-DGT                 PIC 9(07).
    05  CB-BILL-NPI                     PIC X(10).
    05  CB-RECIP-SUBMITTED              PIC X(13).
    05  CB-RECIP-CURRENT                PIC X(13).
    05  CB-RECIP-ORIGINAL               PIC X(13).
    05  CB-FROM-DATE                    PIC 9(08).
    05  CB-THRU-DATE                    PIC 9(08).
    05  CB-BILLED-UVS                   PIC -9(04).
    05  CB-UNITS-VISITS-QUANT           PIC -9(04).
    05  CB-BILLED-AMT                   PIC -9(6).99.
    05  CB-TPL-PAID                     PIC -9(6).99.
    05  CB-COB-OTHER-PAT-AMT            PIC -9(6).99.
    05  CB-PAYMENT                      PIC -9(6).99.
    05  CB-MEDICAID-ALLOWED             PIC -9(6).99.
    05  CB-FORMER-ICN                   PIC 9(13).
    05  CB-FORMER-CHECKWRITE            PIC 9(08).
    05  CB-RECIP-PARISH-CODE            PIC 9(02).
    05  CB-RECIP-RACE                   PIC X(01).
    05  CB-RECIP-SEX                    PIC X(01).
    05  CB-RECIP-AID-CATEG              PIC 9(02).
    05  CB-RECIP-TYPE-CASE              PIC 9(03).
    05  CB-RECIP-BIRTHDATE              PIC 9(08).
    05  CB-RECIP-SSN                    PIC X(09).
    05  CB-MEG                          PIC X(02).
    05  CB-CAT-OF-SERVICE               PIC 9(02).
    05  CB-TYPE-OF-SERVICE              PIC 9(02).
```

```
           05  CB-PA                          PIC X(10).
           05  CB-RA-NUMBER                   PIC X(09).
           05  CB-STATE-ORG-NO                PIC X(04).
           05  CB-ACCID-IND                   PIC X.
           05  CB-EMER-IND                    PIC X.
           05  CB-EPSDT-IND                   PIC X.
           05  CB-BEN-EXHAUST-IND             PIC X.
           05  CB-TRAUMA-IND                  PIC X.
           05  CB-FAMILY-PLAN-IND             PIC X.
           05  CB-EMC-CODE                    PIC X(1).
           05  CB-RECIP-AGE-IN-YEARS          PIC 9(3).
           05  CB-MEDICAL-RECORD-NO           PIC X(30).
           05  CB-REMIT-ID                    PIC 9(7)
```

2.5.1.2 Claim Error

```
       01  EB-ERROR-REC.
           05  ER-CHECKWRITE-DATE             PIC 9(08).
           05  ER-CLAIMID                     PIC 9(08).
           05  ER-ERROR-CODE                  PIC 9(03).
           05  ER-ERROR-SEQUENCE              PIC 9(02).
           05  ER-ERROR-FLAG                  PIC X(01).
```

2.5.1.3 Claim EOB (Explanation of Benefit)

```
       01  EB-EOB-REC.
           05  EB-CHECKWRITE-DATE             PIC 9(08).
           05  EB-CLAIMID                     PIC 9(08).
           05  EB-EOB-CODE                    PIC 9(03).
           05  EB-EOB-SEQUENCE                PIC 9(02).
```

2.5.1.4 Claim Diagnosis

```
       01  EB-DIAGNOSIS-REC.
           05  DX-CHECKWRITE-DATE             PIC 9(08).
           05  DX-CLAIMID                     PIC 9(08).
           05  DX-ICD9-CODE                   PIC X(05).
           05  DX-ICD9-SEQUENCE               PIC 9(01).
```

2.5.1.5 Claim Surgical Diagnosis / Surgical Procedure Code

```
       01  EB-SURGICAL-DX-REC.
```

```
    05  SDX-CHECKWRITE-DATE              PIC 9(08).
    05  SDX-CLAIMID                     PIC 9(08).
    05  SDX-ICD9-CODE                   PIC X(04).
    05  SDX-ICD9-DATE                   PIC 9(08).
```

2.5.1.6 Claim Inpatient

```
01  EB-HOSPITAL-INPATIENT-REC.
    05  HIR-CHECKWRITE-DATE             PIC 9(08).
    05  HIR-CLAIMID                     PIC 9(08).
    05  HIR-TYPE-BILL                   PIC X(03).
    05  HIR-ADMIT                       PIC 9(08).
    05  HIR-PATIENT-STATUS              PIC X(02).
    05  HIR-TOTAL-CHARGE                PIC -9(6).99.
    05  HIR-TOT-NON-COV-CHARGE          PIC -9(6).99.
    05  HIR-COV-DAYS                    PIC -9(3).
    05  HIR-NON-COV-DAYS                PIC -9(3).
    05  HIR-CALC-DAYS                   PIC -9(3).
    05  HIR-ATTEND-PHYS                 PIC X(7).
    05  HIR-ATTEND-PHYS-NPI             PIC X(10).
    05  HIR-OTHER-PHYS                  PIC X(7).
    05  HIR-OTHER-PHYS-NPI              PIC X(10).
    05  HIR-PER-DIEM-RATE               PIC 9(4).99.
    05  HIR-PERCENT-RATE                PIC 9(4).99.
    05  HIR-MOTHER-RECIP-ID             PIC X(13).
```

2.5.1.7 Claim Revenue Codes

```
01  EB-REVENUE-REC.
    05  REV-CHECKWRITE-DATE             PIC 9(08).
    05  REV-CLAIMID                     PIC 9(08).
    05  REV-CODE                        PIC X(3).
    05  REV-UNITS                       PIC 9(3).
    05  REV-CHARGE                      PIC -9(6).99.
    05  REV-RATE                        PIC  9(6).99.
    05  REV-NON-REV-CHARGE              PIC -9(6).99.
```

2.5.1.8 Claim Hospital Outpatient and Home-Health

```
01  EB-HOSPITAL-OUTPATIENT-REC.
    05  HOR-CHECKWRITE-DATE             PIC 9(08).
    05  HOR-CLAIMID                     PIC 9(08).
    05  HOR-TYPE-BILL                   PIC X(03).
```

```
05  HOR-ADMIT                          PIC 9(08).
05  HOR-ATTEND-PHYS                    PIC X(7).
05  HOR-OTHER-PHYS                     PIC X(7).
05  HOR-FED-PROGRAM-IND                PIC X.
05  HOR-NON-COV-CHARGE                 PIC -9(6).99.
05  HOR-HCPC-CODE                      PIC X(5).
05  HOR-HCPC-TOS                       PIC XX.
05  HOR-REV-CODE                       PIC X(5).
05  HOR-PATIENT-STATUS                 PIC X(2).
05  HOR-PAT-STATUS-DATE                PIC X(8).
05  HOR-HH-STATEMENT-FROM-DATE         PIC X(8).
05  HOR-HH-STATEMENT-THRU-DATE         PIC X(8).
05  HOR-EPO-AMT                        PIC 9(6).
05  HOR-ER-VISIT-IND                   PIC X.
05  HOR-ATTEND-PHYS-NPI                PIC X(10).
05  HOR-OTHER-PHYS-NPI                 PIC X(10).
05  HOR-NDC                            PIC X(11).
05  HOR-NDC-UNIT-MEASURE               PIC X(2).
05  HOR-NDC-UNITS                      PIC -9(7).999.
05  HOR-NDC-UNIT-PRICE                 PIC  9(6).9(5).
```

2.5.1.9 Claim Professional

```
01  EB-PROFESSIONAL-REC.
    05  PR-CHECKWRITE-DATE             PIC 9(08).
    05  PR-CLAIMID                     PIC 9(08).
    05  PR-PROC                        PIC 9(05).
    05  PR-TOS                         PIC 9(02).
    05  PR-MOD1                        PIC X(02).
    05  PR-MOD2                        PIC X(02).
    05  PR-MOD3                        PIC X(02).
    05  PR-MOD4                        PIC X(02).
    05  PR-BILL-PROV-SITE              PIC X(03).
    05  PR-REFER-PROV-NO               PIC X(07).
    05  PR-REFER-PROV-NPI              PIC X(10).
    05  PR-REFER-PROV-IND              PIC X(01).
    05  PR-PAT-STATUS                  PIC X(02).
    05  PR-PAT-STAT-DATE               PIC 9(08).
    05  PR-TREAT-PLACE                 PIC X(02).
    05  PR-DME-TITLE18-IND             PIC X(01).
    05  PR-OUT-ATTENDING-PHYS          PIC X(7).
    05  PR-OUT-ATTEND-PHYS-NPI         PIC X(10).
```

```
05  PR-PRE-OP                          PIC 9(3).
05  PR-POST-OP                         PIC 9(3).
05  PR-STATEMENT-FROM-DATE             PIC 9(8).
05  PR-STATEMENT-THRU-DATE             PIC 9(8).
05  PR-NDC                             PIC X(11).
05  PR-NDC-UNIT-MEASURE                PIC X(2).
05  PR-NDC-UNITS                       PIC -9(7).999.
05  PR-NDC-DESC                        PIC X(20).
05  PR-NDC-UNIT-PRICE                  PIC  9(6).9(5).
```

2.5.1.10 Claim Dental

```
01  EB-DENTAL-REC.
    05  DENT-CHECKWRITE-DATE           PIC 9(08).
    05  DENT-CLAIMID                   PIC 9(08).
    05  DENT-PROC                      PIC 9(05).
    05  DENT-TOOTH                     PIC X(02).
    05  DENT-PROC-MOD1                 PIC X(2).
    05  DENT-ORAL-CAVITY-CODE          PIC X(2).
    05  DENT-SURF-1                    PIC X.
    05  DENT-SURF-2                    PIC X.
    05  DENT-SURF-3                    PIC X.
    05  DENT-SURF-4                    PIC X.
    05  DENT-SURF-5                    PIC X.
    05  DENT-TREAT-PLACE               PIC X(2).
    05  DENT-REFER-AGENCY              PIC X(06).
    05  DENT-REFER-AGENCY-NPI          PIC X(10).
    05  DENT-PROSTHESIS-IND            PIC X.
    05  DENT-LEVEL3-CHG                PIC 9(5).99.
    05  DENT-LEVEL2-CHG                PIC 9(5).99.
    05  DENT-LEVEL1-CHG                PIC 9(5).99.
    05  DENT-PA-TRAUMA-IND             PIC X(1).
```

2.5.1.11 Claim Pharmacy

```
01  EB-PHARMACY-REC.
    05  RX-CHECKWRITE-DATE             PIC 9(08).
    05  RX-CLAIMID                     PIC 9(08).
    05  RX-NDC                         PIC 9(11).
    05  RX-PRESC-PHYS                  PIC 9(07).
    05  RX-PRESC-PHYS-NPI              PIC X(10)
    05  RX-SCRIPT-DATE                 PIC 9(08).
    05  RX-DAYS-SUPPLY                 PIC -9(3).
```

```
05  RX-SCRIPT-NO                    PIC X(07).
05  RX-INVOICE-NO                   PIC X(09).
05  RX-MAC-IND                      PIC X.
05  RX-DRUG-PRICE                   PIC  9(4).9(5).
05  RX-MAC-PRICE                    PIC  9(4).9(5).
05  RX-FUL-PRICE                    PIC  9(4).9(5).
05  RX-DISP-FEE                     PIC -9(3).99.
05  RX-REFILL-CODE                  PIC 9.
05  RX-THERP-CLASS                  PIC X(03).
05  RX-SCH2-NARC-IND                PIC X.
05  RX-PRICING-ACTION-CODE          PIC X(3).
05  RX-QUANTITY                     PIC -9(7).999.
05  RX-CO-PAY-MAC-IND               PIC X.
05  RX-CO-PAY                       PIC -9(6).99.
05  RX-DUR-CONFLICT                 PIC XX.
05  RX-DUR-INT                      PIC XX.
05  RX-HICL-SEQ-NO                  PIC XX.
05  RX-ACUTE-THERAPY-IND            PIC X.
05  RX-ROUTE-ADMIN                  PIC X.
05  RX-DATE-PROCESSED               PIC 9(06)
05  RX-TIME-PROCESSED               PIC 9(06).
05  RX-BASIS-OF-COST                PIC X(02).
05  RX-EX-DRUG-PRICE                PIC  9(6).9(5).
05  RX-EX-MAC-PRICE                 PIC 9(6).9(5).
05  RX-EX-FUL-PRICE                 PIC 9(6).9(5).
```

2.5.1.12 Claim EPSDT

```
01  EB-EPSDT-REC.
    05  EPSDT-CHECKWRITE-DATE       PIC 9(08).
    05  EPSDT-CLAIMID               PIC 9(08).
    05  EPSDT-KIDMED-MEDREC-NO      PIC X(13).
    05  EPSDT-DATE-LAST-SCREEN      PIC 9(8).
    05  EPSDT-SCREEN-CODE           PIC X.
    05  EPSDT-COMPLETE-IND          PIC X.
    05  EPSDT-REFER-IND             PIC X.
    05  EPSDT-IMMUN-IND             PIC X.
    05  EPSDT-SUSPECTED-COND1       PIC X.
    05  EPSDT-SUSPECTED-COND2       PIC X.
    05  EPSDT-SUSPECTED-COND3       PIC X.
    05  EPSDT-SUSPECTED-COND4       PIC X.
    05  EPSDT-SUSPECTED-COND5       PIC X.
```

```
05  EPSDT-SUSPECTED-COND6              PIC X.
05  EPSDT-KIDMED-SUBID                 PIC X(7).
05  EPSDT-PROV-SITE-NO                 PIC 9(3).
05  EPSDT-PROV-SITE-PARISH             PIC X(2).
05  EPSDT-REFER-PROVIDER-NO            PIC X(7).
05  EPSDT-REFER-PROVIDER-NPI           PIC X(10).
05  EPSDT-PATIENT-HOME-PHONE           PIC X(10).
05  EPSDT-PATIENT-WORK-PHONE           PIC X(10).
05  EPSDT-GUARDIAN-NAMEL               PIC X(17).
05  EPSDT-GUARDIAN-NAMEF               PIC X(12).
05  EPSDT-GUARDIAN-NAMEM               PIC X(01).
05  EPSDT-NEXT-SCREENING-DATE          PIC X(8).
05  EPSDT-NEXT-SCREENING-TIME          PIC X(4).
05  EPSDT-MEDICAL-CONTRAINDICATED      PIC X(01).
05  EPSDT-REFUSED-TO-PERMIT            PIC X(01).
05  EPSDT-PATIENT-OFF-SCHEDULE         PIC X(01).
05  EPSDT-WERE-SUSP-CONDITIONS         PIC X(1).
05  EPSDT-KATRINA-BYPASS-1             PIC X.
05  EPSDT-KATRINA-BYPASS-2             PIC X.
05  EPSDT-PROC                         PIC X(05).
```

2.5.1.13 Claim EPSDT Suspect

```
01  EB-SUSPECT-REC.
    05  SUSPECT-CHECKWRITE-DATE        PIC 9(08).
    05  SUSPECT-CLAIMID                PIC 9(08).
    05  SUSPECT-UNDER-CARE             PIC X(01).
    05  SUSPECT-REFERRAL-INHOUSE       PIC X(01).
    05  SUSPECT-REFERRAL-OFFSITE       PIC X(01).
```

2.5.1.14 Claim EPSDT Referral

```
01  EB-REFERRAL-REC.
    05  REFERRAL-CHECKWRITE-DATE       PIC 9(08).
    05  REFERRAL-CLAIMID               PIC 9(08).
    05  REFERRAL-SEQUENCE              PIC 9(01).
    05  REFERRAL-NO1                   PIC X(01).
    05  REFERRAL-NO2                   PIC X(01).
    05  REFERRAL-NO3                   PIC X(01).
    05  REFERRAL-NO4                   PIC X(01).
    05  REFERRAL-ASSIST-NEEDED         PIC X(01).
    05  REFERRAL-APPT-DATE             PIC 9(08).
    15  REFERRAL-REASON                PIC X(37).
```

```
    15  REFERRAL-TO-PROV-SITE            PIC X(03).
    15  REFERRAL-TO-NAME                 PIC X(20).
    15  REFERRAL-TO-PROVIDER             PIC 9(07).
    15  REFERRAL-TO-PHONE                PIC 9(10).
```

2.5.2 WEEKLY DECOMPRESSED PHARMACY FILE

The name of the weekly decompressed pharmacy file that Molina sends to our SMO (Magellan) has been updated to add RX at the end of each pharmacy file name. For example, Claims Base Rx, and Claims Errors Rx.

2.5.2.1 Claims Base Rx

```
01  EB-CLAIM-BASE.
     05  CB-CHECKWRITE-DATE              PIC 9(08).
     05  CB-CLAIMID                      PIC 9(08).
     05  CB-ICN                          PIC 9(13).
     05  CB-CLAIM-TYPE                   PIC 9(02).
     05  CB-CLAIM-MOD                    PIC 9(01).
     05  CB-CLAIM-STATUS                 PIC 9(01).
     05  CB-SVC-PROV                     PIC 9(07).
     05  CB-SVC-CHK-DGT                  PIC 9(07).
     05  CB-SVC-NPI                      PIC X(10).
     05  CB-BILL-PROV                    PIC 9(07).
     05  CB-BILL-CHK-DGT                 PIC 9(07).
     05  CB-BILL-NPI                     PIC X(10).
     05  CB-RECIP-SUBMITTED              PIC X(13).
     05  CB-RECIP-CURRENT                PIC X(13).
     05  CB-RECIP-ORIGINAL               PIC X(13).
     05  CB-FROM-DATE                    PIC 9(08).
     05  CB-THRU-DATE                    PIC 9(08).
     05  CB-BILLED-UVS                   PIC -9(04).
     05  CB-UNITS-VISITS-QUANT           PIC -9(04).
     05  CB-BILLED-AMT                   PIC -9(6).99.
     05  CB-TPL-PAID                     PIC -9(6).99.
     05  CB-COB-OTHER-PAT-AMT            PIC -9(6).99.
     05  CB-PAYMENT                      PIC -9(6).99.
     05  CB-MEDICAID-ALLOWED             PIC -9(6).99.
     05  CB-FORMER-ICN                   PIC 9(13).
     05  CB-FORMER-CHECKWRITE            PIC 9(08).
     05  CB-RECIP-PARISH-CODE            PIC 9(02).
```

```
05  CB-RECIP-RACE                  PIC X(01).
05  CB-RECIP-SEX                   PIC X(01).
05  CB-RECIP-AID-CATEG             PIC 9(02).
05  CB-RECIP-TYPE-CASE             PIC 9(03).
05  CB-RECIP-BIRTHDATE             PIC 9(08).
05  CB-RECIP-SSN                   PIC X(09).
05  CB-MEG                         PIC X(02).
05  CB-CAT-OF-SERVICE              PIC 9(02).
05  CB-TYPE-OF-SERVICE             PIC 9(02).
05  CB-PA                          PIC X(10).
05  CB-RA-NUMBER                   PIC X(09).
05  CB-STATE-ORG-NO                PIC X(04).
05  CB-ACCID-IND                   PIC X.
05  CB-EMER-IND                    PIC X.
05  CB-EPSDT-IND                   PIC X.
05  CB-BEN-EXHAUST-IND             PIC X.
05  CB-TRAUMA-IND                  PIC X.
05  CB-FAMILY-PLAN-IND             PIC X.
05  CB-CC-LINK-IND                 PIC X.
05  CB-RECIP-AGE-IN-YEARS          PIC 9(3).
05  CB-MEDICAL-RECORD-NO           PIC X(30).
05  CB-REMIT-ID                    PIC 9(7)
05  CB-EMC-CODE                    PIC X(1).
```

2.5.2.2 Claims Error Rx

```
01  EB-ERROR-REC.
    05  ER-CHECKWRITE-DATE         PIC 9(08).
    05  ER-CLAIMID                 PIC 9(08).
    05  ER-ERROR-CODE              PIC 9(03).
    05  ER-ERROR-SEQUENCE          PIC 9(02).
    05  ER-ERROR-FLAG              PIC X(01).
```

2.5.2.3 Claims EOBs Rx

```
01  EB-EOB-REC.
    05  EB-CHECKWRITE-DATE         PIC 9(08).
    05  EB-CLAIMID                 PIC 9(08).
    05  EB-EOB-CODE                PIC 9(03).
    05  EB-EOB-SEQUENCE            PIC 9(02).
```

2.5.2.4 Claims Diagnosis Rx

```
01  EB-DIAGNOSIS-REC.
    05  DX-CHECKWRITE-DATE                PIC 9(08).
    05  DX-CLAIMID                        PIC 9(08).
    05  DX-ICD9-CODE                      PIC X(05).

05  DX-ICD9-SEQUENCE                  PIC 9(01).
```

2.5.2.5 Claims Pharmacy Rx

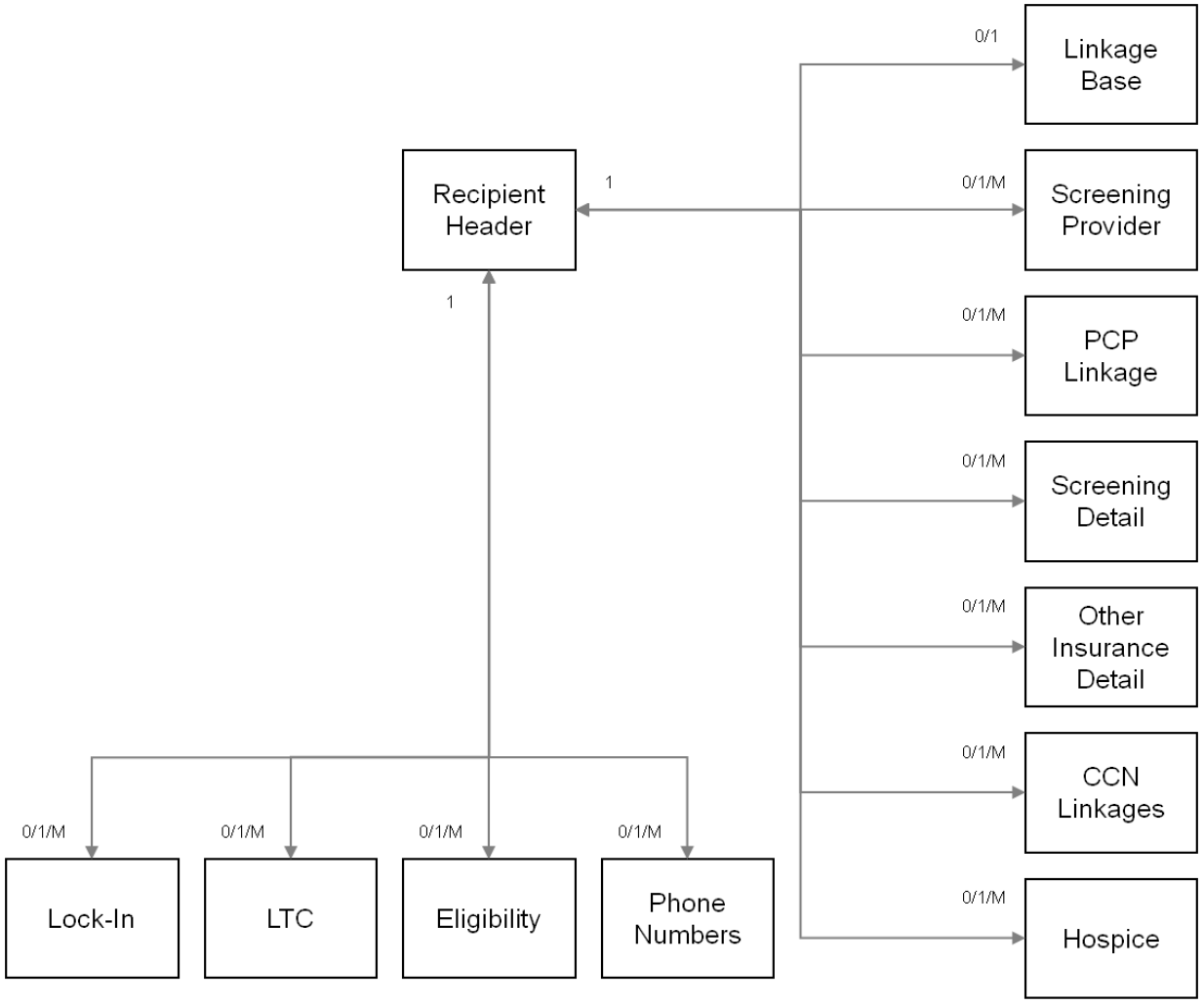
```
01  EB-PHARMACY-REC.
    05  RX-CHECKWRITE-DATE                PIC 9(08).
    05  RX-CLAIMID                        PIC 9(08).
    05  RX-NDC                            PIC 9(11).
    05  RX-PRESC-PHYS                     PIC 9(07).
    05  RX-PRESC-PHYS-NPI                 PIC X(10)
    05  RX-SCRIPT-DATE                    PIC 9(08).
    05  RX-DAYS-SUPPLY                    PIC -9(3).
    05  RX-SCRIPT-NO                      PIC X(07).
    05  RX-INVOICE-NO                     PIC X(09).
    05  RX-MAC-IND                        PIC X.
    05  RX-DRUG-PRICE                     PIC  9(4).9(5).
    05  RX-MAC-PRICE                      PIC  9(4).9(5).
    05  RX-FUL-PRICE                      PIC  9(4).9(5).
    05  RX-DISP-FEE                       PIC -9(3).99.
    05  RX-REFILL-CODE                    PIC 9.
    05  RX-THERP-CLASS                    PIC X(03).
    05  RX-SCH2-NARC-IND                  PIC X.
    05  RX-PRICING-ACTION-CODE            PIC X(3).
    05  RX-QUANTITY                       PIC -9(7).999.
    05  RX-CO-PAY-MAC-IND                 PIC X.
    05  RX-CO-PAY                         PIC -9(6).99.
    05  RX-DUR-CONFLICT                   PIC XX.
    05  RX-DUR-INT                        PIC XX.
    05  RX-HICL-SEQ-NO                    PIC XX.
    05  RX-ACUTE-THERAPY-IND              PIC X.
    05  RX-ROUTE-ADMIN                    PIC X.
    05  RX-DATE-PROCESSED                 PIC 9(06)
    05  RX-TIME-PROCESSED                 PIC 9(06).
    05  RX-BASIS-OF-COST                  PIC X(02).
```

```
05  RX-EX-DRUG-PRICE                    PIC  9(6).9(5).
05  RX-EX-MAC-PRICE                     PIC 9(6).9(5).
05  RX-EX-FUL-PRICE                     PIC 9(6).9(5).
```

2.5.2.6 Claims Files Control Totals Rx

2.5.3 ELIGIBILITY FILES. Sent by Molina to the SMO according to the schedule in Appendix B.

The following diagram, 2.5-B, depicts the file extract schema for Recipient eligibility data.



Join criteria on all tables: Recipient ID (first data item in each file)

2.5.3.1 Recipient Header

```
01  EB-RECIPIENT-HEADER.
    05  RECIP-ID-CURRENT                    PIC X(13).
    05  RECIP-ID-ORIGINAL                   PIC X(13).
    05  RECIP-HIC                           PIC X(12).
    05  RECIP-SSN                           PIC X(09).
    05  RECIP-LAST-NAME                     PIC X(12).
    05  RECIP-FIRST-NAME                    PIC X(12).
    05  RECIP-MID-INITIAL                   PIC X(01).
    05  RECIP-RECIP-TITLE                   PIC X(03).
    05  RECIP-RECIP-SUFFIX                  PIC X(03).
    05  RECIP-PREVIOUS-LAST-NAME            PIC X(12).
    05  RECIP-PREVIOUS-FIRST-NAME           PIC X(12).
    05  RECIP-PREVIOUS-MID-INITIAL          PIC X(01).
    05  RECIP-ADDR-LN1                      PIC X(25).
    05  RECIP-ADDR-LN2                      PIC X(25).
    05  RECIP-CITY                          PIC X(18).
    05  RECIP-STATE                         PIC X(02).
    05  RECIP-ZIP-CODE                      PIC 9(09).
    05  RECIP-BIRTH-DATE                    PIC 9(08).
    05  RECIP-SEX                           PIC X(01).
    05  RECIP-RACE                          PIC X(01).
    05  RECIP-DATE-OF-DEATH                 PIC 9(08).
    05  RECIP-DATE-OF-CERTIF                PIC 9(08).
    05  RECIP-DATE-OF-APPLIC                PIC 9(08).
    05  RECIP-DATE-OF-LAST-ACTIVITY         PIC 9(08).
    05  RECIP-GROSS-INCOME                  PIC 9(05).
    05  RECIP-FAMILY-SIZE                   PIC 9(03).
    05  RECIP-SEX-OVERRIDE-IND              PIC X(01).
    05  RECIP-EPSDT-TRACKING-INDIC          PIC 9(01).
    05  RECIP-EPSDT-SIGNATURE-DATE          PIC 9(08).
    05  RECIP-DX-DISCHRG-DATE               PIC 9(08).
    05  RECIP-LTC-REVIEW-DATE               PIC 9(08).
    05  RECIP-RECIP-EXCP-IND                PIC X(01).
    05  RECIP-SOURCE-OF-INPUT               PIC X(01).
    05  RECIP-TEL-NO                        PIC 9(10).
    05  RECIP-PBS-BEG-DATE                  PIC 9(08).
    05  RECIP-PBS-END-DATE                  PIC 9(08).
    05  RECIP-CASE-MANAGER                  PIC X(07).
    05  RECIP-PID-CARD-NO                   PIC 9(16).
    05  RECIP-PID-CARD-CHK-DIGIT            PIC 9(01).
```

```
05  RECIP-PID-NO-CARD-ISSUED              PIC 9(02).
05  RECIP-MOTHER-PERSON-ID                PIC X(13).
05  RECIP-HEAD-OF-HOUSEHOLD-NAME.
    10  RECIP-HOH-LAST-NAME               PIC X(12).
    10  RECIP-HOH-FIRST-NAME              PIC X(12).
    10  RECIP-HOH-MIDDLE-INIT             PIC X(1).
05  RECIP-HEAD-OF-HOUSEHOLD-SSN           PIC X(9).
05  RECIP-PREFERRED-LANGUAGE-IND          PIC X(2).
```

2.5.3.2 Recipient SURS LockIn

```
01  EB-SURS-LOCKIN-DETAIL.
    05  SURS-LOCKIN-ID-CURR               PIC X(13).
    05  SURS-LOCKIN-ID-ORIG               PIC X(13).
    05  SURS-LOCKIN-IND                   PIC X(01).
    05  SURS-LOCKIN-PHYSICIAN-1           PIC X(07).
    05  SURS-LOCKIN-PHYSICIAN-2           PIC X(07).
    05  SURS-LOCKIN-PHYSICIAN-3           PIC X(07).
    05  SURS-LOCKIN-PHYSICIAN-4           PIC X(07).
    05  SURS-LOCKIN-PHARMACY-1            PIC X(07).
    05  SURS-LOCKIN-PHARMACY-2            PIC X(07).
    05  SURS-LOCKIN-BEGIN                 PIC 9(08).
    05  SURS-LOCKIN-END                   PIC 9(08).
    05  SURS-LOCKIN-LAST-ACT              PIC 9(08).
```

2.5.3.3 Recipient Eligibility

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

2.5.3.4 Recipient Linkage Base

This file will be defunct in May 2012 and no longer used as CommunityCARE is closed.

2.5.3.5 Recipient Screening Provider Detail

This file will be defunct in May 2012 and no longer used as CommunityCARE is closed.

2.5.3.6 Recipient PCP Linkage

This file will be defunct in May 2012 and no longer used as CommunityCARE is closed.

2.5.3.7 Recipient Phone Numbers

This file will be defunct in May 2012 and no longer used as CommunityCARE is closed.

2.5.3.8 Recipient Screening Detail

This file will be defunct in May 2012 and no longer used as CommunityCARE is closed.

2.5.3.9 Recipient Other Insurance Detail

```
01  EB-OTHER-INS-DETAIL.
    05  OTHER-INS-RECIP-ID-CURR            PIC X(13).
    05  OTHER-INS-RECIP-ID-ORIG            PIC X(13).
    05  OTHER-INS-TYPE                     PIC X(02).
        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(9).
```

2.5.3.10 Recipient CCN (BAYOU HEALTH) Linkages Data.

```
       01  EB-CCN-PACE-LINKAGE.
           05  CCN-LINKAGE-RECIP-ID-CURR           PIC X(13).
           05  CCN-LINKAGE-RECIP-ID-ORIG           PIC X(13).
           05  CCN-LINKAGE-ENROLL-TYPE             PIC X(01).
               88  PACE                            VALUE 'V'.
               88  CCNP                            VALUE 'P'.
               88  CCNS                            VALUE 'S'.
           05  CCN-LINKAGE-PLAN-PROV-ID            PIC 9(07).
           05  CCN-LINKAGE-BEGIN-DATE              PIC 9(08).
           05  CCN-LINKAGE-END-DATE                PIC 9(08).
           05  CCN-LINKAGE-LAST-ACT-DATE           PIC 9(08).
           05  CCN-LINKAGE-COV-ACTION-CODE         PIC X(02).
               88  INITIAL-ENROLLMENT              VALUE 'IE'.
               88  CHANGE-ENROLLMENT               VALUE 'CH'.
               88  DIS-ENROLLMENT                  VALUE 'DE'.
           05  CCN-LINKAGE-DISENROLL-REASON        PIC 9(03).
               88  NOT-DISENROLLED            VALUE 000.
               88  HAS-OTHER-HEALTH-INS       VALUE 009.
               88  MOVED-OUT-OF-SERVICE-AREA  VALUE 018.
               88  DOES-NOT-MEET-LOC          VALUE 020.
               88  VOLUNTARY-DISENROLLMENT    VALUE 040.
               88  DEATH-DOD-UNKNOWN          VALUE 048.
               88  INVOLUNTARY-DISENROLLMENT  VALUE 068.
               88  ADMITTED-TO-INSTITUTION    VALUE 077.
               88  MOVED-OUT-OF-STATE         VALUE 078.
               88  DEATH                      VALUE 090.
               88  NOT-CATEGORICALLY-ELIG     VALUE 100.
               88  OPT-OUT-NATIVE-AMERICAN    VALUE 900.
               88  OPT-OUT-FOSTER-CARE        VALUE 901.
               88  OPT-OUT-OYD-OJJ            VALUE 902.
               88  OPT-OUT-UNDER19-SPEC-SERV  VALUE 903.
               88  OPT-OUT-SSI                VALUE 904.
               88  OPT-OUT-OTHER-RSN          VALUE 905.
               88  DISEN-DURING-ANN-ENROLL    VALUE 906.
               88  DISEN-DUE-TO-HOSPICE-ADM   VALUE 907.
               88  DISEN-DUE-TO-MEDICARE-COV  VALUE 908.
```

```
05  CCN-LINKAGE-SRC-CHG          PIC X(02).
    88  ENROLLMENT-BROKER       VALUE 'EB'.
    88  DHH-DIRECTED            VALUE 'DH'.
    88  FISCAL-INTERMEDIARY     VALUE 'FI'. /* PACE ONLY */
    88  ONLINE                  VALUE 'ON'. /* PACE ONLY */
05  CCN-LINKAGE-GEO-CODE        PIC X(01).
    88 PACE-GNO                VALUE '1'.  /* PACE only */
    88 PACE-BR                 VALUE '2'.  /* PACE only */
    88 CCN-1                   VALUE '1'.
    88 CCN-2                   VALUE '2'.
    88 CCN-3                   VALUE '3'.
    88 CCN-4                   VALUE '4'.
    88 CCN-5                   VALUE '5'.
    88 CCN-6                   VALUE '6'.
    88 CCN-7                   VALUE '7'.
    88 CCN-8                   VALUE '8'.
    88 CCN-9                   VALUE '9'.
05  CCN-LINKAGE-AA-IND          PIC X(01).
    88  AUTO-ASSIGNED-BY-EB     VALUE 'A'.
    88  ENROLLEE-CHOICE         VALUE 'C'.
05  CCN-LINKAGE-EB-ID           PIC 9(09).
```

2.5.3.11 Recipient Hospice Data

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

2.5.3.12 Recipient LTC Data

```
01  EB-LTC-DATA.
    05  LTC-RECIP-ID-CURR       PIC X(13).
    05  LTC-RECIP-ID-ORIG       PIC X(13).
```

```
05  LTC-BEGIN-DATE                 PIC 9(8).
05  LTC-END-DATE                   PIC 9(8).
05  LTC-LOC                        PIC X(5).
05  LTC-PROV                       PIC 9(7).
05  LTC-ADMISSION-DATE             PIC 9(8).
05  LTC-DISCHARGE-DATE             PIC 9(8).
05  LTC-WAIVER-TYPE-CASE           PIC 9(3) BLANK WHEN ZERO.
05  LTC-SECONDARY-TC               PIC X(03).
05  LTC-SECONDARY-LOC              PIC X(02).
05  LTC-CANCEL-CODE                PIC X(03).
05  LTC-WAIVER-LOC                 PIC X(02).
```

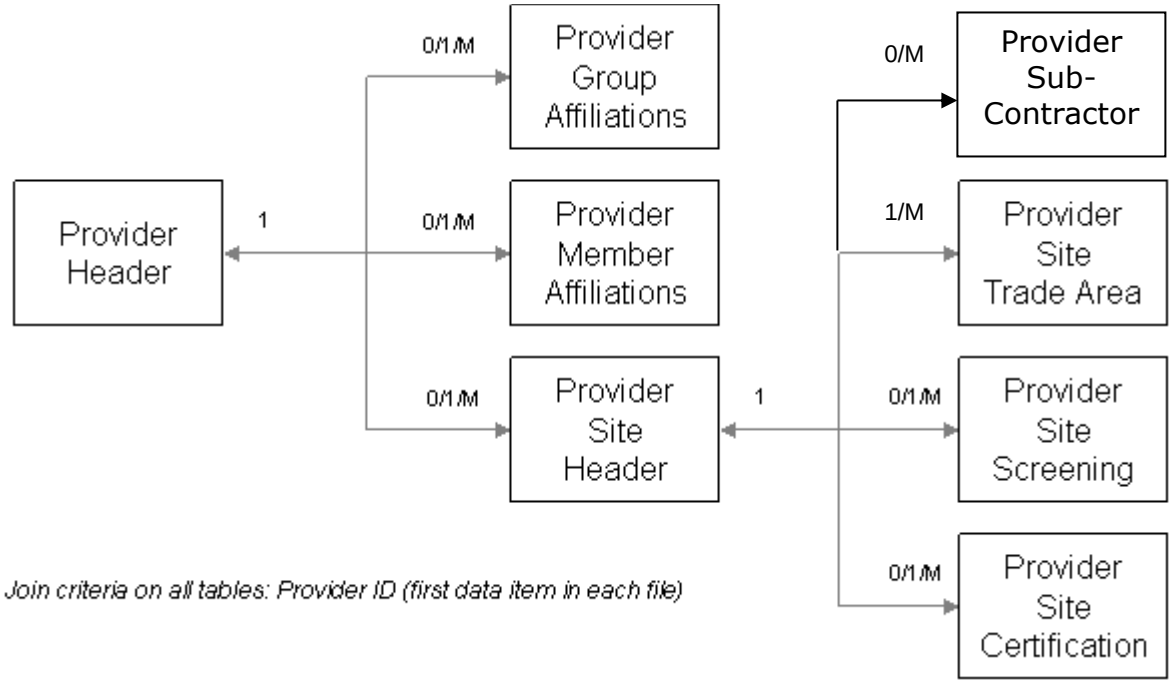
2.5.3.13 TPL Carrier Code Data

```
@1    CARRCODE          $6.     /* Carrier Code = OTHER-INS-COMPANY-NUMBER on
                                 /* RECIPIENT OTHER INSURANCE DETAIL 2.5.2.9 above */
@7    DELIM             $1.
@8    CARRNAME          $53.    /* Carrier Company Name */
@61   DELIM             $1.
@62   ADDR1             $25.    /* Street Address */
@87   DELIM             $1.
@88   ADDR2             $25.    /* 2nd Street Address, if available 8/
@113  DELIM             $1.
@114  CITY              $20.
@134  DELIM             $1.
@135  STATE             $2.     /* USPS state abbreviation */
@136  DELIM             $1.
@137  ZIP               Z9.
@146  DELIM             $1.
```

DELIM is the value "^".

2.5.4 PROVIDER FILES. Sent by Molina to the SMO according to the schedule in Appendix B.

The following diagram, 2.5-C, depicts the file extract schema for provider data.



2.5.4.1 Provider Header

```
01  EB-PROVIDER-HEADER-RECORD.
    05  APR-PROVIDER-ID              PIC 9(7).
    05  APR-CHECK-DIGIT-ID           PIC 9(7).
    05  APR-MEDICARE-UPIN            PIC X(6).
    05  APR-PRESCRIBE-ONLY           PIC X.
    05  APR-PARISH-CODE              PIC 99.
    05  APR-PROVIDER-REGION          PIC 99.
    05  APR-OUT-OF-STATE             PIC 9.
    05  APR-URBAN-OR-RURAL           PIC 9.
    05  APR-PROV-TYPE                PIC X(2).
    05  APR-SPECIALTY                PIC XX.
    05  APR-SUB-SPECIALTY1           PIC XX.
    05  APR-SUB-SPECIALTY2           PIC XX.
    05  APR-SUB-SPECIALTY3           PIC XX.
```

```
05  APR-ENROLL-STATUS           PIC 9.
05  APR-PRACTICE-TYPE           PIC 99.
05  APR-19-BEGIN-DATE           PIC 9(8).
05  APR-19-END-DATE             PIC 9(8).
05  APR-19-CANCEL               PIC 99.
05  APR-19-1BEGIN-DATE          PIC 9(8).
05  APR-19-1END-DATE            PIC 9(8).
05  APR-19-1CANCEL              PIC 99.
05  APR-19-2BEGIN-DATE          PIC 9(8).
05  APR-19-2END-DATE            PIC 9(8).
05  APR-19-2CANCEL              PIC 99.
05  APR-LAST-ACTIVITY-DATE      PIC 9(8).
05  APR-SOC-SEC-NUMBER          PIC 9(9).
05  APR-PROVIDER-LIC-OLD        PIC X(9).
05  APR-PROVIDER-LIC-EFF-DT     PIC 9(8).
05  APR-PROVIDER-LIC-EXP-DT     PIC 9(8).
05  APR-PROVIDER-CERT-NUMBER    PIC X(9).
05  APR-PROVIDER-CERT-EFF-DT    PIC 9(8).
05  APR-PROVIDER-CERT-EXP-DT    PIC 9(8).
05  APR-FACILITY-RATING         PIC 9.
05  APR-FACILITY-CONTROL        PIC 9.
05  APR-NUMBER-OF-BEDS          PIC 9(5).
05  APR-ADMIN-NAME              PIC X(30).
05  APR-LAB-TEST-IND            PIC X.
05  APR-DENTAL-SERVICE-IND      PIC X.
05  APR-NAME-SV                 PIC X(30).
05  APR-ADDR-LN1-SV             PIC X(30).
05  APR-ADDR-LN2-SV             PIC X(30).
05  APR-ADDR-ST-SV              PIC XX.
05  APR-ZIP-SV                  PIC 9(5).9(4).
05  APR-PHONE-SV                PIC 9(10).
05  APR-NAME-ADDRESS-PAY-TO.
05  APR-PROVIDER-NAME-PAY-TO    PIC X(30).
05  APR-OTHER-PAYEE             PIC X(30).
05  APR-ADDR-LN1-PAY-TO         PIC X(30).
05  APR-ADDR-LN2-PAY-TO         PIC X(30).
05  APR-ADDR-ST-PAY-TO          PIC XX.
05  APR-ZIP-PAY-TO              PIC 9(5).9(4).
05  APR-OWNER-NAME1             PIC X(30).
05  APR-OWNER-NAME2             PIC X(30).
05  APR-AMB-SURG-IND            PIC X.
05  APR-EPSDT-MEDICAL           PIC X.
```

```
05  APR-EPSDT-HEARING            PIC X.
05  APR-EPSDT-VISION             PIC X.
05  APR-MC-RECIP-COUNT           PIC 9(5).
05  APR-PHYSICIAN-SERVICE-IND    PIC X.
05  APR-COMMUNITY-CARE-IND       PIC X.
05  APR-MANAGED-CARE-IND         PIC X.
05  APR-RACE                     PIC X.
05  APR-SEX                      PIC X.
05  APR-PRECERT-BEGIN-DATE       PIC 9(8).
05  APR-MEDICAID-EFF-DTE         PIC 9(8).
05  APR-MEDICARE-EFF-DTE         PIC 9(8).
05  APR-AGENCY                   PIC X(5).
05  APR-DIVISION                 PIC X(5).
05  APR-OFFICE                   PIC X(7).
05  APR-UNIT                     PIC X(3).
05  APR-NUMBER-OF-SITES          PIC X(03).
05  APR-PROVIDER-LIC             PIC X(12).
05  APR-PHYS-SUPPL-PAYMENT-IND   PIC X.
05  APR-BELONGS-TO-IND           PIC 99.
05  APR-NUMBER-IN-GRP            PIC 9(4).
```

2.5.4.2 Provider Belongs To (Group Affiliations)

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

2.5.4.3 Provider Members List (Member Affiliations)

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

2.5.4.4 CommCARE Provider Belongs To (Group Site Affiliations)

```
01  EB-CC-PROVIDER-BELONGS-TO.
    05  ACBT-GROUP-ID                    PIC 9(07).
    05  ACBT-GROUP-CHECK-DIGIT-ID        PIC 9(07).
```

```
           05  ACBT-GROUP-SITE                 PIC 9(03).
           05  ACBT-GROUP-NAME                 PIC X(30).
           05  ACBT-MEMBER-PROVIDER-ID         PIC 9(07).
           05  ACBT-MEMBER-CHECK-DIGIT-ID      PIC 9(07).
           05  ACBT-MEMBER-SITE                PIC 9(03).
           05  ACBT-MEMBER-NAME                PIC X(30).
```

2.5.4.5 Provider NPI Cross Reference

```
       01  EB-PROVIDER-NPI.
           05  ANPI-PROVIDER-ID                PIC 9(07).
           05  ANPI-CHECK-DIGIT-PROV-ID        PIC 9(07).
           05  ANPI-NPI                        PIC X(10).
           05  ANPI-TIE-BREAKER-VALUE          PIC X(10).
           05  ANPI-TIE-BREAKER-TYPE           PIC X(01).
               88  NO-TIE-BREAKER              VALUE 0.
               88  TAXONOMY-IS-TIE-BREAKER     VALUE 1.
               88  ZIP-IS-TIE-BREAKER          VALUE 2.
```

2.5.3.6 PROVIDER SITE FILES (COMMUNITYCARE 2.0).

2.5.4.6 Provider Site Header

This file will be defunct and no longer used as CommunityCARE is closed in May 2012.

2.5.5 SMO RECORD LAYOUTS (to be submitted by SMO to Molina)

2.5.4 PROVIDER REGISTRY FILE.

2.5.4.1 Provider Registry File Record Layout

At the onset of the SMO Contract and periodically as changes are necessary, the SMO should submit to Molina a provider directory/registry.

The SMO is required to populate the Other Provider Type Code to a DHH valid provider type code as shown in the list of Provider Types in Appendix C of this document.

The SMO is required to populate the Other Provider Specialty Code to a DHH valid provider specialty code as shown in the list of Provider Specialties in Appendix C of this document.

The following file layout describes the data characteristics and structure of the Provider Registry File as it should be submitted by the SMO to Molina.

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 CCN elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively).					
1-20	NPI	National Provider ID number	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	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
22	Entity Type code	1=Individual, 2=Organization	1		R
23	Delimiter		1	Character, use the ^ character value	
24-43	Replacement NPI	DO NOT USE AT THIS TIME. FOR FUTURE USE.	20	First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	O
44	Delimiter		1	Character, use the ^ character value	
45-74	Provider Name OR the Legal Business Name for Organizations. If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name,		30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	14th position=middle initial (or space), 15-27th characters=last name, 28-30th positions=suffix. If names do not fit in these positions, please truncate the end of the item so that it fits in the positions.				
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O
137	Delimiter		1	Character, use the ^ character value	
138-167	Provider		30	Character	R

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	
334-343	Provider Business Location Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
344	Delimiter		1	Character, use the ^ character value	

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	2	blank.			
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 CCN 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	R
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	
420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	M=Male, F=Female, N=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	
485-534	Authorized Official Contact		50	Character, left-justified, right-fill	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Information (First Name, Middle Name, Last Name)			with spaces.	
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information (Title or Position)		30	Character, left-justified, right-fill with spaces.	O
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	Y=Yes, panel is open. N=No, panel is not open.	1	Character	R for PCPs; otherwise optional.
579	Delimiter		1	Character, use the ^ character value	
580	Language Indicator 1	1=English-speaking patients	1	Character	R for PCPs, specialists and other

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	(this is the primary language indicator)	only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			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	1	Character	O

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
590	Age Restriction Indicator	0=no age restrictions 1=adult only 2=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of patients that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
597	Delimiter		1	Character, use the ^ character value	
598-602	PCP Linkages with CCN	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of CCN enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				PCP/specialist.	
603	Delimiter		1	Character, use the ^ character value	
604-608	PCP Linkages with Others	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not CCN) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
609	Delimiter		1	Character, use the ^ character value	
610	CCN Enrollment Indicator	N=New enrollment C=Change to existing enrollment D=Disenrollment	1	Use this field to identify new providers, changes to existing providers, and disenrolled providers	R
611	Delimiter		1	Character, use the ^ character value	
612-619	CCN Enrollment Indicator	Effective date of Enrollment	8	Numeric, format	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Effective Date	Indicator above.		YYYYMMDD	
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 CCN 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 CCN	2		O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Companion Guide			
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
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
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
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish	2	2-digit parish code value. See the CCN	R

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				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 CCN 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 CCN Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves.	2	2-digit parish code value. See the CCN Companion Guide.	O

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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 CCN Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter	2	2-digit parish code value. See the CCN Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		00.			
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 CCN Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726-749	Spaces	End of record filler	24	Enter all spaces	
750	End of record delimiter		1	Character, use the ^ character value	

2.5.4.2 PROVIDER REGISTRY EDIT REPORT (FROM MOLINA TO MAGELLAN) (Sample Report Shown, 3 pages: Detail, Edits Legend, and Summary)

SAMPLE DETAIL PAGE (there may be multiple detail pages in the report, depending on the SMO registry submission volume).

Report: MW-W-06 *RUN DATE: 20120120* *1*

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
LBHP/CSoC
Report MW-W-06: Weekly Provider Registry Edit/Update Report

20:00 Friday, January 20, 2012

RECORD TYPE	PROV ID	NPI	NAME	TAXONOMY 1	ASSIGNED MEDICAID ID	ACC REJ	ERR1	ERR2	ERR3	ERR4	ERR5	ERR6	ERR7	ERR8	ERR9	ERR10
C	1035548	1629298278	BRIAN JGALOFARO MD	207Q00000X	7229697	A	000	000	000	000	000	000	000	000	000	000
C	1313009	1427065911	HARRY KDAY MD	207R00000X	7295118	A	000	000	000	000	000	000	000	000	000	000
C	1347311	1942450945	SAMAKI SGREEN NP	363LF0000X	7295606	A	000	000	000	000	000	000	000	000	000	000
C	1073881	1619168317	MARCELLE MROUSSEAU MD	207R00000X	7294901	A	000	000	000	000	000	000	000	000	000	000
C	1694207	1275559817	PATTI CWASCOM FNP	363LF0000X	7294499	A	000	000	000	000	000	000	000	000	000	000
C	1345679	1609060193	EMILIO ARUSSO MD	207Q00000X	7229107	A	000	000	000	000	000	000	000	000	000	000
C	1656801	1699758433	LIONEL PBURGEOIS MD	207Q00000X	7294553	A	000	000	000	000	000	000	000	000	000	000
C	1424196	1003820721	STACY GREENE MD	207RI0200X	7294880	A	000	000	000	000	000	000	000	000	000	000
N	1070068	1255516720	MIA HHARRIS MD	207Q00000X	0000000	R	011	000	000	000	000	000	000	000	000	000
N	1061344	1891813515	MICHAELA DKING DO	208000000X	0000000	R	011	000	000	000	000	000	000	000	000	000
N	1650960	1164442885	ELIZABETH MCAIN MD	207Q00000X	7480560	A	000	000	000	000	000	000	000	000	000	000
C	1348457	1407877426	MADELINE CHECK MD	207RI0200X	7295151	A	000	000	000	000	000	000	000	000	000	000
N	1111821	1598879314	WILLIAM PCROOKS MD	207Q00000X	7480586	A	000	000	000	000	000	000	000	000	000	000
N	1655902	1023038684	RICHARD DFRIEND MD	207Q00000X	7480594	A	000	000	000	000	000	000	000	000	000	000
C	1196584	1568478550	BARBARA BMAXWELL NP	363LS0200X	7294618	A	000	000	000	000	000	000	000	000	000	000
N	1094471	1053571158	CANDICE LKNIGHT MD	207Q00000X	7480616	A	000	000	000	000	000	000	000	000	000	000
N	1997439	1962436006	LEANNE LLEBLANC MD	207Q00000X	7480624	A	000	000	000	000	000	000	000	000	000	000
N	1035769	1609087527	DAVID RPERSAUD MD	207Q00000X	7480632	A	000	000	000	000	000	000	000	000	000	000
C	1097624	1619035763	DIEP BMORRIS PA	363A00000X	7294669	A	000	000	000	000	000	000	000	000	000	000

SAMPLE EDITS LEGEND PAGE (will appear once as the 2nd to last page in the report).

Report: MW-W-06 ***RUN DATE: 20120120*** ***20***

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
LBHP/CSoC
Report MW-W-06: Weekly Provider Registry Edit/Update Report

20:00 Friday, January 20, 2012

```
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, or D)
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 0,1,2,3,4,5. 1st indicator cannot be 0)
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  LBHP/CSoC  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  LBHP/CSoC  Contract begin date
018=(R) Missing/Invalid  LBHP/CSoC  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)  LBHP/CSoC  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 or Specialty does not match MMIS enrollment file
035=(A) Non-Par Contractor
```

SAMPLE SUMMARY PAGE (will appear once as the last page of the report).

Report: MW-W-06 *RUN DATE: 20120120* *21*

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
LBHP/CSoC
Report MW-W-06: Weekly Provider Registry Edit/Update Report

20:00 Friday, January 20, 2012

Accept/Reject Code				
error_ind	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A	459	93.29	459	93.29
R	33	6.71	492	100.00

2.5.5 ENCOUNTER DATA

2.5.5.1 Encounter Data Specifics

See Section 2.5.1. Encounters will be included in claims data, where CB-EMC-CODE of **CB-CLAIM-BASE** will have value '7' for encounter data.

Molina set up a process to send Magellan Weekly Encounter Feeds (including encounters for the BYU plans). This will be the third file delivered to Magellan containing claims extracts, with non-encounters being the first, and pharmacy claims the second.

The file name is ENCNTRS_WEEKLY_{DAILY8}.ZIP

As per LIFT 9553, the weekly claims extract that is sent to Maximus, Magellan, and MCNA repurposed a single field in the Claims base record. This field, CB-CC-LINK-IND, was previously used to indicate within the claim record a CC/KIDMED active linkage at the time of claims processing. The CC/KIDMED programs have been inactive since 06/2012, with the onset of BYU. The LIFT repurposed that single field to CB-EMC-CODE, which is populated with either a space ' ' for fee for service claims, or a '7' denoting that the claim is an encounter. At this time, Maximus is not scheduled to receive encounters, but both Magellan and MCNA will receive their submitted encounters.

There should be no impact on Maximus with this repurpose, but they need to be contacted to verify that their system does not use this field. This change will not affect file lengths in the extracts sent.

2.6 Data Element Dictionary (DED) Changes

2.6.1 Mainframe CLAIMS Data

DataBase Name:	EB-CLAIM-BASE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
CB-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
CB-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record The last two digits of the claim ICN are the CLAIM LINE NUMBER. The first 11 digits uniquely identify an original claim document.
CB-ICN	Numeric			Internal Claim Number, may not be unique per claim line.	FORMAT of ICN: 1st digit=last digit of year of receipt 2-4 digits=Julian day of the year of receipt 5th digit=Media Code with the following values: 0=Orig paper, 1=EMC, 2,3,4=Paper Adj/Void, 5=Paper with Attachment, 6=Resubmission, CCARE Invoice, 7=POS, 8=Special Batch or Mixed Media. 9=Unassigned 6-8 digits=3-digit batch number 9-11 digits=3-digit sequential number in batch 12-13 digits=2-digit line item number of document.
CB-CLAIM-TYPE	CHAR	01=Inpatient Hospital 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=EMT (Transportation) 08=NEMT (Transportation) 09=DME 10=Dental EPSDT 11=Dental Adult 12=Pharmacy 13=EPSDT 14=Medicare Cross-over Institutional 15=Medicare Cross-over Professional 16=Adult Day Care			

DataBase Name:	EB-CLAIM-BASE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
CB-CLAIM-STATUS	CHAR	1=Original 2=Adjustment 3=Denied			
CB-CLAIM-MOD	CHAR	1=Original 2=Adjustment 3=Void of Original for Adjustment (auto-generated by MMIS) 4=Void of Original for Adjustment (from Provider)			
CB-SVC-PROV	Numeric			Servicing or Attending Provider ID number	
CB-SVC-CHK-DGT	Numeric			Servicing or Attending Provider ID number, check-digit ID	
CB-SVC-NPI	Numeric			Servicing or Attending Provider NPI	
CB-BILL-PROV	Numeric			Billing Provider ID number	
CB-BILL-CHK-DGT	Numeric			Billing Provider ID number, check-digit ID	
CB-BILL-NPI	Numeric			Billing Provider NPI	
CB-RECIP-SUBMITTED	Numeric			Medicaid Recipient ID submitted on claim	
CB-RECIP-CURRENT	Numeric			Current Medicaid Recipient ID	
CB-RECIP-ORIGINAL	Numeric			Original Medicaid Recipient ID	
CB-FROM-DATE	Numeric	Format YYYYMMDD		DOS From	
CB-THRU-DATE	Numeric	Format YYYYMMDD		DOS Through	
CB-BILLED-UVS	Numeric			Units of Service or days billed on the claim	
CB-UNITS-VISITS-QUANT	Numeric			Units of Service or days paid on the claim	
CB-BILLED-AMT	Numeric			Billed amount in dollars and cents	
CB-TPL-PAID	Numeric			TPL payments amount in dollars and cents	
CB-COB-OTHER-PAT-AMT	Numeric			Other COB payment amount associated with the patient, such as deductible, co-pay, co-ins. In dollars and cents.	
CB-PAYMENT	Numeric			Amount Medicaid paid on the claim, in dollars and cents.	
CB-MEDICAID-ALLOWED	Numeric			Amount allowed by Medicaid, in dollars and cents	May not = payment due to TPL COB and other cut-back measures taken during claims adjudication and payment process.
CB-FORMER-ICN	Numeric	Same format as CB-ICN		For an adjustment or void, this represnts the ICN of the previously submitted claim line being adjusted or voided.	
CB-FORMER-CHECKWRITE	Numeric	Format YYYYMMDD		For an adjustment or void, this represnts the checkwrite date of the previously submitted claim line being adjusted or voided.	

DataBase Name:	EB-CLAIM-BASE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
CB-RECIP-PARISH-CODE	Numeric	See Appendix C Other value=unknown or out-of-state.		Parish of residence of the recipient on the DOS that the claim was processed.	
CB-RECIP-RACE	CHAR	See Appendix C 0=Unknown,		CMS-designated Race code	
CB-RECIP-SEX	CHAR	1=Male, 2=Female, 9=Unknown.			
CB-RECIP-AID-CATEG	CHAR	See Appendix C		Recipient'a Aid Category on the DOS of the claim. If the recipient was not eligible on the DOS of the claim, then it is an inconsistent value.	
CB-RECIP-TYPE-CASE	CHAR	See Appendix C		Recipient'a Type Case on the DOS of the claim. If the recipient was not eligible on the DOS of the claim, then it is an inconsistent value.	
CB-RECIP-BIRTHDATE	Numeric	Format=YYYYMMDD			
CB-RECIP-SSN	CHAR			Social Security Number of the Recipient	
CB-MEG	CHAR	C1=Community Care Eligible with Aid Category 03 or 13 and not in LaChip -- PCCM Payments Excluded C2=Community Care Eligible with Aid Category 02 or 04 -- PCCM Payments Excluded C3=LaChip and Community Care Eligible -- PCCM Payments Excluded C4=LaCHIP 4 and CommunityCARE Eligible excluding PCCM Payments L3=LaChip Recipient Expenditures that are not eligible for Community Care L4=LaCHIP 4 Eligible and Not CommunityCARE Eligible MA=Money Follows Person, MFP within 365 days MB=Money Follows Person, MFP exceeding 365 days N1=N1 = NOW type case 149 N2=N2 = NOW type case 150 P1=Community Care Eligible with Aid Category 03 or 13 and not in LaChip -- PCCM Payments Only P2=Community Care Eligible with Aid		2-character Medicaid Eligiblity Group or ISIS sub-object code. Not applicable to most claims.	

DataBase Name:	EB-CLAIM-BASE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		Category 02 or 04 -- PCCM Payments Only P3=LaChip and Community Care Eligible -- PCCM Payments Only P4=LaCHIP 4 and CommunityCARE Eligible PCCM Payments Only			
CB-CAT-OF-SERVICE	CHAR	See Appendix C		2-digit claim category of service	
CB-TYPE-OF-SERVICE	CHAR	See Appendix C		2-digit claim type of service	
CB-PA	CHAR			Prior Authorization number or Precert number, if appropriate.	
CB-RA-NUMBER	CHAR			Referral Authorization number if appropriate	
CB-STATE-ORG-NO	CHAR			ISIS Organization number	ISIS=Integrated Statewide Information System (the State's integrated accounting system.
CB-ACCID-IND	CHAR	Values are Y, N, and blank.		Claim accident indicator submitted on claim	
CB-EMER-IND	CHAR	Values are Y, N, and blank.		Claim emergency indicator submitted on claim	
CB-EPSDT-IND	CHAR	Y=Claim is for an EPSDT Patient N=No, claim is for an Adult Patient or a non-EPSDT patient.		EPSDT indicator	
CB-TRAUMA-IND	CHAR	1=Yes, 0=No.		Trauma indicator submitted on claim.	
CB-FAMILY-PLAN-IND	CHAR	Y=Family Planning indicator of 1 on the diagnosis or procedure file, or PT=71 (Family Planning clinic), or on a UB claim there is a cond code=A1. N or 0 or blank=Family Planning indicator is equal to 0 or space on the diagnosis or procedure file.		Family Planning indicator	
CB-CC-LINK-IND	CHAR	0=Not Linked on DOS 1=Linked on DOS.		CommunityCARE Linkage indicator, if the recipient was linked to a CC PCP on the DOS.	
CB-AGE-IN-YEARS	Numeric	3-digit age of recipient at DOS on claim			
CB-MEDICAL-RECORD-NO	CHAR	30-character medical record number submitted by provider on claim			
CB-REMIT-ID	Numeric	7-digit remittance ID number			
CB-EMC-CODE	CHAR	blank=Paper or POS, 0=Paper, 1=Tape, 2=Disc, 3=Telecom, 4=Future Use, 5=EMC (837)		Can be used to distinguish claims and encounters.	

DataBase Name:	EB-CLAIM-BASE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		6=ClaimCheck added claim line 7=Encounter (for CCN and LBHP).			

DataBase Name:	EB-ERROR-REC
Location:	File Extract
NOTES:	There will always be at least 1 error record on a claim that denied. There will never be an error record on a paid or adjusted claim. There may be many error records per base claim line (denied).

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
ER-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
ER-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
ER-ERROR-CODE	Numeric	001 through 999		Louisiana Proprietary edit error code, only available on denied claims	
ER-ERROR-SEQUENCE	Numeric	1 through 99		Identifies the priority sequence of the edit error code: 1=1st code of highest significance, 2=2nd code, etc.	
ER-ERROR-FLAG	CHAR	D=Deny, P=Pend, E=Educational,		Identifies the effect of the error code in respect to the claim.	

DataBase Name:	EB-EOB-REC
Location:	File Extract
NOTES:	EOB record(s) may or may not occur on claims of any status: paid, denied, adjusted, voided. There may be many EOB records per base claim line. EOB=explanation of benefit, which is usually an educational, explanatory edit for a special claim adjudication circumstance.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
EB-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
EB-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
EB-EOB-CODE	Numeric	001 through 999		Louisiana Proprietary edit EOB code, that may occur on paid, adjusted or denied claims	
EB-EOB-SEQUENCE	Numeric	1 through 99		Identifies the priority sequence of the edit EOB code: 1=1st code of highest significance, 2=2nd code, etc.	

DataBase Name:	EB-DIAGNOSIS-REC
Location:	File Extract
NOTES:	Claims may or may not have diagnosis records. Not all claims require a diagnosis. There may be many diagnosis records per base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
DX-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
DX-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
DX-ICD9-CODE	Numeric	A valid ICD-9-CM Diagnosis code, period is not included.		ICD-9-CM diagnosis code, without the period.	
DX-ICD9-SEQUENCE	Numeric	1 through 99		Identifies the priority sequence of the edit EOB code: 1=1st code of highest significance, 2=2nd code, etc.	

DataBase Name:	EB-SURGICAL-DX-REC
Location:	File Extract
NOTES:	Claims may or may not have surgical records. Only applicable to inpatient hospital claims. There may be many surgical records per inp hosp base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
SDX-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
SDX-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
SDX-ICD9-CODE	Numeric	A valid ICD-9-CM Surgical Procedure code, period is not included.		ICD-9-CM Surgical procedure code, without the period.	
SDX-ICD9-DATE	Numeric	Format YYYYMMDD		Date of the surgery	

DataBase Name:	EB-HOSPITAL-INPATIENT-REC
Location:	File Extract
NOTES:	Only applicable to inpatient hospital claims. There is only 1 hosp inp record per hosp inp base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
HIR-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
HIR-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
HIR-TYPE-BILL	Numeric	3-character UB04 Bill Type values		3-character UB04 Bill type values.	
HIR-ADMIT	Numeric	Format YYYYMMDD		Date of the admission	
HIR-PATIENT-STATUS	CHAR	UB04 Patient Status code		UB04 Patient Status code	
HIR-TOTAL-CHARGE	Numeric			Total Revenue charges billed by hospital	
HIR-TOT-NON-COV-CHARGE	Numeric			Total Non-Revenue charges billed by hospital	
HIR-COV-DAYS	Numeric			Total covered days billed by the hospital	
HIR-NON-COV-DAYS	Numeric			Total non-covered days billed by the hospital	
HIR-ATTEND-PHYS	Numeric	7-digit Medicaid Provider ID of the attending physician		7-digit Medicaid Provider ID of the attending physician	
HIR-ATTEND-PHYS-NPI	Numeric	NPI of the attending physician		NPI of the attending physician	
HIR-OTHER-PHYS	Numeric	7-digit Medicaid Provider ID of the other physician, if available		7-digit Medicaid Provider ID of the other physician, if available	
HIR-OTHER-PHYS-NPI	Numeric	NPI of the other physician, if available		NPI of the other physician, if available	
HIR-PER-DIEM-RATE	Numeric			Hospital's Medicaid per-diem rate	
HIR-MOTHER-RECIP-ID	Numeric	Medicaid Recipient ID number		Medicaid Recipient ID of the mother if this is a claim for the baby.	

DataBase Name:	**EB-REVENUE-REC**
Location:	File Extract
NOTES:	Claims may or may not have revenue records. Only applicable to claims that use 837I or UB04 standard. There may be many revenue records per base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
REV-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
REV-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
REV-CODE	Numeric	A valid UB04 revenue code, 3-digit.		3-digit revenue code as defined in UB04 manual (we do not retain the 1st digit of the 4-digit code).	
REV-UNITS	Numeric			Billed revenue units	
REV-CHARGE	Numeric			Billed revenue charge amount	
REV-RATE	Numeric			Revenue rate on file for provider.	
REV-NON-REV-CHARGE	Numeric			Billed non-revenue charge amount.	

DataBase Name:	EB-HOSPITAL-OUTPATIENT-REC
Location:	File Extract
NOTES:	Only applicable to inpatient hospital claims. There is only 1 o/p record per o/p base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
HOR-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
HOR-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
HOR-TYPE-BILL	Numeric	3-character UB04 Bill Type values		3-character UB04 Bill Type values	
~~HOR-ADMIT~~	~~Numeric~~	~~Format YYYYMMDD~~		~~Date of the O/P visit.~~	
HOR-ATTEND-PHYS	Numeric	7-digit Medicaid Provider ID of the attending physician		7-digit Medicaid Provider ID of the attending physician	
HOR-ATTEND-NPI	Numeric	NPI of the attending physician		NPI of the attending physician	
HOR-OTHER-PHYS	Numeric	7-digit Medicaid Provider ID of the other physician, if available		7-digit Medicaid Provider ID of the other physician, if available	
HOR-OTHER-NPI	Numeric	NPI of the other physician, if available		NPI of the other physician, if available	
HOR-NON-COV-CHARGE	Numeric			Non-covered revenue charges amount	
HOR-HCPC-CODE	CHAR	Standard HCPCS code set		HCPCS procedure code	
HOR-HCPC-TOS	CHAR	See CB-TYPE-OF-SERVICE for valid value set.		TOS associated with HCPCS procedure code.	
HOR-REV-CODE	CHAR	UB04 o/p revenue code		O/P claims are paid at the revenue code level.	
HOR-PATIENT-STATUS	CHAR	UB04 patient status value		UB04 patient status value	
HOR-PATIENT-STATUS-DATE	Numeric	Format YYYYMMDD			
HOR-HH-STATEMENT-FROM-DATE	Numeric	Format YYYYMMDD		For Home Health claims, this is the begin date of the HH service	
HOR-HH-STATEMENT-THRU-DATE	Numeric	Format YYYYMMDD		For Home Health claims, this is the end date of the HH service.	
HOR-EPO-AMT	Numeric	0 to 999999		EPO units as reported on claim.	
HOR-ER-VISIT-IND	CHAR	Space or 0=Not Applicable 1=Low Level Emergency Physician Care 3=High Level Emergency Physician Care		Identifies the O/P claim as an ER visit and what type.	
HOR-NDC	CHAR	National Drug Code value set		For some HCPCS values (specifically J-codes and Hemodialysis codes), the NDC is required.	
HOR-NDC-UNIT-MEASURE	CHAR	F2 -International Unit GR-Gram ML-Milliliter UN- Unit ME-Metric			
HOR-NDC-UNITS	Numeric			Actual units of the drug dispensed on the claim	

DataBase Name:	EB-HOSPITAL-OUTPATIENT-REC
Location:	File Extract
NOTES:	Only applicable to inpatient hospital claims. There is only 1 o/p record per o/p base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
HOR-NDC-UNIT-PRICE	Numeric			Actual unit cost of the drug as submitted on the claim.	

DataBase Name:	EB-PROFESSIONAL-REC
Location:	File Extract
NOTES:	Only applicable to professional claims. There is only 1 professional record per professional base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
PR-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
PR-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
PR-PROC	CHAR	5-character CPT4 code (period not included)		5-character CPT4 code (period not included)	
PR-TOS	CHAR	See Appendix C		Type of Service associated with PR-PROC	
PR-MOD1	CHAR	Reference CMS procedure modifiers		1st modifier, if applicable	
PR-MOD2	CHAR	Reference CMS procedure modifiers		2nd modifier, if applicable	
PR-MOD3	CHAR	Reference CMS procedure modifiers		3rd modifier, if applicable	
PR-MOD4	CHAR	Reference CMS procedure modifiers		4th modifier, if applicable	
PR-BILL-PROV-SITE	CHAR			3 digit code to identify provider facility locations	
PR-REFER-PROV-NO	Numeric	Medicaid Provider ID			
PR-REFER-PROV-NPI	Numeric	NPI			
PR-PAT-STATUS	CHAR	Reference CMS Patient Status code value set.		CMS-standard patient status code	
PR-PAT-STAT-DATE	Numeric	Format YYYYMMDD			
PR-TREAT-PLACE	CHAR	Reference CMS Place of Service code value set.		CMS-standard place of service	
PR-OUT-ATTENDING-PHYS	Numeric	Medicaid Provider ID number		ID of attending/servicing physician	
PR-OUT-ATTEND-PHYS-NPI	Numeric	NPI		NPI of attending/servicing physician	
PR-NDC	CHAR	National Drug Code value set		For some CPT values (specifically J-codes), the NDC is required.	
PR-NDC-UNIT-MEASURE	CHAR	F2 -International Unit GR-Gram ML-Milliliter UN- Unit ME-Metric			
PR-NDC-UNITS	Numeric			Actual units of the drug dispensed on the claim	
PR-NDC-UNIT-PRICE	Numeric			Actual unit cost of the drug as submitted on the claim.	
PR-NDC-DESC	CHAR			Brief description of NDC	

DataBase Name:	**EB-DENTAL-REC**
Location:	File Extract
NOTES:	Only applicable to professional claims. There is only 1 dental record per dental base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
DENT-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
DENT-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
DENT-PROC	CHAR	5-character ADA dental code (period not included)		5-character ADA dental code (period not included)	
DENT-TOOTH	CHAR	01-32			
DENT-PROC-MOD1	CHAR	Reference ADA billing standards			
DENT-ORAL-CAVITY-CODE	CHAR	Reference ADA billing standards			
DENT-SURF-1	CHAR	Reference ADA billing standards			
DENT-SURF-2	CHAR	Reference ADA billing standards			
DENT-SURF-3	CHAR	Reference ADA billing standards			
DENT-SURF-4	CHAR	Reference ADA billing standards			
DENT-SURF-5	CHAR	Reference ADA billing standards			
DENT-TREAT-PLACE	CHAR	Reference CMS-standard Place of Service code set.			
DENT-REFER-AGENCY	Numeric			Medicaid Provider ID of referring provider	
DENT-REFER-NPI	Numeric			NPI of Referring provider	
DENT-PA-TRAUMA-IND	CHAR			Indicates if the services performed were due to an accident	

DataBase Name:	EB-PHARMACY-REC
Location:	File Extract
NOTES:	Only applicable to pharmacy claims. There is only 1 pharmacy record per Rx base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
RX-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
RX-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
RX-NDC	CHAR	11-character national drug code		11-character national drug code	
RX-PRESC-PHYS	Numeric	7-digit Medicaid Provider ID number		Prescribing Physician	
RX-PRESC-PHYS-NPI	Numeric	10-digit Provider NPI		Prescribing Physician	
RX-SCRIPT-DATE	Numeric	Format YYYYMMDD		Date script was written by MD	
RX-DAYS-SUPPLY	Numeric			The days supply of the dispensed drug	
RX-SCRIPT-NO	CHAR			Prescription Number: the number assigned by a pharmacist to a prescription when it is filled.	
RX-INVOICE-NO	CHAR			Pharmacy invoice number supplied on claim	
RX-MAC-IND	CHAR				
RX-DRUG-PRICE	Numeric				
RX-MAC-PRICE	Numeric				
RX-FUL-PRICE	Numeric			FUL: The Federal Upper Limit price associated with the NDC and claim dates of service	
RX-DISP-FEE	Numeric			Dispensing Fee associated with billed charge	
RX-REFILL-CODE	CHAR	0=1st script, 1=1st refill, 2=2nd refill,… 5=5th refill		Pharmacy Refill Code: the code indicating whether a prescription is an original or a refill.	
RX-THERP-CLASS	CHAR	3-character NCPDP-standard therapeutic class value set.			
RX-SCH2-NARC-IND	CHAR	N=Not applicable Y=Schedule 2 Narcotic.		Schedule-2 Narcotics Indicator: an indicator of the procedure formulary file which identifies the type of narcotic.	
RX-PRICING-ACTION-CODE	CHAR	PAC=Pricing Action Code. 720=Deny 7K0=MAC drug. Pay based on lesser of LEAC amount and MAC amount unless MAC override is indicated; then pay LEAC. 750=Pay and price at Level III 755=Pay for insulin, diabetic supplies,		Pharmacy PAC Code: the drug pricing action code which determines how the drug has been priced.	

DataBase Name:	EB-PHARMACY-REC
Location:	File Extract
NOTES:	Only applicable to pharmacy claims. There is only 1 pharmacy record per Rx base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
		catheters, and cath trays. (Maximum allowable reimbursement cost plus 50%). For these drugs, the amount shown in the MAC amount column of the pricing file is the unit cost of the drug plus 50% . NOTE: Drugs with PAC=7K0 and CLRX_MAC_CODE='C' are paid at AWP - discount.			
RX-QUANTITY	Numeric			Quantity of the drug prescription. May contain fractional units out to 4 decimal places.	
RX-CO-PAY-MAC-IND	CHAR	Q = Pregnancy (MAC drug) P = Pregnancy (non-MAC drug) F = Emergency (MAC drug) E = Emergency (non-MAC drug) M = LTC (MAC drug) L = LTC (non-MAC drug) T = Family Planning (MAC drug) S = Family Planning (non-MAC drug) C = All Others (MAC drug) space=All Others (non-MAC drug).		Indicator to determine if a recipient is required to pay a co-pay.	
RX-CO-PAY	Numeric			Co-pay amount collected from the Recipient by the Pharmacist (and kept by the Pharmacy). May or may not be collected.	
RX-DUR-CONFLICT	CHAR			Based on Drug Utilization Review - the interaction (conflict) of multiple drugs (DUR=Drug Utilization Review).	
RX-DUR-INT	CHAR			Steps or measures the pharmacist performed based on the conflict code (DUR=Drug Utilization Review).	
RX-HICL-SEQ-NO	CHAR	4-character NCPDP-standard HICL Sequence number value set.			
RX-ACUTE-THERAPY-IND	CHAR	blank=Not applicable 1=Acute Therapy Indicated		Acute Therapy Indicator: emergency administration of a medication, generally heavy doses, based on a patient's critical need or condition.	
RX-ROUTE-ADMIN	CHAR	0=Hemodialysis 1=Oral 2=Injection 3=Rectal		Route of Administration: the route of drug in the body (administer).	

DataBase Name:	EB-PHARMACY-REC
Location:	File Extract
NOTES:	Only applicable to pharmacy claims. There is only 1 pharmacy record per Rx base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
		4=Mucous Membrane 5=Topical 6=Ophthalmic 7=Nasal 8=Otic 9=Intradermal A=Intravenous B=Buccal C=Intramuscular D=Dental E=Epidural F=Perfusion G=Subcutaneous H=Inhalation I=Intracavernous J=Intraarterial K=Intraaortic L=Translingual M=Miscellaneous N=Implantation O=Intrathecal P=Intraperitoneal Q=Intravesic R=Irrigation S=Sublingual T=Transdermal U=Urethral V=Vaginal W=Intraocular X=Intrapleural Y=In Vitro			
RX-DATE-PROCESSED	Numeric	Format YYYYMMDD			
RX-TIME-PROCESSSED	Numeric				

DataBase Name:	EB-EPSDT-REC
Location:	File Extract
NOTES:	Only applicable to EPSDT claims. There is only 1 EPSDT record per EPSDT base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
EPSDT-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
EPSDT-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
EPSDT-KIDMED-MEDREC-NO	CHAR			Medical record number field is used by KidMed to identify claim ICN in the KidMed subsystem.	
EPSDT-DATE-LAST-SCREEN	Numeric	Format YYYYMMDD		Date of recipient's last scheduled examination with a screening provider.	
EPSDT-SCREEN-CODE	CHAR	0=Not Available I = Initial screening by nurse S= Initial screening by physician P= Periodic screening by nurse D= Periodic screening by physician. blank=Not available/not entered		Indicates the person performing the screening,nurse or M.D.; if first or subsequent screenings.	
EPSDT-COMPLETE-IND	CHAR	Y=All screenings completed N=All screenings NOT completed.			
EPSDT-REFER-IND	CHAR	Y=EPSDT Referral N=Not a referral or N/A.		Indicates the service provided was EPSDT referral related to diagnosis or treatment according to the "yes" or "no" checked on the claim form.	
EPSDT-IMMUN-IND	CHAR	blank=Not available/not entered Y=Immunizations completed for age of recipient N=Incomplete/No immunizations.		EPSDT Immunization Indicator: indicates if immunization(s) were given during the screening examination	
EPSDT-SUSPECTED-COND1	CHAR	A=Medical B=Vision C=Hearing D=Dental E=Nutritional F=Developmental G=Abuse/Neglect H=Psychological/Social I=Speech/Language		Itemizes possibly abnormal conditions a recipient may have detected during the screening examination.	
EPSDT-SUSPECTED-COND2	CHAR	See EPSDT-SUSPECTED-COND1		See EPSDT-SUSPECTED-COND1	

DataBase Name:	EB-EPSDT-REC
Location:	File Extract
NOTES:	Only applicable to EPSDT claims. There is only 1 EPSDT record per EPSDT base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
EPSDT-SUSPECTED-COND3	CHAR	See EPSDT-SUSPECTED-COND1		See EPSDT-SUSPECTED-COND1	
EPSDT-SUSPECTED-COND4	CHAR	See EPSDT-SUSPECTED-COND1		See EPSDT-SUSPECTED-COND1	
EPSDT-SUSPECTED-COND5	CHAR	See EPSDT-SUSPECTED-COND1		See EPSDT-SUSPECTED-COND1	
EPSDT-SUSPECTED-COND6	CHAR	See EPSDT-SUSPECTED-COND1		See EPSDT-SUSPECTED-COND1	
EPSDT-KIDMED-SUBID	Numeric			The EMC submitter ID for KidMed contractor (EMC=Electronic Media Claims).	
EPSDT-PROV-SITE-NO	CHAR	PCP's site number.			
EPSDT-PROV-SITE-PARISH	CHAR	See Appendix C			
EPSDT-REFER-PROVIDER-NO	Numeric	Medicaid Provider ID number		The referring provider	
EPSDT-REFER-PROVIDER-NPI	Numeric	NPI		The referring provider	
EPSDT-PATIENT-HOME-PHONE	Numeric			May be 0.	
EPSDT-PATIENT-WORK-PHONE	Numeric			May be 0.	
EPSDT-GUARDIAN-NAMEL	CHAR			Last Name of Guardian, may be blank	
EPSDT-GUARDIAN-NAMEF	CHAR			First Name of Guardian, may be blank	
EPSDT-GUARDIAN-NAMEM	CHAR			Middle init of Guardian, may be blank	
EPSDT-NEXT-SCREENING-DATE	Numeric	Format YYYYMMDD			
EPSDT-NEXT-SCREENING-TIME	Numeric				
EPSDT-MEDICAL-CONTRAINDICATED	CHAR				
EPSDT-REFUSED-TO-PERMIT	CHAR				
EPSDT-PATIENT-OFF-SCHEDULE	CHAR				
EPSDT-WERE-SUSP-CONDITIONS	CHAR				
EPSDT-PROC	CHAR	CPT Procedure code			

DataBase Name:	EB-SUSPECT-REC
Location:	File Extract
NOTES:	There may be multiple suspect records per EPSDT base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
SUSPECT-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
SUSPECT-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
SUSPECT-UNDER-CARE	CHAR				
SUSPECT-REFERRAL-INHOUSE	CHAR				
SUSPECT-REFERRAL-OFFSITE	CHAR				

DataBase Name:	EB-REFERRAL-REC
Location:	File Extract
NOTES:	Only applicable to EPSDT claims. There may be multiple referral records per EPSDT base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
REFERRAL-CHECKWRITE-DATE	Numeric	Date in the format YYYYMMDD	P	Payment cycle date of the claim.	1st part of composite key of record
REFERRAL-CLAIMID	Numeric	1 through 99999999	P	Unique claim line number that starts at 1 and ends at the last claim line for the cycle.	2nd part of composite key of record
REFERRAL-NO1	CHAR				
REFERRAL-NO2	CHAR				
REFERRAL-NO3	CHAR				
REFERRAL-NO4	CHAR				
REFERRAL-ASSIST-NEEDED	CHAR				
REFERRAL-APPT-DATE	Numeric	Format YYYYMMDD			
REFERRAL-REASON	CHAR				
REFERRAL-TO-PROV-SITE	CHAR				
REFERRAL-TO-NAME	CHAR				
REFERRAL-TO-PROVIDER	Numeric	Medicaid Provider ID			

DataBase Name:	EB-REFERRAL-REC
Location:	File Extract
NOTES:	Only applicable to EPSDT claims. There may be multiple referral records per EPSDT base claim line.

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
REFERRAL-TO-PHONE	Numeric				

2.6.2 Mainframe ELIGIBILITY (RECIPIENT) Data

DataBase Name:	EB-RECIPIENT-HEADER				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
RECIP-ID-CURRENT	Numeric	13-digit Medicaid Recipient ID number	P	The recipient's current Medicaid ID number	In most cases the current and original ID are the same.
RECIP-ID-ORIGINAL	Numeric	13-digit Medicaid Recipient ID number		The recipient's original Medicaid ID number	
RECIP-HIC	CHAR			SSOC CLAIM BENEFITS(HIC) NUMBER	
RECIP-SSN	Numeric				
RECIP-LAST-NAME	CHAR				
RECIP-FIRST-NAME	CHAR				
RECIP-MID-INITIAL	CHAR				
RECIP-RECIP-TITLE	CHAR				
RECIP-RECIP-SUFFIX	CHAR				
RECIP-PREVIOUS-LAST-NAME	CHAR				
RECIP-PREVIOUS-FIRST-NAME	CHAR				
RECIP-PREVIOUS-MID-INITIAL	CHAR				
RECIP-ADDR-LN1	CHAR			Street Address	
RECIP-ADDR-LN2	CHAR			Street Address, additional if necessary	
RECIP-CITY	CHAR				
RECIP-STATE	CHAR	Uses USPS Standard State Abbreviation			
RECIP-ZIP-CODE	Numeric	9-digit USPS ZIP code			
RECIP-ID-ORIGINAL	Numeric	13-digit Medicaid Recipient ID number		The recipient's original Medicaid ID number	In most cases the current ID will = the original ID. For some long-time Medicaid recipients, this will not be the case.
RECIP-BIRTH-DATE	Numeric	Format YYYYMMDD		The recipient's DOB	
RECIP-SEX	CHAR	1=Male, 2=Female, 9=Unknown.			
RECIP-RACE	CHAR	See Appendix C			
RECIP-DATE-OF-DEATH	Numeric	Format YYYYMMDD			
RECIP-DATE-OF-CERTIF	Numeric	Format YYYYMMDD			
RECIP-DATE-OF-APPLIC	Numeric	Format YYYYMMDD			
RECIP-DATE-OF-LAST-	Numeric	Format YYYYMMDD			

DataBase Name:	EB-RECIPIENT-HEADER				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
ACTIVITY					
RECIP-GROSS-INCOME	Numeric	GROSS INCOME IN WHOLE DOLLARS			May or may not be provided.
RECIP-FAMILY-SIZE	Numeric	The number of persons in the family of which a recipient is a member. FAMILY SIZE NOT > 255			
RECIP-SEX-OVERRIDE-IND	CHAR	BLANK=NO RESTRICTION Y = SEX RESTRICTION A = AGE RESTRICTION B = SEX AND AGE RESTRICTION		Used in MMIS claims processing to override specific age or sex restricted procedures due to special circumstances and/or conditions associated with the recipient.	
RECIP-EPSDT-TRACKING-IND	CHAR	1=Requested medical & dental screening 2=Requested only medical screening 3=Requested only dental screening 6=Non-participant 7=Non-participant 8=Currently participates in program.		A code that Indicates the recipient's response to an offer of EPSDT services.	This field is used exclusively by the MMIS Claims Processing subsystem to facilitate EPSDT/KidMed claims processing. It allows the programs to quickly detect recipients who have ever been or are presently in KidMed so that we don't have to search KidMed linkages for all recipients, just for those who have this indicator set. We don't believe SMO should use this field since it is not date-specific; instead, we believe SMO should use table: **EB-RECIP-PCP-LINKAGE-DETAIL.**
RECIP-EPSDT-SIGNATURE-DATE	Numeric	Format YYYYMMDD			This field indicates the latest date that an individual accepted EPDST participation.
RECIP-DX-DISCHARGE-DATE	Numeric	Format YYYYMMDD			
RECIP-LTC-REVIEW-DATE	Numeric	Format YYYYMMDD			
RECIP-RECIP-EXCP-IND	CHAR	N or space=Not exempt Y=Eligible is exempt from CommunityCARE.			
RECIP-SOURCE-OF-INPUT	CHAR	W Weekly BHSF update tape O On-line (RC-1 Form) L On-line (Lock-in) Community Care D Daily MEDS update P On-line (DX Discharge or CPE Date Modified)			
RECIP-PREFERRED-LANGUAGE	CHAR	See Appendix C. C.18			Used to identify recipient's preferred language.
RECIP-TEL-NO	Numeric	May be 0.			

DataBase Name:	EB-RECIPIENT-HEADER				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
RECIP-PBS-BEG-DATE	Numeric	Format YYYYMMDD			Used to identify Chisholm-class recipients. Note that Chisholm-class recipients should not also be waiver recipients.
RECIP-PBS-END-DATE	Numeric	Format YYYYMMDD			Used to identify Chisholm-class recipients
RECIP-CASE-MANAGER	Numeric	Medicaid Provider ID number		This is the case manager for Chisholm recipients, but it is optional. Not all Chisholm-class recipients will be assigned a case manager, and so this value may be 0.	
RECIP-HEAD-OF-HOUSEHOLD-SSN	CHAR	Head of Household or responsible party SSN		May or may not be available.	
RECIP-HEAD-OF-HOUSEHOLD-NAME	CHAR	Head of Household or responsible party		May or may not be available.	
RECIP-PID-CARD-NO	Numeric	16-digit number in the format **777nnnnnnnnnnss** where **nnnnnnnnnn** is a unique number and **ss** is the card sequence number, starting at 01. Each replacement card has the same first 14 digits, but the card sequence number is incremented by 1. Only the last card number assigned is valid.		Recipient's current plastic ID card number, sometimes called a CCN=card control number.	

DataBase Name:	EB-SURS-LOCKIN-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
SURS-LOCKIN-ID-CURR	Numeric	Recipient Medicaid ID number	P		Join column with EB-RECIPIENT-HEADER
SURS-LOCKIN-ID-ORIG	Numeric	Recipient Medicaid ID number			
SURS-LOCKIN-IND	CHAR	1=Physician and Pharmacy 3=Pharmacy Only			
SURS-LOCKIN-PHYSICIAN-1	Numeric	Medicaid Provider ID number		If not = 0, then this is the 1st MD Provider ID	
SURS-LOCKIN-PHYSICIAN-2	Numeric	Medicaid Provider ID number		If not = 0, then this is the 2nd MD Provider ID	

DataBase Name:	EB-SURS-LOCKIN-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
SURS-LOCKIN-PHYSICIAN-3	Numeric	Medicaid Provider ID number		If not = 0, then this is the 3rd MD Provider ID	
SURS-LOCKIN-PHYSICIAN-4	Numeric	Medicaid Provider ID number		If not = 0, then this is the 4th MD Provider ID	
SURS-LOCKIN-PHARMACY-1	Numeric	Medicaid Provider ID number		If not = 0, then this is the 1st RX Provider ID	
SURS-LOCKIN-PHARMACY-2	Numeric	Medicaid Provider ID number		If not = 0, then this is the 2ND RX Provider ID	
SURS-LOCKIN-BEGIN-DATE	Numeric	Format=YYYYMMDD		Begin date of the lockin	
SURS-LOCKIN-END-DATE	Numeric	Format=YYYYMMDD		End date of the lockin	
SURS-LOCKIN-LAST-ACT	Numeric	Format=YYYYMMDD		Last date of activity on this lockin segment.	

DataBase Name:	EB-ELIGIBILITY-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
ELIG-ID-CURR	Numeric	Recipient Medicaid ID number	P		Join column with EB-RECIPIENT-HEADER
ELIG-ID-ORIG	Numeric	Recipient Medicaid ID number			
ELIG-BEGIN-DATE	Numeric	Format=YYYYMMDD			
ELIG-END-DATE	Numeric	Format=YYYYMMDD		Open end date is 20201231	
ELIG-AID-CATEGORY	CHAR	See Appendix C			
ELIG-TYPE-CASE	CHAR	See Appendix C			
ELIG-CANCEL-RSN	CHAR	See Appendix C		MEDS Cancel reason, if the segment is ended prior to 20201231	
ELIG-MONEY-CODE	CHAR	1 = CATEGORICALLY NEEDY RECEIVING MAINT 3 = CATEGORICALLY NEEDY NOT RECEIVING MAINT 4 = MEDICALLY NEEDY 5 = CREATED PRIOR TO 1988 LEGIS 6 = CREATED MCCA 1988 AND LATER		A code used to indicate whether or not a Recipient currently receives a public assistance money payment.	
ELIG-MEDS-CASE-ID	CHAR			MEDS Case ID number	
ELIG-MEDS-SEQ-ID	CHAR			Sequence number sent by MEDS in the daily MEDS-to-Recipient update process.	
ELIG-APPROVAL-CODE	CHAR	See Appendix C		MEDS Approval Code.	

DataBase Name:	EB-ELIGIBILITY-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
ELIG-BUDGET-AID	CHAR	A=Old age, categorically needy B=Aid to needy blind, categorically needy C=Aid to dependent children, categorically needy D=Disability assistance, categorically needy E=Refugee, categorically needy F=Foster Care regular, categorically needy G=General assistance, categorically needy I=Foster Care/AFDC, categorically needy R=Spanish/Latin American, categorically needy J=Other K=Old age assistance, no money payment L=Aid to needy blind, no money payment M=Aid to dependent children, no money payment N=Disability Assistance, no money payment O=Asian American, no money payment P=Foster Care regular, no money payment Q=General Assistance, no money payment S=Foster Care/AFDC, no money payment T=Spanish/Latin American, no money payment U=Other, no money payment V=Old age assistance, medically needy only W=Aid to needy blind, medically needy only X=Aid to dependent children, medically needy only Y=Disability assistance, medically needy only Z=Asian American, medically needy only 1=Foster Care regular, medically needy only 2=General assistance, medically needy only 3=Foster Care/AFDC, medically needy only 4=Spanish/Latin American, medically			

DataBase Name:	EB-ELIGIBILITY-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		needy only 5=Other, medically needy only 8=Sobra presumptive eligible 9=Sobra regular eligible			
ELIG-SEG-ADD-DATE	Numeric	Format=YYYYMMDD		Date the segment was added to the Recipient File	
ELIG-LAST-ACT-DATE	Numeric	Format=YYYYMMDD		Last date the segment was updated.	

DataBase Name:	EB-OTHER-INS-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
OTHER-INS-RECIP-ID-CURR	Numeric	Recipient Medicaid ID number	P		Join column with EB-RECIPIENT-HEADER
OTHER-INS-RECIP-ID-ORIG	Numeric	Recipient Medicaid ID number			
OTHER-INS-TYPE	CHAR	PR=Private TPL MA=Medicare Part A MB=Medicare Part B LH=LaHIPP (Employers' Health Insurance Premium Payment)			
OTHER-INS-COMPANY-NUMBER	CHAR	Standard Insurance Company Number			
OTHER-INS-SCOPE-OF-COVERAGE	CHAR	See Appendix C			
OTHER-INS-MEDICARE-HIC-NO	CHAR			SSOC HIC Number	
OTHER-INS-BEGIN-DATE	Numeric	Format YYYYMMDD			
OTHER-INS-END-DATE	Numeric	Format YYYYMMDD			
OTHER-INS-GROUP-NO	Character	15-character group number from the insurance company		Up to 15-characters: group number of the Insurance company.	
OTHER-INS-POLICY-NO	Character	Up to 13 character policy number assigned by the insurance company		Up to 13-character policy number assigned by the insurance company.	
OTHER-INS-POLICY-HOLDER-NAME	Character	20 bytes: LN is first 12 then FN is next 7, then MI is last one.		Name of the Policy holder as reported by the insurance company, may or may not be present.	
OTHER-INS-POLICY-HOLDER-SSN	Character	9-digit SSN		SSN of the Policy holder as reported by the insurance company, may or may not be present.	
OTHER-INS-AGENT-NAME	Character	25 bytes		Name of Agent, may or may not be present	

DataBase Name:	EB-OTHER-INS-DETAIL				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
OTHER-INS-AGENT-PHONE	Character	10-digit phone		May or may not be present.	
OTHER-INS-AGENT-STREET	Character	25-characters		May or may not be present.	
OTHER-INS-AGENT-CITY	Character	20-characters		May or may not be present.	
OTHER-INS-AGENT-STATE	Character	2-character USPS state abbreviation		May or may not be present.	
OTHER-INS-AGENT-ZIP	Character	5- or 9-digit zip code		May or may not be present.	

DataBase Name:	TPL Carrier Code Data				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
CARRCODE	Character	6-character carrier code		Insurance company code: first 4 character is the carrier ID of the company, and last 2 characters is the office id.	
CARRNAME	Character	53-character insurance company name		Insurance company name	
ADDR1	Character	25-character street address		Street Address	
ADDR2	Character	25-character other street address		Other/additional street address info, may or may not be present.	
CITY	Character	20-character			
STATE	Character	2-character USPS state abbreviation			
ZIP	Numeric	9-digit zip+4		+4 may be all 0s.	

DataBase Name:	EB-CCN-PACE-LINKAGE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
CCN-LINKAGE-RECIP-ID-CURR	Numeric	Recipient Medicaid ID number	P		Join column with EB-RECIPIENT-HEADER
CCN-LINKAGE-RECIP-ID-ORIG	Numeric	Recipient Medicaid ID number			
CCN-LINKAGE-ENROLL-TYPE	CHAR	V=PACE P=CCNP (Pre-paid) S=CCNS (Shared Savings)			
CCN-LINKAGE-PLAN-PROV-ID	Numeric	Medicaid Provider ID number		The provider ID number assigned to the plan (PACE, CCNP, or CCNS)	
CCN-LINKAGE-COV-ACTION-CODE	CHAR	IE=Initial Enrollment CH=Change Enrollment DE=Disenrollment			
CCN-LINKAGE-DISENROLL-REASON	Numeric	000=Not disenrolled 009=HAS-OTHER-HEALTH-INS 018=MOVED-OUT-OF-SERVICE-AREA 020=DOES-NOT-MEET-LOC 040=VOLUNTARY-DISENROLLMENT 048=DEATH-DOD-UNKNOWN 068=INVOLUNTARY-DISENROLLMENT 077=ADMITTED-TO-INSTITUTION 078=MOVED-OUT-OF-STATE 090=DEATH 100=NOT-CATEGORICALLY-ELIG /* TBD by MEDS */ 900=OPT-OUT-NATIVE-AMERICAN 901=OPT-OUT-FOSTER-CARE 902=OPT-OUT-OYD-OJJ 903=OPT-OUT-UNDER19-SPEC-SERV 904=OPT-OUT-SSI. 905=Opt-out, Other reason. 906=Disenrollment during Annual Enrollment. 907=Disenrolled due to Hospice admission 908=Disenrolled due to Medicare coverage			
CCN-LINKAGE-BEGIN-DATE	Numeric	Format YYYYMMDD			
CCN-LINKAGE-END-DATE	Numeric	Format YYYYMMDD			
CCN-LINKAGE-SRC-CHG	CHAR	EB=Enrollment Broker DH=DHH-Directed FI=Fiscal Intermediary (PACE only) ON=Online (PACE only)			
CCN-LINKAGE-GEO-CODE	CHAR	1=New Orleans (PACE only) 2=Baton Rouge (PACE only)			

DataBase Name:	EB-CCN-PACE-LINKAGE				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		1=Region 1 (CCNP and CCNS) 2=Region 2 (CCNP and CCNS) 3=Region 3 (CCNP and CCNS) 4=Region 4 (CCNP and CCNS) 5=Region 5 (CCNP and CCNS) 6=Region 6 (CCNP and CCNS) 7=Region 7 (CCNP and CCNS) 8=Region 8 (CCNP and CCNS) 9=Region 9 (CCNP and CCNS) See Appendix C for Region descriptions A=Auto-Assigned by EB			
CCN-LINKAGE-AA-CODE	CHAR	C=Enrollee Choice		Auto-Assignment code	
CCN-LINKAGE-EB-ID	Numeric	Maximum of 9-digits		Unique ID assigned by EB	

DataBase Name:	EB-HOSPICE-DATA				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
HSP-RECIP-ID-CURR	Numeric	Recipient Medicaid ID number	P		Join column with EB-RECIPIENT-HEADER
HSP-RECIP-ID-ORIG	Numeric	Recipient Medicaid ID number			
HSP-ENTITLE-DATE	Numeric	Format YYYYMMDD			
HSP-BEGIN-DATE	Numeric	Format YYYYMMDD			
HSP-END-DATE	Numeric	Format YYYYMMDD			
HSP-DIAG1	CHAR	ICD-9-CM Diagnosis Code			
HSP-DIAG2	CHAR	ICD-9-CM Diagnosis Code			
HSP-CLOSURE-CODE	CHAR	See Appendix C			
HSP-PROV	Numeric	Medicaid Provider ID number		Provider ID of the Hospice facility	
HSP-HOSPICE-TYPE	CHAR	See Appendix C, LOC			
HSP-PERIOD-IND	CHAR	1=1st 90 days 2=2nd 90 days 3=60 days Other values 4, 5, 6, 7, 8, 9 (values are undetermined at this time)			

DataBase Name:	EB-LTC-DATA				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
LTC-RECIP-ID-CURR	Numeric	Recipient Medicaid ID number	P		Join column with EB-RECIPIENT-HEADER
LTC-RECIP-ID-ORIG	Numeric	Recipient Medicaid ID number			
LTC-BEGIN-DATE	Numeric	Format YYYYMMDD			
LTC-END-DATE	Numeric	Format YYYYMMDD			
LTC-LOC	CHAR	See Appendix C, LOC		Level of Care associated with institutional stay	
LTC-PROV		Medicaid Provider ID number		Provider ID of the LTC or ICF facility	
LTC-ADMISSION-DATE	Numeric	Format YYYYMMDD			
LTC-DISCHARGE-DATE	Numeric	Format YYYYMMDD			

2.6.3 Mainframe PROVIDER Data

DataBase Name:	EB-PROVIDER-HEADER-RECORD				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
APR-PROVIDER-ID	Numeric	Medicaid Provider ID, non-check-digit	P		Primary key
APR-CHECK-DIGIT-ID	Numeric	Medicaid Provider ID, check-digit			
APR-MEDICARE-UPIN	Numeric	Standard CMS UPIN		UPIN assigned by CMS	
APR-PRESCRIBE-ONLY	CHAR	Blank=Not Applicable 0= Full Rx authority 1= Resident with Rx authority 2= Limited Rx authority (PA/NP) 3= Sanctioned 4= Full Rx authority plus ability to Rx Suboxone 5= Pharmacist can give immunizations			A code which indicates if the provider is authorized to only prescribe medications to Medicaid recipients, but not bill for services.
APR-PARISH-CODE	CHAR	See Appendix C, Provider Parish			
APR-PROVIDER-REGION	CHAR	Values 1 through 9. See Appendix C.		This is not the geographical region, but it is an administrative region used for accounting purposes.	
APR-OUT-OF-STATE	CHAR	0=In-State, 1=Out-of-State.			
APR-URBAN-OR-RURAL	CHAR	1=Urban 2=Rural 3=DHH Identified Small Rural Hospital.			
APR-PROV-TYPE	CHAR	See Appendix C			
APR-SPECIALTY	CHAR	See Appendix C			
APR-SUB-SPECIALTY1	CHAR	See Appendix C			
APR-SUB-SPECIALTY2	CHAR	See Appendix C			
APR-SUB-SPECIALTY3	CHAR	See Appendix C 0 = Group members only, cannot bill individually 1 = May or may not be group member, but may bill individually. 1 = If Pharmacy, then Independent store. 2 = Pharmacy Chain			
APR-ENROLL-STATUS	CHAR	3 = American Indian			
APR-PRACTICE-TYPE	CHAR	THIS CODE IS NOT RELIABLE. The value is taken from the Provider Application Form PE-50 and it reflects ownership information supplied by the			

DataBase Name:	EB-PROVIDER-HEADER-RECORD				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		provider: 01 = Individual 02 = Partnership 03 = Corporation/LLC 04 = Hospital-Based Physician, 05 = HMO 06 = Group Practice Private 07 = Teaching Provider (Physician or Dentist) 08 = Public Clinic or Group.			
APR-19-BEGIN-DATE	Numeric	Format YYYYMMDD		Current Enrollment Begin Date	
APR-19-END-DATE	Numeric	Format YYYYMMDD		Current Enrollment End Date	
APR-19-CANCEL	CHAR	See Appendix C			
APR-19-1BEGIN-DATE	Numeric	Format YYYYMMDD		Prior 1 Enrollment Begin Date	
APR-19-1END-DATE	Numeric	Format YYYYMMDD		Prior 1 Enrollment End Date	
APR-19-1CANCEL	CHAR	See Appendix C			
APR-19-2BEGIN-DATE	Numeric	Format YYYYMMDD		Prior 2 Enrollment Begin Date	
APR-19-2END-DATE	Numeric	Format YYYYMMDD		Prior 2 Enrollment End Date	
APR-19-2CANCEL	CHAR	See Appendix C			
APR-LAST-ACTIVITY-DATE	Numeric	Format YYYYMMDD			
APR-SOC-SEC-NUMBER	Numeric	This is the provider's social security number		This is the provider's social security number	
APR-PROVIDER-LIC-OLD	CHAR	This is the provider's old license number		This is the provider's old license number	
APR-PROVIDER-LIC-EFF-DATE	Numeric	Format YYYYMMDD		Provider license effective date	
APR-PROVIDER-LIC-EXP-DATE	Numeric	Format YYYYMMDD		Provider license expiration date	
APR-PROVIDER-CERT-NUMBER	CHAR	This is the provider's certification number		Provider's certification number	
APR-PROVIDER-CERT-EFF-DATE	Numeric	Format YYYYMMDD		Provider's certification effective date	
APR-PROVIDER-CERT-EXP-DATE	Numeric	Format YYYYMMDD		Provider's certification expiration date	
APR-FACILITY-RATING	CHAR	obsolete		obsolete	obsolete
APR-FACILITY-CONTROL	CHAR	1=Private 2=Profit 3=Non-Profit 4=Public 5=LSU (other than hospital) 6=State (OPH)		Otherwise known as provider PPI=Private/Public Indicator	

DataBase Name:	EB-PROVIDER-HEADER-RECORD				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		7=LSU hospitals(PT 60 & 69) 8=School Board 9=All state providers not included in PPI of 5-8			
APR-NUMBER-OF-BEDS	Numeric			Number of beds in hospital, NH, ICF, LTC, LTAC	Only applicable to Hospitals, NH, ICF, and other institutions.
APR-ADMIN-NAME	CHAR			Provider's administrative name	
APR-NAME-SV	CHAR			Provider's service name	
APR-ADDR-LN1-SV	CHAR			Provider's service street address	
APR-ADDR-LN2-SV	CHAR			Provider's service city	
APR-ADDR-ST-SV	CHAR	USPS State abbreviation		Provider's service state	
APR-ZIP-SV	Numeric			Provider's service zip+4	
APR-PHONE-SV	Numeric			Provider's service phone number	
APR-NAME-ADDRESS-PAY-TO	CHAR			Provider's pay-to or billing name	
APR-PROVIDER-NAME-PAY-TO	CHAR			Provider's pay-to or billing name	
APR-OTHER-PAYEE	CHAR			Provider's pay-to or billing other name	
APR-ADDR-LN1-PAY-TO	CHAR			Provider's pay-to or billing street address or PO Box	
APR-ADDR-LN2-PAY-TO	CHAR			Provider's pay-to or billing city	
APR-ADDR-ST-PAY-TO	CHAR	USPS State abbreviation		Provider's pay-to or billing state	
APR-ZIP-PAY-TO	Numeric			Provider's pay-to or billing zip+4	
APR-OWNER-NAME1	CHAR			Provider owner name # 1	
APR-OWNER-NAME2	CHAR			Provider owner name # 2	
APR-AMB-SURG-IND	CHAR	A=Outpatient ambulance and procedures code must be HR540-HR549 Space=not applicable		Ambulatory Surgical Indicator	
APR-EPSDT-MEDICAL	CHAR	0=Not allowed to bill EPSDT medical 1=Allowed to bill EPSDT medical.			
APR-EPSDT-HEARING	CHAR	0=Not allowed to bill EPSDT hearing screenings 1=Allowed to bill EPSDT hearing screenings.			
APR-EPSDT-VISION	CHAR	0=Not allowed to bill EPSDT vision screenings 1=Allowed to bill EPSDT vision screenings.			
APR-PHYSICIAN-SERVICE-IND	CHAR	0=N 1=Y		This field is used to identify anesthesiologists (Provider specialty 05)	

DataBase Name:	EB-PROVIDER-HEADER-RECORD				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
				who can bill physician services as well as anesthesia	
APR-COMMUNITY-CARE-IND	CHAR	Blank or 0 = Not a CommunityCARE Provider 1=CommCARE Provider - Individual or Group 2=CommCARE Provider - Former/Suspended 3=CommCARE Provider - Individual in Group.			
APR-RACE	CHAR	See Appendix C			
APR-SEX	CHAR	W=Woman Owned Other value=not applicable			
APR-PRECERT-BEGIN-DATE	Numeric	Format YYYYMMDD			
APR-MEDICAID-EFF-DTE	Numeric	Format YYYYMMDD			
APR-MEDICARE-EFF-DTE	Numeric	Format YYYYMMDD			
APR-AGENCY	CHAR	DHH EDUC GB-CO JPHSA LSD LSU LSVI OAD OCDD OMH OPH VILLA		Used by State providers only. Identifies state agency using official Louisiana agency designations. State providers are identified by PPI>=5.	
APR-DIVISION	CHAR	CAHSD FPHSA HCSD HSCNO HSCS JPHSA MHSD OAAS OBH OCDD OPH		Used by State providers only. Identifies division of state agency using official Louisiana division designations. State providers are identified by PPI>=5.	
APR-OFFICE	CHAR	CHABERT CONWAY EKL HPLONG		For state hospitals, identifies the individual office (physical hospital).	

DataBase Name:	EB-PROVIDER-HEADER-RECORD				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
		JOHNJ LALLIEK MCL-NO MHC MHR PSY HOS SHREVE UMC-LAF VILLA WO MOSS WSH-ST			
APR-UNIT	CHAR	Not used at this time, value=spaces		Not used at this time.	
APR-NUMBER-OF-SITES	Numeric	A number from 0 to 999		Total number of sites supported by provider	
APR-PROVIDER-LIC	CHAR	Provider's current license number		Provider's current license number	
APR-BELONGS-TO-IND	Numeric	1-20		Number of groups to which the provider is associated	
APR-NUMBER-IN-GRP	Numeric	1-1500		Number of other providers that are associated to the this provider.	

DataBase Name:	EB-PROVIDER-BELONGS-TO				
Location:	File Extract				
Column Name or Field name	**Data Type**	**Accepted Values**	**Indx Info**	**Description**	**Purpose or Usage Notes**
APBT-PROVIDER-ID	Numeric	Medicaid Provider ID, non-check-digit	P		Primary key
APBT-CHECK-DIGIT-ID	Numeric	Medicaid Provider ID, check-digit			
APBT-GROUP-ID	Numeric	Medicaid Provider ID, non-check-digit		Affiliated group id (group that the provider belongs to).	
APBT-BEGIN-DATE	Numeric	Format YYYYMMDD			
APBT-END-DATE	Numeric	Format YYYYMMDD			
APBT-CANCEL-RSN	CHAR	2-digit cancel reason, See Appendix C			

DataBase Name:	EB-PROVIDER-MEMBER-LIST
Location:	File Extract

Column Name or Field name	Data Type	Accepted Values	Indx Info	Description	Purpose or Usage Notes
APML-PROVIDER-ID	Numeric	Medicaid Provider ID, non-check-digit	P		Primary key
APML-CHECK-DIGIT-ID	Numeric	Medicaid Provider ID, check-digit			
APML-PROVIDER-MEMBER-ID	Numeric	Medicaid Provider ID, non-check-digit		If provider is a group, then this ID represents the member of the group.	

2.7 Interfaces

2.7.1 Molina will access a secure FTP server at SMO via a secure connection to “push” the files described in Sections 2.5.1 through 2.5.4 above. SMO will provide to Molina a login id and a non-expiring password.

2.7.2 Molina will “pull” the file described in 2.5.5 above from the SMO secure FTP server.

2.8 Network Specifications

No changes needed.

2.9 Security

2.9.1 Secure FTP connection from Molina to SMO required. Molina recommends FTP SSL.

2.10 Software/Hardware

No changes needed.

2.11 Production Control/Computer Operations Changes

2.11.1 Production Control will execute a job-stream on all but the last business day of the week (and also not on state holidays) to extract recipient, provider, and provider-site records that have changed. On the last business day of the week, all recipient, provider, and provider site records will be extracted. The extracted records will be formatted and sent to SMO via secure FTP the next business day.

2.11.2 Each weekend, paid claim records will be extracted and formatted files will be delivered to SMO on the morning of the first work day of the week.

2.12 Manual Procedures

No changes needed.

APPENDIX A – GLOSSARY

There are no new terms for Glossary updates included in this deliverable.

AC = Aid Category

AHS = American Health Systems, Inc.

BBS = Bulletin Board System

CCN = Coordinated Care Network

CMS = Center for Medicare and Medicaid Services

COS = (State) Category of Service

EDI = Electronic Data Interchange

FCOS = Federal Category of Service

FTP = File Transfer Protocol

ISIS = Integrated Statewide Information System

LaMOM= Louisiana Moms Program

LaPOP = Louisiana Personal Options Program

LOC = Level of Care

MAS/BOE
= Maintenance Assistance Status / Basis of Eligibility (part of CMS MSIS database application)

MDW = Medicaid Data Warehouse

MEG = Medicaid Eligibility Group (subobject)

MSIS = Medicaid Statistical Information Set (CMS database that replaces the old HCFA 2082 reports)

PA = Prior Authorization

PACE = Program for All-Inclusive Care for the Elderly

PETS = Provider Enrollment Tracking System

PreCert = Inpatient Hospital Pre-Admission Certification

PS = Provider Specialty

PT = Physical Therapy

PT = Provider Type

ROW = Residential Options Waiver

SRI = Statistical Resources, Inc.

SSL = Secured Sockets Layer

TBD = To Be Determined

TC = Type Case

TOS = Type of Service

TRRS = Transaction Receipt and Response System

VSAM = Virtual Sequential Access Method, a mainframe database type.

APPENDIX B – FILE SUBMISSION SCHEDULE

Recipient Update File – Nightly (Monday through Friday) after Eligibility files are received and processed, ~~except for the last business day of the week~~. (Note that no update files will be generated on nights of a state holiday). The process would generally be completed by 5:00 am the following morning.

Provider Update File – Nightly after Provider file updates have been processed, except for the last business day of the week. (Note that no update files will be generated on nights of a state holiday). The process would generally be completed by 5:00 am the following morning.

Recipient Full File – Every Saturday, generally available at 12:00 midnight Sunday morning.

Provider Full File – Every Saturday, generally available at 5:00pm.

Weekly Claims File – Every Sunday, generally available at 5:00pm

APPENDIX C – COMMON DATA ELEMENTS

C.1 Recipient Region

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

C.2 Recipient 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
65	EAST JEFFERSON	1
77	Out-of-State	n/a

C.3 Race Code

1=White
2=Black or African American
3=American Indian or Alaskan Native
4=Asian
5=Hispanic or Latino (no other race info)
6=Native Hawaiian or Other Pacific Islander
7=Hispanic or Latino and one or more other races
8=More than one race indicated (and not Hispanic or Latino)
9=Unknown

C.4 Recipient Aid Category / Category of Assistance

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
40	Family Planning	Family Planning Waiver

C.5 Recipient Type Case

LAMMIS Type Case	Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)	SSI Status (1=SSI, 0=Non-SSI)	Entitlement Code (1=XIX, 2=XVIII, 3=XXI, 9=N/A)
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	0	1
002	Deemed Eligible	0	1
003	SSI Conversion	0	1
004	SSI SNF	1	1
005	SSI/LTC	1	1
006	12 Months Continuous Eligibility	0	1
007	LACHIP Phase 1	0	3
008	PAP - Prohibited AFDC Provisions	0	1
009	LIFC - Unemployed Parent / CHAMP	0	1
010	SSI in ICF (II)- Medical	1	1
011	SSI Villa SNF	1	1
012	Presumptive Eligibility, Pregnant Woman	0	1
013	CHAMP Pregnant Woman (to 133% of FPIG)	0	1
014	CHAMP Child	0	1
015	LACHIP Phase 2	0	3
016	Deceased Recipient - LTC	0	1
017	Deceased Recipient - LTC (Not Auto)	0	1
018	ADHC (Adult Day Health Services Waiver)	0	1
019	SSI/ADHC	1	1
020	Regular MNP (Medically Needy Program)	0	1
021	Spend-Down MNP	0	1
022	LTC Spend-Down MNP (Income > Facility Fee)	0	1
023	SSI Transfer of Resource(s)/LTC	1	1
024	Transfer of Resource(s)/LTC	0	1
025	LTC Spend-Down MNP	0	1
026	SSI/EDA Waiver	1	1
027	EDA Waiver	0	1

028	Tuberculosis (TB)	0	1
029	Foster Care IV-E - Suspended SSI	0	1
030	Regular Foster Care Child	0	1
031	IV-E Foster Care	0	1
032	YAP (Young Adult Program)	0	1
033	OYD - V Category Child	0	1
034	MNP - Regular Foster Care	0	1
035	YAP/OYD	0	1
036	YAP (Young Adult Program)	0	9
037	OYD (Office of Youth Development)	0	9
038	OCS Child Under Age 18 (State Funded)	0	9
039	State Retirees	0	9
040	SLMB (Specified Low-Income Medicare Beneficiary)	0	2
041	OAA, ANB or DA (GERI HP-ICF(I) SSI-No)	0	1
042	OAA, ANB or DA (GERI HP-ICF(I) SSI Pay)	1	1
043	New Opportunities Waiver - SSI	1	1
044	OAA, ANB or DA (GERI HP-ICF(2) SSI-Pay)	1	1
045	SSI PCA Waiver	1	1
046	PCA Waiver	0	1
047	Illegal/Ineligible Aliens Emergency Services	0	1
048	QI-1 (Qualified Individual - 1)	0	2
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	0	2
050	PICKLE	0	1
051	LTC MNP/Transfer of Resources	0	1
052	Breast and/or Cervical Cancer	0	1
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	0	1
054	Reinstated Section 4913 Children	0	1
055	LACHIP Phase 3	0	3
056	Disabled Widow/Widower (DW/W)	0	1
057	BPL (Walker vs. Bayer)	0	1
058	Section 4913 Children	0	1
059	Disabled Adult Child	0	1

060	Early Widow/Widowers	0	1
061	SGA Disabled W/W/DS	0	1
062	SSI/Public ICF/DD	1	1
063	LTC Co-Insurance	0	1
064	SSI/Private ICF/DD	1	1
065	Private ICF/DD	0	1
066	AFDC- Private ICF DD - 3 Month Limit	0	1
067	AFDC or IV-E(1) Private ICF DD	0	1
068	SSI-M (Determination of disability for Medicaid Eligibility)	1	1
069	Roll-Down	0	1
070	New Opportunities Waiver, non-SSI	0	1
071	Transitional Medicaid	0	1
072	LAMI Pseudo Income	0	1
073	Recipient (65 Plus) Eligible SSI/Ven Pay Hospital	1	1
074	Description not available	0	
075	TEFRA	0	1
076	SSI Children's Waiver - Louisiana Children's Choice	1	1
077	Children's Waiver - Louisiana Children's Choice	0	1
078	SSI (Supplemental Security Income)	1	1
079	Denied SSI Prior Period	0	1
080	Terminated SSI Prior Period	1	1
081	Former SSI	1	1
082	SSI DD Waiver	1	1
083	Acute Care Hospitals (LOS > 30 days)	0	1
084	LaCHIP Pregnant Woman Expansion (185-200%)	0	3
085	Grant Review	0	1
086	Forced Benefits	0	1
087	CHAMP Parents	0	1
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	0	1
089	Recipient Eligible for Pay-Habitation and Other	0	1
090	LTC (Long Term Care)	0	1
091	A, B, D Recipient in Geriatric SNF; No SSI Pay	0	1
092	AFCD, GA, A, B, D in SNF; No AFDC Pay	0	1
093	DD Waiver	0	1

094	QDWI (Qualified Disabled/Working Individual)	0	2
095	QMB (Qualified Medicare Beneficiary)	0	2
097	Qualified Child Psychiatric	0	1
098	AFDC, GA, A, B, D ICF(2) No AFDC/Other Pay	0	1
099	Public ICF/DD	0	1
100	PACE SSI	1	1
101	PACE SSI-related	0	1
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	0	1
109	LaChoice, Childless Adults	0	1
110	LaChoice, Parents with Children	0	1
111	LHP, Childless Adults	0	1
112	LHP, Parents with Children	0	1
113	LHP, Children	0	1
115	Family Planning, Previous LAMOMS eligibility	0	1
116	Family Planning, New eligibility / Non LaMOM	0	1
117	Supports Waiver SSI	1	1
118	Supports Waiver	0	1
119	Residential Options Waiver - SSI	1	1
120	Residential Options Waiver - NON-SSI	0	1
121	SSI/LTC Excess Equity	1	1
122	LTC Excess Equity	0	1
123	LTC Spend Down MNP Excess Equity	0	1
124	LTC Spend Down MNP Excess Equity(Income over facility fee)	0	1
125	Disability Medicaid	0	1
127	LaChip Phase IV: Non-Citizen Pregnant Women Expansion	0	3
130	LTC Payment Denial/Late Admission Packet	0	1
131	SSI Payment Denial/Late Admission	1	1
132	Spend-down Denial of Payment/Late Packet	0	1
133	Family Opportunity Program	0	1
134	LaCHIP Affordable Plan	0	3
136	Private ICF/DD Spend-down Medically Needy Program	0	1
137	Public ICF/DD Spend-down Medically Needy Program	0	1
138	Private ICF/DD Spend-down MNP/Income Over Facility Fee	0	1
139	Public ICF/DD Spend-down MNP/Income Over Facility Fee	0	1

140	SSI Private ICF/DD Transfer of Resources	1	1
141	Private ICF/DD Transfer of Resources	0	1
142	SSI Public ICF/DD Transfer of Resources	1	1
143	Public ICF/DD Transfer of Resources	0	1
144	Public ICF/DD MNP Transfer of Resources	0	1
145	Private ICF/DD MNP Transfer of Resources	0	1
146	Adult Residential Care/SSI	1	1
147	Adult Residential Care	0	1
148	Youth Aging Out of Foster Care (Chaffee Option)	0	1
149	New Opportunities Waiver Fund	0	1
150	SSI New Opportunities Waiver Fund	1	1
151	ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	0	1
152	ELE School Lunch (Express Lane Eligibility -School Lunch)	0	1
178	Disabled Adults authorized for special hurricane Katrina assistance	0	1

C.6 Provider Type

Note to SMO: Rows shaded in green are specific to SMO provider registry.

Provider Type Code	Description	Notes
01	Fiscal Agent - Waiver	
02	Transitional Support - Waiver	
03	Children's Choice - Waiver (in-state only)	
04	Pediatric Day Health Care (PDHC) facility	In effect on/after 8/1/2010
05	CCN-P Organization (Coordinated Care Network, Pre-Paid)	In effect on/after 1/1/2011
06	NOW Professional (Registered Dietician, Psychologist, Social Worker)	
07	Case Mgmt - Infants & Toddlers (in-state only)	
08	Case Mgmt - Elderly (in-state only)	
09	Hospice Services (in-state only)	
10	Comprehensive Community Support Services	In effect for ROW on 8/1/2008 - Removed from ROW on 10/2/2009.
11	Shared Living - Waiver (in-state only)	In effect for ROW in June 2010
12	Multi-Systemic Therapy (in-state only)	
13	Pre-Vocational Habilitation (in-state only)	
14	Adult Day Habilitation - Waiver (in-state only)	
15	Environmental Accessibility Adaptation - Waiver (in-state only)	Changed 6/29/2011
16	Personal Emergency Response Systems - Waiver	
17	Assistive Devices - Waiver	
18	Community Mental Health Center (in-state only)	
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	No Longer Enrolled
23	Independent Lab	
24	Personal Care Services (LTC/PCS/PAS) (in-state only)	eff. 9/1/2003
25	Mobile X-Ray/Radiation Therapy Center	
26	Pharmacy (out-of-state for crossovers only)	
27	Dentist and Dental Group	
28	Optometrist and Optometrist Group	
29	EarlySteps and EarlySteps Group (in-state only)	Title V Part C Agency
30	Chiropractor and Chiropractor Group	
31	Medical or Licensed Psychologist	
32	Podiatrist and Podiatrist Group	

33	Prescribing Only Provider	
34	Audiologist	
35	Physical Therapist	
36	Not assigned	Not assigned
37	Occupational Therapist	
38	School-Based Health Center (in-state only)	
39	Speech/Language Therapist	In effect for ROW in June 2010, Description changed for OAAS Community Choices Waiver on 6/29/2011.
40	DME Provider (out-of-state for crossovers only)	
41	Registered Dietician	In effect for ROW in June 2010
42	Non-Emergency Medical Transportation (in-state only)	
43	Case Mgmt - Nurse Home Visit - 1st Time Mother (in-state only)	
44	Home Health Agency (in-state only)	
45	Case Mgmt - Contractor (in-state only)	
46	Case Mgmt - HIV (in-state only)	
47	Case Mgmt - CMI	No Longer Enrolled
48	Case Mgmt - Pregnant Woman	No Longer Enrolled
49	Case Mgmt - DD	No Longer Enrolled
50	PACE Provider	eff. 7/1/2005
51	Ambulance Transportation	
52	CCN-S Organization (Coordinated Care Network, Shared Savings)	In effect 1/1/2011
53	Direct Care Worker	In effect for CSOC on 3/1/2011.
54	Ambulatory Surgical Center (in-state only)	
55	Emergency Access Hospital	
56	CCN Prescribing Only Provider	In effect for CCN 2/1/2012
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	No Longer Enrolled
64	Mental Health Hospital (Free-Standing)	
65	Rehabilitation Center (in-state only)	
66	KIDMED Screening Clinic (in-state only)	
67	Prenatal Health Care Clinic	
68	Substance Abuse and Alcohol Abuse Center	
69	Hospital - Distinct Part Psychiatric Unit (in-state only)	

70	LEA and School Board (EPSDT Health Services) (in-state only)	LEA=Licensed Educational Agency
71	Family Planning Clinic	
72	Federally Qualified Health Center (in-state only)	
73	Licensed Clinical Social Worker (LCSW)	
74	Mental Health Clinic	
75	Optical Supplier (in-state only)	
76	Hemodialysis Center (in-state only)	
77	Mental Health Rehabilitation (in-state only)	
78	Nurse Practitioner and Nurse Practitioner Group	APRN
79	Rural Health Clinic (Provider Based) (in-state only)	
80	Nursing Facility (in-state only)	
81	Case Mgmt - Ventilator Assisted Care Program	
82	Personal Care Attendant - Waiver (in-state only)	also used for CSOC
83	Respite Care (Center Based)- Waiver (in-state only)	
84	Substitute Family Care - Waiver (in-state only)	
85	ADHC Home and Community Based Services - Waiver (in-state only)	
86	ICF/DD Rehabilitation	No Longer Enrolled
87	Rural Health Clinic (Independent) (in-state only)	
88	ICF/DD - Group Home (in-state only)	
89	Supervised Independent Living - Waiver (in-state only)	
90	Nurse-Midwife	APRN
91	CRNA or CRNA Group	APRN
92	Private Duty Nurse	No Longer Enrolled
93	Clinical Nurse Specialist	APRN
94	Physician Assistant	
95	American Indian / Native Alaskan "638" Facilities	
96	Psychiatric Residential Treatment Facility	Effective 7/2007
97	Adult Residential Care	Planned effective date is 9/1/2010
98	Supported Employment - Waiver (in-state only)	
99	Greater New Orleans Community Health Connection (in-state only)	Effective 10/2010 (per LIFT 7350)
AB	Prepaid Inpatient Health Plan (PIHP)	Effective 1/2012 (per CSoC/PIHP project)
AC	Family Support Organization	Effective 1/2012 (per CSoC/PIHP project)
AD	Transition Coordination (Skills Building)	Effective 1/2012 (per CSoC/PIHP project)
AE	Respite Care Service Agency	Effective 1/2012 (per CSoC/PIHP project)
AF	Crisis Receiving Center	Effective 1/2012 (per CSoC/PIHP project)
AG	Behavioral Health Rehabilitation Provider Agency	Effective 1/2012 (per CSoC/PIHP project)
AH	Licensed Marriage & Family Therapist (LMFT)	Effective 1/2012 (per CSoC/PIHP project)

AJ	Licensed Addiction Counselors (LAC)	Effective 1/2012 (per CSoC/PIHP project)
AK	Licensed Professional Counselors (LPC).	Effective 1/2012 (per CSoC/PIHP project)
AL	Community Choices Waiver Nursing	Effective 10/1/2011 per CCW Waiver
AM	Home Delivered Meals	Effective 10/1/2011 per CCW Waiver
AN	Caregiver Temporary Support	Effective 10/1/2011 per CCW Waiver

C.7 Provider Specialty, Sub-specialty

Note to SMO: Rows shaded in green are specific to SMO provider registry.

NOTES:		
ADHC=Adult Day Health Care		
CCN=Coordinated Care Network		
CCW=Community Choices Waiver (replaces EDA in October 2011)		
CSoC=Coordinated System of Care		
DD=Developmental Disability		
DO=Doctor of Osteopathy		
EAA=Environmental Accessibility Adaptation		
EDA=Elderly and Disabled Adult waiver		
EMT=Emergency Transportation		
FOC=Freedom of Choice		
FQHC=Federally Qualified Health Center		
GNOCHC=Greater New Orleans Community Health Center		
LaPOP=Louisiana Personal Options Program		
LBHP=Louisiana Behavioral Health Program		
LEA=Licensed Educational Agency		

NEMT=Non-emergency Transportation	-	-
NOW=New Opportunities Waiver	-	-
OAAS=Office of Aging and Adult Services	-	-
OAD=Office of Addictive Disorders (merged with OBH in 2010)	-	-
OBH=Office of Behavioral Health	-	-
OCDD=Office for Citizens with Developmental Disabilities	-	-
OPH=Office of Public Health	-	-
OT=Occupational Therapy	-	-
PACE=Program for All-Inclusive Care for the Elderly	-	-
PAS=Personal Assistive Services	-	-
PBS=Psychological Behavioral Services	-	-
PCS=Personal Care Services	-	-
PDHC=Pediatric Day Health Care	-	-
PIHP=Pre-paid Inpatient Health Plan	-	-
PLT=Provider Locator Tool	-	-
PRCS=Psychological Recovery Center Services	-	-
PT=Physical Therapy	-	-
RHC=Rural Health Center	-	-
ROW=Residential	-	-

Options Waiver
RT=Respiratory Therapy
S/L T=Speech and Language Therapy
SBHC=School-Based Health Center
SMO=Statewide Management Organization
TOS=Type of Service

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty	Related Specialty (if Subspecialty)	Related Provider Types	Comments
00	All Specialties	1		n/a	
01	General Practice	1		19,20	
02	General Surgery	1		19, 20, 93	
03	Allergy	1		19,20	
04	Otology, Laryngology, Rhinology	1		19,20	
05	Anesthesiology	1		19, 20, 91	
06	Cardiovascular Disease	1		19,20	
07	Dermatology	1		19,20	
08	Family Practice	1		19, 20, 78	
09	Gynecology (DO only)	1		19	DO=Doctor of Osteopathy
10	Gastroenterology	1		19,20	
11	Not in Use	n/a		n/a	
12	Manipulative Therapy (DO only)	1		19	DO=Doctor of Osteopathy
13	Neurology	1		19,20	
14	Neurological Surgery	1		19,20	
15	Obstetrics (DO only)	1		19	DO=Doctor of Osteopathy
16	OB/GYN	1		19, 20, 78, 90	
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1		19	DO=Doctor of Osteopathy
18	Ophthalmology	1		20	
19	Orthodontist	1		19,20	
20	Orthopedic Surgery	1		19,20	
21	Pathologic Anatomy; Clinical Pathology (DO	1		19	DO=Doctor of Osteopathy

	only)				
22	Pathology	1		20	
23	Peripheral Vascular Disease or Surgery (DO only)	1		19	DO=Doctor of Osteopathy
24	Plastic Surgery	1		19,20	
25	Physical Medicine Rehabilitation	1		19,20	
26	Psychiatry	1		19, 20, 93	
27	Psychiatry; Neurology (DO only)	1		19	DO=Doctor of Osteopathy
28	Proctology	1		19,20	
29	Pulmonary Diseases	1		19,20	
30	Radiology	1		19,20	
31	Roentgenology, Radiology (DO only)	1		19	DO=Doctor of Osteopathy
32	Radiation Therapy (DO only)	1		19	DO=Doctor of Osteopathy
33	Thoracic Surgery	1		19,20	
34	Urology	1		19,20	
35	Chiropractor	1		30,35	
36	Pre-Vocational Habilitation	1		13	
37	Pediatrics	1		19, 20, 78	
38	Geriatrics	1		19,20	
39	Nephrology	1		19,20	
40	Hand Surgery	1		19,20	
41	Internal Medicine	1		19,20	
42	Federally Qualified Health Centers	1		72	
43	Not in Use	n/a		n/a	
44	Public Health/EPSDT	1		66,70	TOS=46 indicates LEA (Licensed Educational Agency)
45	NEMT - Non-profit	1		42	NEMT=Non-emergency Transportation
46	NEMT - Profit	1		42	NEMT=Non-emergency Transportation
47	NEMT - F+F	1		42	NEMT=Non-emergency Transportation, Friends & Family
48	Podiatry - Surgical Chiropody	1		20, 32	
49	Miscellaneous (Admin. Medicine)	1		20	
50	Day Habilitation	1		14	
51	Med Supply / Certified Orthotist	1		40	

52	Med Supply / Certified Prosthetist	1		40	
53	Med Supply / Certified Prosthetist Orthotist	1		40	
54	Med Supply / Not Included in 51, 52, 53	1		40	
55	Indiv Certified Orthotist	1		40	
56	Indiv Certified Protherist	1		40	
57	Indiv Certified Protherist - Orthotist	1		40	
58	Indiv Not Included in 55, 56, 57	1		40	
59	Ambulance Service Supplier, Private	1		51	
60	Public Health or Welfare Agencies & Clinics	1		61, 62, 66, 67	
61	Voluntary Health or Charitable Agencies	1		unknown	
62	Psychologist Crossovers only	1		29, 31	
63	Portable X-Ray Supplier (Billing Independently)	1		25	
64	Audiologist (Billing Independently)	1		29,34	
65	Indiv Physical Therapist	1		29,35	
66	Dentist, DDS, DMS	1		27	
67	Oral Surgeon - Dental	1		27	
68	Pedodontist	1		27	
69	Independent Laboratory (Billing Independently)	1		23	
70	Clinic or Other Group Practice	1		19, 20, 68, 74, 76, 91	
71	Speech Therapy	1		29	
72	Diagnostic Laboratory	1		23	
73	Social Worker Enrollment	1		73	
74	Occupational Therapy	1		29,37	
75	Other Medical Care	1		65	
76	Adult Day Care	1		85	
77	Habilitation	1		85	
78	Mental Health Rehab	1		77	
79	Nurse Practitioner	1		78	
80	Environmental Modifications	1		15	
81	Case Management	1		07, 08, 43, 46, 81	
82	Personal Care Attendant	1		82	
83	Respite Care	1		83	
84	Substitute Family Care	1		84	
85	Extended Care Hospital	1		60	

86	Hospitals and Nursing Homes	1		55, 59, 60, 64, 69, 80, 88	
87	All Other	1		26,40,44, 60	
88	Optician / Optometrist	1		28,75	
89	Supervised Independent Living	1		89	
90	Personal Emergency Response Sys (Waiver)	1		16	
91	Assistive Devices	1		17	
92	Prescribing Only Providers	1		33	
93	Hospice Service for Dual Elig.	1		09	
94	Rural Health Clinic	1		79,87	
95	Psychologist (PBS Program Only)	1		31	
96	Psychologist (PBS Program and X-Overs)	1		31	
97	Family Planning Clinic	1		71	
98	Supported Employment	1		98	
99	Provider Pending Enrollment	1		n/a	
1A	Adolescent Medicine	2	37	19,20	
1B	Diagnostic Lab Immunology	2	37	19,20	
1C	Neonatal Perinatal Medicine	2	37	19,20	
1D	Pediatric Cardiology	2	37	19,20	
1E	Pediatric Critical Care Medicine	2	37	19,20	
1F	Pediatric Emergency Medicine	2	37	19,20	
1G	Pediatric Endocrinology	2	37	19,20	
1H	Pediatric Gastroenterology	2	37	19,20	
1I	Pediatric Hematology - Oncology	2	37	19,20	
1J	Pediatric Infectious Disease	2	37	19,20	
1K	Pediatric Nephrology	2	37	19,20	
1L	Pediatric Pulmonology	2	37	19,20	
1M	Pediatric Rheumatology	2	37	19,20	
1N	Pediatric Sports Medicine	2	37	19,20	
1P	Pediatric Surgery	2	37	19,20	
1S	BRG - Med School	2		19,20	BRG=Baton Rouge General Hospital
1T	Emergency Medicine	1		19,20	
1Z	Pediatric Day Health Care	1		04	In effect on/after 8/1/2010
2A	Cardiac Electrophysiology	2	41	19,20	
2B	Cardiovascular Disease	2	41	19,20	

2C	Critical Care Medicine	2	41	19,20	
2D	Diagnostic Laboratory Immunology	2	41	19,20	
2E	Endocrinology & Metabolism	2	41	19,20	
2F	Gastroenterology	2	41	19,20	
2G	Geriatric Medicine	2	41	19,20	
2H	Hematology	2	41	19,20	
2I	Infectious Disease	2	41	19,20	
2J	Medical Oncology	2	41	19,20	
2K	Nephrology	2	41	19,20	
2L	Pulmonary Disease	2	41	19,20	
2M	Rheumatology	2	41	19,20	
2N	Surgery - Critical Care	2	41	19,20	
2P	Surgery - General Vascular	2	41	19,20	
2Q	Nuclear Medicine	1		19,20	eff. 7/1/2011 per LIFT 7970.
2R	Physician Assistant	1		94	
2S	LSU Medical Center New Orleans	2		19,20	
2T	American Indian / Native Alaskan	2		95	
2Y	OPH Genetic Disease Program	1		40	eff. 5/1/2005, OPH=Office of Public Health
3A	Critical Care Medicine	2	16	19,20	
3B	Gynecologic oncology	2	16	19,20	eff. 7/1/2003
3C	Maternal & Fetal Medicine	2	16	19,20	eff. 7/1/2003
3D	Community Choices Waiver - Respiratory Therapy	2	87, 75	44, 65	eff. 10/1/2011 for CCW, RT=Respiratory Therapy
3E	Community Choices Waiver - PT and OT	2	87, 75	44, 66	eff. 10/1/2011 for CCW, PT=Physical Therapy, OT=Occupational Therapy
3F	Community Choices Waiver - PT and S/L T	2	87, 75	44, 67	eff. 10/1/2011 for CCW, S/L T=Speech and Language Therapy
3G	Community Choices Waiver - PT and RT	2	87, 75	44, 68	eff. 10/1/2011 for CCW
3H	Community Choices Waiver - OT and S/L T	2	87, 75	44, 69	eff. 10/1/2011 for CCW
3J	Community Choices Waiver - OT and RT	2	87, 75	44, 70	eff. 10/1/2011 for CCW
3K	Community Choices Waiver - S/L T and RT	2	87, 75	44, 71	eff. 10/1/2011 for CCW
3L	Community Choices Waiver - PT, OT & S/L T	2	87, 75	44, 72	eff. 10/1/2011 for CCW
3M	Community Choices Waiver - PT, OT & RT	2	87, 75	44, 73	eff. 10/1/2011 for CCW
3N	Community Choices Waiver - PT, S/L T & RT	2	87, 75	44, 74	eff. 10/1/2011 for CCW
3Q	Community Choices Waiver - OT, S/L T & RT	2	87, 75	44, 75	eff. 10/1/2011 for CCW

3R	Community Choices Waiver - All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2	87, 75	44, 76	eff. 10/1/2011 for CCW
3S	LSU Medical Center Shreveport	2		19,20	eff. 7/1/2003
3U	Community Choices Waiver – Assistive Devices – Home Health	2			eff. 10/1/2011 for CCW
4A	Home and Community-Based Services	1		01,02	eff. 7/1/2003, Eff for ROW 5/1/10.
4B	NOW RN	1		06	eff. 7/1/2004, NOW=New Opportunities Waiver
4C	NOW LPN	1		06	eff. 7/1/2004, NOW=New Opportunities Waiver
4D	NOW Psychologist	1		06	eff. 7/1/2004, NOW=New Opportunities Waiver
4E	NOW Social Worker	1		06	eff. 7/1/2004, NOW=New Opportunities Waiver
4R	Registered Dietician	1		41	In effect for ROW, 5/1/10, in effect for NOW, 9/1/09
4S	Ochsner Med School	2		19,20	eff. 7/1/2003
4W	Waiver Services	1		42	In effect for ROW, 5/1/10.
4X	Waiver-Only Transportation	1		42	In effect for ROW, 5/1/10.
5A	PCS-LTC	1		24	eff. 7/1/2003, PCS=Personal Care Services
5B	PCS-EPSDT	1		24	eff. 7/1/2003, PCS=Personal Care Services
5C	PAS	1		24	eff. 7/1/2003, PCS=Personal Care Services
5D	PCS-LTC, PCS-EPSDT	1		24	PCS=Personal Care Services, PAS=Personal Assistive Services
5E	PCS-LTC, PAS	1		24	PCS=Personal Care Services, PAS=Personal Assistive Services
5F	PCS-EPSDT, PAS	1		24	PCS=Personal Care Services, PAS=Personal Assistive Services
5G	OCS-LTC, PCS-EPSDT, PAS	1		24	PCS=Personal Care Services, PAS=Personal Assistive Services
5H	Community Mental Health Center			18	
5I	Statewide Management Organization (SMO)	1		AB	In effect for CSoC/PIHP 1/1/2012

5J	Youth Support	1		AC	In effect for CSoC/PIHP 1/1/2012
5K	Family Support	1		AC	In effect for CSoC/PIHP 1/1/2012
5L	Both Youth and Family Support	1		AC	In effect for CSoC/PIHP 1/1/2012
5M	Multi-Systemic Therapy			12	
5N	Substance Abuse and Alcohol Abuse Center	1		68	In effect for CSoC/PIHP 1/1/2012
5P	PACE	1		50	eff. 7/1/2005, Program for All-Inclusive Care for the Elderly
5Q	CCN-P (Coordinated Care Network, Pre-paid)	1		05	In effect on/after 1/1/2011
5R	CCN-S (Coordinated Care Network, Shared Savings)	1		52	In effect on/after 1/1/2011
5S	Tulane Med School	2		19,20	
5U	Individual	1		AD	In effect for CSoC/PIHP 1/1/2012
5V	Agency/Business	1		AD	In effect for CSoC/PIHP 1/1/2012
5W	Community Choices Waiver - Personal Assistance Service	2	87	44	eff. 10/1/2011 for CCW
5X	Therapeutic Group Homes	1			In effect for CSoC/PIHP 1/1/2012
5Y	PRCS Addiction Disorder	1			In effect for CSoC/PIHP 1/1/2012
5Z	Therapeutic Group Home Disorder	1			In effect for CSoC/PIHP 1/1/2012
6A	Psychologist -Clinical	1		31	
6B	Psychologist-Counseling	1		31	
6C	Psychologist - School	1		31	
6D	Psychologist - Developmental	1		31	
6E	Psychologist - Non-Declared	1		31	
6F	Psychologist - All Other	1		31	
6H	LaPOP	1		01	eff. With LaPOP program, used to identify the LaPOP fiscal agent.
6N	Endodontist	1		27	eff. 7/31/09 with CHIPRA project on FOC/PLT
6P	Periodontist	1		27	eff. 7/31/09 with CHIPRA project on FOC/PLT
6S	E Jefferson Fam Practice Ctr - Residency Program	2		19,20	

6T	Community Choices Waiver - Physical Therapy	2	65, 87, 75	35, 44, 65	eff. 10/1/2011 for CCW
7A	SBHC - NP - Part Time - less than 20 hrs week	1		38	SBHC = School-Based Health Center
7B	SBHC - NP - Full Time - 20 or more hrs week	1		38	SBHC = School-Based Health Center
7C	SBHC - MD - Part Time - less than 20 hrs week	1		38	SBHC = School-Based Health Center
7D	SBHC - MD - Full Time - 20 or more hrs week	1		38	SBHC = School-Based Health Center
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	1		38	SBHC = School-Based Health Center
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	1		38	SBHC = School-Based Health Center
7G	Community Choices Waiver - Speech/Language Therapy	2	71, 87, 75	39, 44, 65	eff. 10/1/2011 for CCW
7H	Community Choices Waiver - Occupational Therapy	2	74, 87, 75	37, 44, 65	eff. 10/1/2011 for CCW
7M	Retail Convenience Clinics	2	70	19,20,78	eff 7/2010
7N	Urgent Care Clinics	2	70	19,20,79	eff 7/2010
7S	Leonard J Chabert Medical Center - Houma	2		19,20	eff 10/2009
8A	EDA & DD services	2	82	82	
8B	EDA services	2	82	82	
8C	DD services	2	82	82	
8D	Community Choices Waiver - Caregiver Temporary Support	1	82, 83	82, 83	eff. 10/1/2011 for CCW
8E	CSoC/Behavioral Health	1, 2		AB, AC, AD, AE, AF, AG, AH, AJ, AK, 82, 31, 68, 70, 73, 83, 53	In effect for CSoC/PIHP 1/1/2012
8F	Community Choices Waiver - Caregiver Temporary Support - Home Health	2	8D	AN	eff. 10/1/2011 for CCW
8G	Community Choices Waiver - Caregiver Temporary Support - Assisted Living	2	8D	AN	eff. 10/1/2011 for CCW
8H	Community Choices Waiver - Caregiver Temporary Support - ADHC	2	8D	AN	eff. 10/1/2011 for CCW
8J	Community Choices Waiver - Caregiver Temporary Support - Nursing Facility	2	8D	AN	eff. 10/1/2011 for CCW
8K	ADHC HCBS	1		AL	eff. 10/1/2011 for CCW
8M	Community Choices Waiver - Home-Delivered Meals	1		AM	eff. 10/1/2011 for CCW
8N	Community Choices Waiver - Nursing	2		44, 78	eff. 10/1/2011 for CCW

8Q	Community Choices Waiver - EAA Assessor, Inspector, Approver	2		15	eff. 10/1/2011 for CCW
9B	Psychiatric Residential Treatment Facility	1		96	eff. 7/1/2007
9D	Residential Care	1		97	Planned eff date is 4/1/2009
9E	Children's Choice Waiver	1		03	
9L	RHC/FQHC OPH Certified SBHC	1		72	eff. 2/15/2010
9P	GNOCHC - Greater New Orleans Community Health Connection	1		99	eff. 1/1/2011
9Q	PT 21 - EDI Independent Billing Company	2		21	eff. 7/9/2010
9U	Medicare Advantage Plans	1		21	Batch 270 submitter: Planned eff date is 3/1/2009
9V	OCDD - Point of Entry	1		21	Batch 270 submitter: Planned eff date is 3/1/2009
9W	OAAS - Point of Entry	1		21	Batch 270 submitter: Planned eff date is 3/1/2009
9X	OAD	1		21	Batch 270 submitter: Planned eff date is 8/1/2009
9Y	Juvenile Court/Drug Treatment Center	1		21	Batch 270 submitter: Planned eff date is 10/1/2010
9Z	Other Contract with a State Agency	1		21	Batch 270 submitter: Planned eff date is 4/1/2010.

C.8 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)

C.9 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

C.10 TPL (Private Insurance) Scope of Coverage

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

C.11 Recipient Approval Code

Approval Code	Description
002	Deprivation Based on Absence from the Home
003	Deprivation Based on Incapacity
004	Deprivation Based on Death
005	Deprivation Based on Unemployment
006	Caretaker Relative
009	SSI Recipient
010	SSI Recipient
011	LIS Batch
016	KINSHIPCARE REF
017	"Pure" Qualified Medicare Beneficiary
018	OCS Child (Category O only)
023	IV-E (Category I)
024	IV-E/SSI Adoption Subsidy Not Verified
025	IV-E/SSI Adoption Subsidy SDX Verified
031	Mississippi Evacuee (for children under age 19, pregnant women, and LTC)
032	Mississippi individual with disabilities
033	Mississippi low income Medicare recipient
034	Rita evacuees with existing Medicaid eligibility
035	Rita evacuees newly enrolled in Medicaid
036	Mississippi parent of child under age 19
037	Alabama evacuee(for children under age 19, pregnant women, and LTC)
038	QUALIFIED INDIVIDUAL 2
042	Alabama low income Medicare recipient
043	Alabama parent of child under age 19
044	Katrina evacuees with existing Medicaid eligibility
045	Katrina evacuees newly enrolled in Medicaid
046	Alabama individual with disabilities
049	Affected Children
053	Extended Medicaid - Disabled Adult Children (DAC) and Early Widows/Widowers
054	Extended Medicaid - Disabled Widow(er)
056	Extended Medicaid - Pickle
058	Refugee Medical Assistance Only (Category 05)
060	Deemed Eligible Child

061	Medical Care Cost
063	Pregnant Woman in a Two-Parent Household (Medicaid coverage for eligible recipients)
064	Eligible Child Born After 10-01-83
065	Pregnant Woman Certification
066	Pregnant Minor Certification
067	Prior Medical Eligibility - Case Currently on File
068	Prior Medical Eligibility - Case Not on File
071	Step-parent Income
072	Sibling's Income
073	Grandparent's Income
074	Adoption Assistance
077	Refugees Eligible in Category E (05) (AFDC Payment Standards)
078	Optional Qualified Aliens
081	Increased Need for Medical Care
086	Category A (from Category D)
087	State Funded Regular MNP
088	Cases with Conversion Errors
090	IV-E Foster Care Maintenance Cases
093	Closed in Error
095	Mandatory Qualified Alien (Not for use in E category)
099	Other Reason

C.12 Recipient Closure Code / Cancel Reason

Cancel Code	Description
002	Segment Information Change
004	Earnings sufficient for Assistance Unit
007	Minor Unmarried Mother reaches age 18
008	Court _Ordered child support payments
009	Has other Health Insurance
010	Katrina-Receiving assistance out-of-state
011	Absent parent returns to the home
012	Marriage or remarriage of parent
013	Failure to cooperate with SES
014	Discharge
016	Non-Payment of Medicaid Premium for Premium Payment Programs
018	Moved Out of PACE/CCN Service Area
020	Does Not Meet Level of Care
021	Needs met by support from absent parent
022	Needs met by person outside home (not AP)
023	Removal of portion of QMB eligibility
024	Child has reached maximum age
025	IV-E child receiving assistance in another state
026	Recipient has moved out of the home
027	Close before start date- opened in error
028	State Office closure after start date
029	LAMI/MEDS closure by State Office
030	Emergency Services - pay one day only
031	Increase in SS, Pension, Work Comp, etc
035	Resources in excess of maximum allowed
036	Failed to pass LIFC filter
037	Suspended - Eligible for LAMI Cert
038	Failure to comply with FITAP requirements
040	Voluntary PACE/CCN Disenrollment
041	Increased resources, property value, etc
042	Deemed Eligible Child Surrendered - Adoption
043	Disposed property w/o sufficient return

044	TEFRA- Cost effective requirement not met
047	Discontinued TC 85 closed by State Office
048	Death - date of death unknown
049	Break in continuity of stay
050	Transitional Assistance State Office closure
051	Ineligible-change in law or agency policy
052	Decreased need for medical care
055	Failed to provide Citizenship document
056	Failed to provide Identity document
058	Failure to comply w/ Project Independence
059	Refugee closure only
061	Income Unit member is on strike
062	Failed to provide Citiz/Ident document
063	Payee has left the home
064	SSI elig closed due to Medicaid Qualifying Trust
066	Open/close State Office use only
067	QI Cert closure State Office use only
068	Involuntary PACE/CCN Disenrollment
070	Recipient was ineligible when certified
073	Recipient is no longer incapacitated
074	Failed to respond/return Renew form
075	Failed to provide requested verification
076	No eligible child in home
077	Recipient admitted to an institution
078	Moved out of state
079	Failure to Enroll in Employee Sponsored Insurance
080	Client Requested Hospice Closure
081	SSI Recipient age 65 - certify in Cat 1
085	End of Presumptive Eligible preriod
086	Certified for Foster Care
087	Certified for SSI
089	Death w/ no DOD - Interface use only
090	Death
091	Recipient request closure
092	LAMI Client died, close remaining AUMEMs
093	Incarceration
094	Unable to locate

095	Recipient included in other Cert
096	Use only if no other code appropriate
097	SSI check returned
098	Closure by State Office MMIS only
100	Not categorically eligible
101	Has Insurance
102	Increased Income
103	Reapply Later
104	No Income Verification
105	Child Healthy
106	Death of Payee
107	No Reason Given
108	LaCHIP to CHAMP
109	Unhappy with Program
111	Replace PW with Take Charge
112	First Premium Never Received
113	Post Partum End-Pregnancy and Two Month Post-Partum Eligibility Period Ended And Enrollee Is Not Eligible For Any Other Medicaid Program
114	Miscarried/Not Eligible For any Other Medicaid Program
115	Discharged from the Nursing Facility
116	Discharged from Waiver
117	Discharged from Waiver to Nursing Facility
118	Discharged from Nursing Facility to Waiver
119	LTC/SD to Medicare Unit
120	Changed Waiver Type
122	MPP – No longer meets work requirement
123	Acute Care - left the hospital
124	Did not respond to renewal request
125	Eligibility period exhausted (Used for any program where a there is a limited eligibility period) (TM, RMA)
900	CCN Opt-out, American Indian with Tribal Registry
901	CCN Opt-out, Foster Care Individual
902	CCN Opt-out, OYD/OJJ Individual
903	CCN Opt-out, Recipient < 19 with special services needs
904	CCN Opt-out, SSI recipient
905	CCN Opt-out, Other reason

906	Reserved for future use.
907	CCN Disenrollment due to hospice admission
908	CCN Disenrollment due to Medicare coverage

C.13 Level of Care (LOC)

LOC code	Description
20	SNF
21	ICF-I
22	ICF-II
23	Mental Facility - Under 21
24	Mental Facility - Over 65
25	TB Hospital
26	ICF/DD or Disability Determination
27	Adult Day Care
28	SNF TDC
29	Rehab-ICFDD
30	SNF-ID
31	NF Rehab
32	NF Complex Care
41	Private ICFDD - Pervasive (Rev Code 193)
42	Private ICFDD - Extensive (Rev Code 192)
43	Private ICFDD - Limited (Rev Code 191)
44	Private ICFDD - Intermittent (Rev Code 190)
50	PACE
88	Case Mix
99	Hospice in Community

C.14 Provider Cancel Reasons

Code	Description
00	Not cancelled
10	Phone number disconnected/no answer
11	Out of business - whereabouts unknown
12	Gustav
13	Disaster
20	Temporary closure - pending additional information
21	Provider no longer with group
22	Only one professional with group
29	Old code for sanction - no longer used
30	OIG & State Exclusions (sanction)
31	Contact DHH program
32	License Suspended
33	License Revoked
34	Temporary license
35	Contact SURS
36	Research ownership
37	Moved out of state
38	License Invalid/Inactive/Expired
39	Change of ownership
40	Cancel - provider request
41	Deceased
42	Cancel - bad address
43	No longer meets eligibility requirement
44	Provider retired
45	Suspend - lapse in insurance
48	Cancel - Short-term eligibility
49	Closure - Special Project - Mass Closure
50	Contact DHH Pharmacy program
51	Group converted to RHC/FQHC
93	Provider has 2 numbers
94	Prescriber number changed to full enrollment
95	Contact program integrity before re-enrolling
96	Residency Status Change

97	Cancel - Reason Unknown
98	Cancel - Negative Balance owed
99	Cancel - Incorrect Eligibility Date

C.15 Provider Sub-Specialty Codes

Refer to Section C.7 for values.

C.18 Preferred Language Indicator

Code	Language
01	English
02	Spanish
03	American Sign
04	Arabic
05	Armenian
06	Cantonese
07	Farsi
08	French
09	German
10	Greek
11	Haitian-Creole
12	Hindi
13	Hmong
14	Italian
15	Japanese
16	Khmer
17	Korean
18	Laotian
19	Mandarin
20	Polish
21	Portuguese
22	Russian
23	Samoan
24	Tagalog
25	Vietnamese
26	Yiddish

27	27 SDX Other Lang.
28	ACA Other
99	Not Declared

C.19 BAYOU HEALTH (CCN) Plan Information

Chk Digit Prov ID	Non check-digit ID	Prov Type	Company Name
2162934	0116293	05	LaCARE
2162519	0116251	05	AMERIGROUP OF LOUISIANA
2162845	0116284	05	LOUSIANA HEALTHCARE CONNECTION
2162438	0116243	52	UNITED HEALTHCARE OF LOUISIANA
2162446	0116244	52	COMMUNITY HEALTH SOLTIONS OF AMERICA

APPENDIX D – ENCOUNTER PROCESSING EDITS

Error or EOB Code	Short Description	Long Description	Status: D=Deny, E=Educational, N/A=not applicable	Notes	Reparable? Y, N or Situational
002	INVALID-PROV-NO	INVALID PROVIDER NUMBER	D		Y
003	INVALID-RECIP-NO	INVALID RECIPIENT NUMBER	D		Y
005	INVALID-STMT-FROM-DTE	INVALID STATEMENT FROM DATE	D		Y
006	INVALID-STMT-THRU-DTE	INVALID STATMENT THRU DATE	D		Y
007	SERV THRU LT SERV FM	SERVICE THRU DATE LESS THAN SERVICE FROM DATE	D		Y
008	SERV FRM GT ENTR DTE	SERVICE FROM DATE LATER THAN DATE PROCESSED	D		Y
009	SRV-THRU-GT-ENTRY	SERVICE THRU DATE GREATER THAN DATE OF ENTRY	D		Y
010	INV PRIOR AUTH DATE	PRIOR AUTHORIZATION DATE NOT NUMERIC	N/A		N/A
011	INVALID TPL INDICATR	TPL INDICATOR NOT Y N OR SPACE	N/A		N/A
012	ORG CLM W/ADJ/VD CDE	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID REASON CODE	D		Y
013	ORG CLM W ADJ/VD ICN	ORIGINAL CLAIM WITH AN ADJUSTMENT OR VOID ICN	D		Y
014	IMM COMPL MISS/INVLD	IMMUN COMPLETE AND CURRENT FOR THIS AGE PATIENT MISSING	n/a		N/A
015	INVALID ACCIDENT IND	ACCIDENT INDICATOR MUST BE Y N SPACE	D		Y
016	INVALID ACCID IND	ACCIDENT INDICATOR NOT Y N OR SPACE	D		Y
017	INVALID EPSDT IND	EPSDT INDICATOR NOT Y N OR SPACE	D		Y
020	DIAG-MISSING	MISSING DIAGNOSIS CODE (every encounter needs a primary diag)	D		Y
020	PRIM-OR-SEC-DIAG-REQD	INVALID OR MISSING DIAGNOSIS CODE	D		Y
021	INVALID FORMER REFNO	FORMER REFERENCE NUMBER MISSING OR INVALID	n/a		n/a
022	BILLED-CHRGS-ERR	INVALID BILLED CHARGES	D		Y
023	INV PARTIAL RECIP	RECIPIENT NAME IS MISSING	D		Y
024	INV BILLING PROV NO	BILLING PROVIDER NUMBER NOT NUMERIC	D		Y
025	IMM NOT COMP RSN MIS	IMMUN NOT COMPLETE AND CURRENT REASON CODE MISSING	N/A		N/A
026	TOTAL-DOCUMENT-CHARGE-MISSING	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMERIC	D		Y
027	PROC NEEDS DOCUMENT.	PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT	N/A		N/A
028	INVALID-MISSING-PROC-CODE	INVALID MISSING PROCEDURE CODE	D		Y
029	SERV MORE THAN 12 MO	SERVICE MORE THAN 12 MONTHS OLD	E		N/A
030	SERV-THRU-DATE-TOO-OLD	SERVICE THRU DATE TOO OLD	E		N/A

032	EOB/CARR.CD MISMATCH	EOB(S) ATTACHED/CARRIER CODE DOES NOT MATCH	N/A		N/A
033	NEED EOB-CARR/RECIP.	NEED EOB FOR EACH CARRIER INDICATED ON RESOURCE FILE	N/A		N/A
034	22 MOD.NOT JUSTIFIED	22 MOD.SERVICES NOT JUSTIFIED/PAID AT UNMODIFIED RATE	N/A		N/A
035	REBILL CORRECT HCPC	ASC OP FAC/PHYS.BILLED DIFF CODE;REBILL CORRECT HCPC	N/A		N/A
037	MEDICARE ADJUSTMENT	MEDICARE ADJUSTMENT/VOID ADJUST OR ADJUST MEDICARE CLAI	N/A		N/A
038	MOD52-REDUCED-PAY	99297-52 NICU PAID AT REDUCED RATE	N/A		N/A
039	PROC-MOD-NOT-APPLICABLE	MODIFIER NOT USED TO PROCESS CLAIM	N/A		N/A
040	INVALID-ADMISSION-DTE-ERR	ADMISSION DATE MISSING OR INVALID	D		Y
041	ADMISN-DTE-GT-SERV-FROM-DTE	ADMISSION DATE GREATER THAN SERVICE FROM DATE	D		Situational
042	INVALID-TYP-HOSP-BILL	INVALID UB92, ETC TYPE BILL CODE	D		Situational
043	INVALID-ATTEND-PHYS	INVALID ATTENDING PHYSICIAN	D		Y
044	INVALID-NATURE-OF-ADMISN-ERR	NATURE OF ADMISSION MISSING OR INVALID	D		Situational
045	INV PATIENT STATUS	PATIENT STATUS CODE INVALID OR MISSING	D		Y
046	INV PATIENT STAT DTE	PATIENT STATUS DATE MISSING OR INVALID	D		Y
047	PAT STAT DTE GT THRU	PATIENT STATUS DATE GREATER THAN THRU DATE	D		Y
048	INVALID-SURGICAL-PROC	INVALID OR MISSING PROCEDURE CODE	D		Situational
049	INVALID-CONFLICT-SURG-DATE	INVALID/CONFLICT SURGICAL DATE	D		Situational
050	INV BLOOD NOT REPL	BLOOD NOT REPLACED AMOUNT INVALID	N/A		N/A
051	INV BLOOD/PINT CHG	BLOOD CHARGE PER PINT INVALID	N/A		N/A
052	BLOOD-CHG-ERR	TOTAL BLOOD CHARGE INVALID	N/A		N/A
053	MISSING-OR-INVALID-ACCOM-DAYS	ACCOMMODATION DAYS MISSING OR INVALID	N/A		N/A
054	MISSING-OR-INVALID-ACCOM-RATE	ACCOMMODATION RATE MISSING OR INVALID	N/A		N/A
055	INVALID-ANCILLARY-ACCOM-CHRG	ACCOMMODATION/ANCILLARY CHARGE MISSING OR INVALID	D		Y
056	INV ANCILLARY CHARGE	ANCILLARY CHARGE INVALID	N/A		N/A
057	WERE SUSP COND -MISS	WERE THERE SUSPECTED CONDITIONS-MISSING	N/A		N/A
058	SUSP COND DISCRPANCY	WERE THERE SUSPECTED CONDITIONS IS NO BUT COND EXISTS	N/A		N/A
059	SUSP COND MISSNG/REQ	SUSPECTED CONDITIONS ARE MISSING AND REQUIRED	N/A		N/A
060	MISSING-OR-INVALID-COV-DAYS	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING	D		Y
061	INVALID-PSRO-DATE	A PSRO DATE IS NOT A VALID DATE	N/A		N/A
062	INVALID APPROVED DYS	THE APPROVED STAY DAYS IS NOT NUMERIC	N/A		N/A

063	INVALID TOTAL CHARGE	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC	D		Y
064	INVALID NET AMOUNT	THE NET BILLED AMOUNT IS NOT NUMERIC	D		Y
065	INVALID-SIGNATURE-INDICATOR	THE SIGNATURE INDICATOR MUST BE Y, N, OR BLANK	D		Y
066	INV BENEFIT EXHAUST	BENEFITS EXHAUSTED INDICATOR INVALID	N/A		N/A
067	INVALID NON-COVERED	NON COVERED HOSP DAYS NOT NUMERIC OR MISSING	N/A		N/A
068	INVALID-SOURCE-ADMISN	INVALID SOURCE OF ADMISSION	D		Y
069	INVALID-OCUR-DATE	INVALID OCCURRENCE DATE	D		Y
070	PSRO-CLAIM-DENIED	PSRO/UR CLAIM DENIED	N/A		N/A
071	INV STMT COVERS FROM	STATEMENT COVERS FROM DATE INVALID	D		Y
072	INV STMT COVER THRU	STATEMENT COVERS THRU DATE INVALID	D		Y
073	STMT FRM LT SERV FRM	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM DATE	D		Y
074	STMT THRU GT SRV THR	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE THRU	D		Y
075	INVALID TYPE SERVICE	TYPE SERVICE FOR AMBULANCE MUST BE 3 OR 9	N/A		N/A
076	INVALID-DME-PA-AMOUNT	INVALID DME PA AMOUNT (PRIOR AUTHORIZATION AMOUNT NOT NUMERIC)	N/A		N/A
077	NEED REV CODE DESCRP	REVENUE CODE REQUIRES WRITTEN DESCRIPTION	N/A		N/A
078	RESUB W/ DOCUMENTS	RESUB W/ DOCUMNTS CALL 800-473-2783	N/A		N/A
079	FOUND-NO-PSRO-CODE	PSRO (PROFESSIONAL STANDARDS REVIEW ORGANIZATION) CODE MISSING OR INVALID	N/A		N/A
080	INVALID LAB INDICATR	LABORATORY INDICATOR MUST BE Y N OR BLANK	N/A		N/A
081	INVALID STATUS DATE	INVALID OR MISSING PATIENT STATUS DATE	D		Y
082	INVALID STATUS CODE	INVALID PATIENT STATUS CODE	D		Y
083	INVALID SERVICE CODE	INVALID SERVICE CODE	N/A		N/A
084	TREATMENT-PLACE-INVALID	TREATMENT PLACE INVALID	E		N/A
085	INVALID UNITS/VISITS	INVALID OR MISSING UNITS VISITS AND STUDIES	D		Y
086	PEND-FOR-RECYCLE	CLAIM PENDED FOR FUTURE RECYCLE	N/A		N/A
087	MISSING-COINS-DAYS	MISSING OR INVALID CO-INSURANCE DAYS	N/A		N/A
090	REFER-PROV-NOT-ON-FILE	REFERRING PROVIDER NUMBER NOT ON FILE	N/A		N/A
091	FP-PROC-CODE-NOT-ON-FILE	PROCEDURE IS NOT COVERED BY THE TAKECHARGE FAMILY PLANNING WAIVER PROGRAM	N/A		N/A
092	INVALID-PROC-MODIFIER	INVALID PROCEDURE MODIFIER (INVALID OR MISSING MODIFIER)	D		Y
093	REV-CODE-MISSING	REVENUE CODE MISSING/INVALID	D		Y
094	MISSING-PTS-BLOOD	MISSING PINTS BLOOD	N/A		N/A
095	FROM-THRU-NOT-EQUAL	CONDITION CODE 40 FROM THROUGH NOT EQUAL	D		Y
096	REV-CHG-MISSING	REVENUE CHARGE MISSING OR INVALID	D		Y

097	NON-COV-GT-BILLED	NON-COVERED CHARGES EXCEED BILLED CHARGES	D		Y
098	BILL-CODE-REQ-MC-CHG	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54	D		Y
099	DME COVERAGE ONLY	ITEM COVERED UNDER DURABLE MED EQUIP. PROG ONLY	N/A		N/A
101	INVALID EMER IND	INVALID EMERGENCY INDICATOR	D		Y
102	INVALID-SURF-CODE	INVALID TOOTH SURFACE CODE	N/A		N/A
103	INV TOOTH/CAVITY CDE	INVALID TOOTH CODE/ORAL CAVITY DESIGNATOR	N/A		N/A
104	IND3-CPT-INVALID	INDICATOR 3 INVALID WITH CPT CODES-PCP REFERRAL REQUIRED	N/A		N/A
105	REFER-BY-CASE-MANAGER	REFERRING MUST BE CASE MANAGER	N/A		N/A
106	CCARE-LOCKIN-NOT-MATCHED	COMMUNITYCARE LOCKIN NOT MATCHED	N/A		N/A
107	PARTIAL-HOSP-NOT-COVERED	PARTIAL HOSPITAL NOT PAYABLE FOR MEDICAID ONLY	N/A		N/A
108	PROV-TYPE-AGE-RESTRICT	PROVIDER TYPE SERVICES NOT COVERED FOR RECIPIENT AGE	E		N/A
109	NOT-HCBS-LOCKED-IN	NOT HOME AND COMMUNITY BASED SERVICES LOCKED IN	N/A		N/A
110	REBILL OB/ABORT D&C	REBILL OB OR ABORTION D & C CPT CODE WITH REPORTS	N/A		N/A
112	AUTH.PORT X-RAY	NO DOCUMENT/EDIT OVERRIEDE PORT. X-RAY	N/A		N/A
113	ONE ER CDE PER VISIT	ONLY ONE ER REVENUE (450/459) CODE PER VISIT	N/A		N/A
114	INVALID-HCPCS-CODE	INVALID OR MISSING HCPCS CODE	D		Y
115	HCPCS-CODE-NOF	HCPCS CODE NOT ON FILE	D		Y
116	DEFRA-REDUCTION	DEFRA REDUCTION (PAYMENT REDUCED TO MEDICARE MAXIMUM)	N/A		N/A
117	ALLOWED-2-DAYS	MAXIMUM OF 2 DAYS ALLOWED TO TRANSFER MHISA PATIENTS	D	Robert to research. The SMO is responsible for services performed by out-of-state hospital, and so this edit should stay in place on encounter data. Per the conference call with Mercer that took place on 7/18/11.	N

118	HOSP-ALLOWED-EMERGY-ONLY	HOSPITAL LIMITED TO EMERGENCY CARE & TRANSFER OF MHISA PATIENTS	N/A	Robert to research. The SMO is responsible for services performed by out-of-state hospital, and so this edit should stay in place on encounter data. Per the conference call with Mercer that took place on 7/18/11.	N/A
119	INVEST EXPER OR NOT	NOT COVERED-IS INVESTIG. EXPERI.OR NOT MED.NECESSARY	N/A		N/A
120	QTY-INVALID-MISSING	QUANTITY INVALID/MISSING	D		Y
121	INVALID-PRESC-PHYS	INVALID PRESCRIBING PHYSICIAN (A PRESCRIBING PHYSICIAN NPI OR MEDICAID ID REQUIRED)	N/A		N/A
122	INVALID RX DATE	RX DATE MISSING OR INVALID	N/A		N/A
123	RX > SERVICE DATE	RX DATE WAS AFTER DATE FILLED	N/A		N/A
124	INVALID DAYS SUPPLY	DAYS SUPPLY MISSING NOT NUMERIC OR ZERO	N/A		N/A
125	PRESCRIP NO MISSING	PRESCRIPTION NUMBER MISSING	N/A		N/A
126	INVALID REFILL CODE	REFILL CODE MISSING NOT NUMERIC OR GREATER THAN 5	N/A		N/A
127	NDC-INVALID-MISSING	NDC INVALID/MISSING	D		Y
128	INVALID MAC INDICATR	THE MAC OVERRIDE INDICATOR MUST BE A 'C'	N/A		N/A
129	PRESCRIB PROV NPI NO	PRESCRIBING PROV NPI MISSING/NOT ON FILE	N/A		N/A
130	DENY-PROV-9999999	ALL PROVIDERS 9999999 TO BE DENIED	N/A		N/A
131	PRIM-DIAG-NOT-ON-FILE	PRIMARY DIAGNOSIS NOT ON FILE	D		Y
132	SEC-DIAG-NOT-ON-FILE	SECONDARY DIAGNOSIS NOT ON FILE	D		Y
135	PATIENT NOT COVERED	PATIENT NOT COVERED FOR PHARMACY SERVICE	N/A		N/A
136	NO ELIG SERVICE PAID	NO ELIGIBLE SERVICE PAID - ENCOUNTER DENIED	D		Y
137	MEDICARE REPLACEMENT	MEDICARE REPLACEMENT; SUBMIT HARDCOPY ADJ OR VOID CLAIM	N/A		N/A
138	REBILL W/ALL DETAILS	ADJUNCT CD RPTD AS ONLY DETAIL LNE: REBILL W/ALL DETAIL	N/A		N/A
139	REBILL W/APPROP CODE	ONE ADJUNCT CODE ALLOWED PER DDS: REBILL W/APPROP CODE	N/A		N/A
140	INVALID REQUEST DATE	INVALID SCREENING REQUEST DATE	N/A		N/A
141	INVLD LAST SCRN DATE	INVALID DATE FOR LAST SCREENING	N/A		N/A
142	BILL PROV NPI NOF	BILLING PROVIDER NPI MISSING/NOT ON FILE	E		N/A
143	SERV PROV NPI NOF	SERVING PROVIDER NPI MISSING/NOT ON FILE	E		N/A
144	REF/PCP PROV NPI NOF	REF OR PCP PROVIDER NPI MISSING/NOT ON FILE	N/A		N/A
145	BILL PROV NPI NO MAT	BILLING PROVIDER NPI MISMATCH	E		N/A

146	SER PROV NPI NO MATC	SERVICING PROVIDER NPI MISMATCH	E		N/A
147	REF/PCP NPI NO MATCH	REFERRING/PCP NPI MISMATCH	N/A		N/A
148	9F REF AUTH MISSING	9F REFERENCE AUTHORIZATION MISSING IN LOOP 2300	N/A		N/A
149	DESI-NOT PAYABLE	DESI INEFFECTIVE-NOT PAYABLE	N/A		N/A
154	INVALID-SITE-NUMBER	INVALID SITE NUMBER	N/A		N/A
155	REF MISS/REQ-MEDICAL	REFERRAL MISSING AND REQUIRED FOR MEDICAL	N/A		N/A
156	REF MISS/REQ-VISION	REFERRAL MISSING AND REQUIRED FOR VISION	N/A		N/A
157	EXCEEDS LIMIT OF 8	EXCEEDS LIMIT OF 8 CO-INS DAYS	N/A		N/A
158	REF MISS/REQ-HEARING	REFERRAL MISSING AND REQUIRED FOR HEARING	N/A		N/A
159	LTC-PROV-NOT-MATCHED	LTC PROVIDER NOT MATCHED	N/A		N/A
160	PRECERT-NOT-ON-FILE	PRECERT NUMBER NOT ON FILE	N/A		N/A
161	HOSP-STAY-REQUIRES-PRECERT	HOSPITAL STAY REQUIRES PRECERTIFICATION	N/A		N/A
162	PRECERT-NOT-APPROVED	PRECERT NOT APPROVED	N/A		N/A
163	CLAIM-DOS-NOT-PRECERT-COVERED	CLAIM DATE OF SERVICE NOT PRECERT COVERED	N/A		N/A
164	CLAIM > PRECERT LOS	CLAIM EXCEEDS PRECERT AUTHORIZED DAYS	N/A		N/A
165	SURG-REQUIRES-PRECERT	SURGERY REQUIRES PRECERT	N/A		N/A
166	PRECERT-RECIP-NOT-MATCHED	CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRECERT FILE	N/A		N/A
167	PRECERT-PROV-NOT-MATCHED	CLAIM PROVIDER ID DOES NOT MATCH ID ON PRECERT FILE	N/A		N/A
168	PRECRT SURG DATE ERR	CLAIM SURGERY DATE DOES NOT MATCH DATE ON PRECERT FILE	N/A		N/A
169	CUTBACK-TO-PRECERT-DAYS	DAYS CUTBACK TO PRECERT APPROVED DAYS	N/A		N/A
170	PRECERT-PEND-REVIEW	PRECERT PEND REVIEW	N/A		N/A
171	PRECERT-NOF-RESUBMIT	NO HOSPITAL PRECERT ON FILE; RESUBIT WITH DOCUMENTATION	N/A		N/A
172	CLM/PA DTE MUST MTCH	CLAIM DATES MUST MATCH PRIOR AUTHORIZATION DATES	N/A		N/A
173	LOC-NOT-MATCHED	LEVEL OF NEED / LEVEL OF CARE NOT MATCHED	N/A		N/A
174	RECIP NOT XREF	NO MEDICAID ID FOUND FOR MEDICARE ID	N/A	Crossovers are the responsibility of the SMO.	N/A
175	CHARGES MISSING	NO CHARGES/COINS/DEDUCT GIVEN	N/A		N/A
176	INVALID DEDUCTIBLE	THE DEDUCTIBLE FIGURE MUST BE NUMERIC	N/A		N/A
177	INVALID COINSURANCE	THE COINSURANCE FIGURE MUST BE NUMERIC	N/A		N/A
178	INVALID BLOOD DEDUCT	THE BLOOD DEDUCTIBLE FIGURE MUST BE NUMERIC	N/A		N/A
179	REF MISS/REQ-DENTAL	REFERRAL MISSING AND REQUIRED FOR DENTAL	N/A		N/A

180	INVALID ADMIT DATE	THE ADMISSION DATE WAS NOT A VALID DATE	D		Y
181	INVALID COVERED DAYS	THE COVERED DAYS WAS NOT A VALID NUMERIC AMOUNT	N/A		N/A
182	PROC-CLAIM-TYP-CONFLICT	PROCEDURE CLAIM TYPE CONFLICT	D		Y
183	SURG-PROC-NOF	SURGICAL PROCEDURE NOT ON FILE	D		Y
184	PROGRAM-IND-REQUIRES-REVIEW	REFERRAL MISSING AND REQUIRED FOR NUTRITIONAL	N/A		N/A
186	CRNA-MUST-BILL-CORRECT-MOD	CERTIFIED REGISTERED NURSE ANESTHETISTS MUST BILL CORRECT MODIFIER	D		Y
187	PA-THRU-CLAIM-THRU-NOT-SAME	CLAIM THRU DOS MUST = PA 30 DAY THRU PERIOD	N/A		N/A
188	TRIP CANC BY DISPTCH	TRIP CANCELED BY DISPATCH (CLAIM VOIDED)	N/A		N/A
189	PUT PA# IN BLOCK 23	CORRECT PA# MUST BE IN BLOCK 23 ON CLAIM	N/A		N/A
190	PA-NOT-ON-FILE	PA NUMBER NOT ON FILE	N/A		N/A
191	PROC-REQUIRES-PRIOR-AUTH	PROCEDURE REQUIRES PRIOR AUTHORIZATION	N/A		N/A
192	PA-NOT-APPROVED	PA HAS NOT BEEN APPROVED	N/A		N/A
193	CLAIM-DATE-NOT-PA-COVERED	DATE ON CLAIM NOT COVERED BY PA	N/A		N/A
194	PA-ALREADY-CONSUMED	CLAIM EXCEEDS PRIOR AUTHORIZED LIMITS	N/A		N/A
195	PA-TOTAL-NOT-SPANNED	MUST HAVE SPANNING DOS IF BILLING FOR TOTAL AUTHORIZATION AMOUNT	N/A		N/A
196	PA-RECIP-ID-NOT-MATCHED	CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRIOR AUTHORIZATION FILE	N/A		N/A
197	PA-PROV-NOT-MATCHED	PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID	N/A		N/A
198	PA-PROC-NOT-MATCHED	PA PROCEDURE NOT SAME AS CLAIM PROCEDURE	N/A		N/A
199	TRIP-CANCELLED	TRIP CANCELED NON PAYABLE	N/A		N/A
200	PROVIDER-NOT-ON-FILE	PROVIDER/ATTENDING PROVIDER NOT ON FILE	D		Situational
201	PROVIDER-NOT-ELIGIBLE	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE	E		N/A
202	SVC NOT COVERED, MORAL/RELIG	SERVICE NOT COVEREDDUE TO CCN MORAL/RELIGIOUS OBJECTION	N/A		N/A
203	PROVIDER-ON-REVIEW	PROVIDER ON REVIEW	N/A		N/A
204	GRP-NOT-ON-INDIV-REC	BILLING PROVIDER NOT ON ATTENDING PROVIDER RECORD ON DOS	N/A		N/A
205	BILL-ATTEND-PROV-CONF	ATTENDING PROVIDER NOT IN GROUP ON DATE OF SERVICE	N/A		N/A
206	BILL PROV NOT ON FIL	BILLING PROVIDER NOT ON FILE	D		Y
207	BILL-PROV-NOT-ELIG	BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE	E		N/A
208	PRESCRIBING-PROV-ONLY	PRESCRIBING PROVIDER ONLY-CALL 1-800-473-2783 FOR INFO (UNISYS PROVIDER RELATIONS DEPARTMENT)	N/A		N/A
209	PROV-MUST-BILL-AS-GRP	GROUP MUST BILL FOR PROVIDER	N/A		N/A

210	PROV-PROCEDURE-CONFLICT	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE	D		N
211	DOS-LESS-THAN-DOB	DATE OF SERVICE LESS THAN DATE OF BIRTH	D		Y
212	NO-SERVICING-PROV-NO	NO SERVICING PROVIDER NUMBER (ATTENDING PROVIDER MUST BE INDIVIDUAL)	D		Y
213	PROVIDER-NOT-COVERED	PROVIDER NOT COVERED FOR SERVICES RENDERED BY MEDICAID	N/A		N/A
214	PROV-ALLOW-ONE-PROC	PROVIDER ALLOWED 1 SERVICE PER RECIPIENT PER DAY	N/A		N/A
215	RECIPIENT-NOT-ON-FILE	RECIPIENT NOT ON FILE	D		Y
216	RECIPIENT-NOT-ELIGIBLE	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	D		Situational
217	RECIP-NAME-MISMATCH	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RECORD	D		Situational
218	RECIPIENT-PROV-RESTRICT	RECIPIENT IS MD, PHARMACY RESTRICTED-MD INVALID	N/A		N/A
219	EPSDT-REFER-AGE-ERR	EPSDT REFERRAL FOR RECIPIENT OVER 21 years old	D		N
220	SPD-DOWN-NOT-MED-NDY	SPEND DOWN AMOUNT NOT MEDICALLY NEEDY	N/A	Robert to research. As a result of 7/26/11 meeting, spend-down is the responsibility of the SMO for LBHP services	N/A
221	GENERAL-ASSIST-NOT-COVRD	STATE ONLY ASSISTANCE - SERVICE NOT COVERED	N/A		N/A
222	RECIP-ELIG-DATE-OVERLAP	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATE(S)	D		N
223	RECYCLED-RECIP-NOF	RECYCLED RECIPIENT NOT ON FILE	D		Situational
224	INVALID-BIRTHDATE	INVALID BIRTHDATE ON RECIPIENT FILE	D		Situational
225	SOBRA-PE-NOT-COVRD	CLAIM NOT COVERED FOR PRESUMED ELIGIBLE RECIPIENT	N/A		N/A
226	MOD-RESTRICTED	COMPONENTS OF SURGERY PAID ONLY TO TEACHING FACILITIES	N/A		N/A
227	POSSIBLE-707	POSSIBLE 707 PEND (CLAIM IN PROCESS)	N/A		N/A
228	POSSIBLE-713	POSSIBLE 713 PEND (CLAIM IN PROCESS)	N/A		N/A
229	POSSIBLE-714	POSSIBLE 714 PEND (CLAIM IN PROCESS)	N/A		N/A
230	PROC-REQ-REVIEW	PROCEDURE REQUIRES REVIEW	N/A		N/A
231	NDC-NOT-ON-FILE	NDC IS NOT ON THE PROCUDURE FORMULARY FILE	D		N
232	PROC-CODE-NOT-ON-FILE	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM	N/A		N/A
233	PF-DATE-RESTRICT	PROCEDURE/NDC NOT COVERED FOR SERVICE DATE GIVEN	D		N
234	PF-AGE-RESTRICT	PROCEDURE/NDC NOT COVERED FOR AGE GIVEN	D		N
235	PF-SEX-RESTRICT	PROCEDURE/NDC NOT COVERED FOR SEX GIVEN	N/A		Situational
236	PF-PLACE-RESTRICT	PROCEDURE/NDC NOT COVERED FOR PLACE GIVEN	N/A		N/A
237	PF-PROV-RESTRICT	PROCEDURE/NDC NOT COVERED FOR PROVIDER SPECIALTY GIVEN	D		N

238	INVALID-PAC	INVALD PRICING ACTION CODE VS DATE OF SERVICE ; CALL THE HELP DESK	N/A		N/A
239	PF-COST-ERROR	PRICE MISSING FOR DATE OF SERVICE ON PROCEDURE FORMULARY, CALL HELP DESK	N/A		N/A
240	U-AND-C-COST-ERROR	USUAL AND CUSTOMARY FILE - NO VALID PRICE FOR DOS	N/A		N/A
241	PREVAILING COST ERR	CLAIM IN PROCESS	N/A		N/A
242	INPUT-SPENDDOWN-AMT	110-MINIMUM PAYMENT REQUIRED FOR RECIPIENT'S LIABILITY AMOUNT	N/A		N/A
243	POT-NOT-ICFI-OR-II	PLACE OF TREATMENT MUST BE INTERMEDIATE CARE FACILITY-I OR INTERMEDIATE CARE FACILITY-II	N/A		N/A
244	PROVIDER-RATE-NOF	PROVIDER FILE DOES NOT CONTAIN VALID RATE FOR DOS	N/A		N/A
245	INVALID-PROC-TOS-TRANS	INVALID PROCEDURE TOS FOR TRANSPORTATION	N/A		N/A
246	STAND-BY-CHGS	PROLONGED ATTENDANCE BILLED; PENDED FOR REVIEW	N/A		N/A
248	BILL-NEW-CODE	DELETED, BILL CURRENT CODE	N/A		N/A
249	SURG-REQ-REVIEW	SURGERY REQUIRES REVIEW FOR ATTACHMENTS	N/A		N/A
250	DIAG-REQ-REVIEW	DIAGNOSIS/PROCEDURE REQUIRES REVIEW	N/A		N/A
251	DENIED-DUE-TO-DIAG	PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS	N/A		N/A
252	DIAGNOSIS-NOT-ON-FILE	DIAGNOSIS NOT ON FILE	D		Situational
253	DIAG-DATE-RESTRICT	DIAGNOSIS DATE RESTRICTION	N/A		N/A
254	DIAG-AGE-RESTRICT	DIAGNOSIS AGE RESTRICTION	D		Situational
255	DIAG-SEX-RESTRICT	DIAGNOSIS SEX RESTRICTION	D		Situational
256	DIAG-PROCEDURE-ERROR	DIAGNOSIS/PROCEDURE RESTRICTION	N/A		N/A
257	PAS-90TH-PERCENTILE-ZEROS	DX CODE REQUIRES 5TH DIGIT TO CALCULATE PAS DAYS	N/A		N/A
258	SPANNING-DATES-QUANT-DIFF	DIFFERENCE BETWEEN SERVICE DATES AND QUANTITY	D		Situational
259	ANESTH-UNITS-REQ-REVIEW	ANESTHESIA UNITS/MINUTES REQUIRE MEDICAL REVIEW	N/A		N/A
260	ANESTHESIA-UNITS-NOF	ANESTHESIA BASE UNITS ARE NOT ON FILE	D		Y
261	INSERT-PROV-PAY-AMT	INSERT PROVIDER PAID AMOUNT BY MEDICARE	N/A		Jeff to research
262	ADJ-REQUIRES-REVIEW	PROVIDER'S ADJUSTMENTS ON REVIEW	N/A		N/A
263	PROCEDURE-AGE-RESTRT	PROCEDURE ALLOWED FOR RECIPIENT 0-30 DAYS OLD	N/A		Situational
264	PA-01 REQUIRES REVIE	PA-01 FORM REQUIRES REVIEW FOR VALIDITY	N/A		N/A
265	SURG REQUIRES PA-0	SURGERY DONE AS IP REQUIRES VALID PA-01 FORM	N/A		N/A
266	INVALID-AMB-SURG-REV	REVENUE CODE INVALID FOR AMBULATORY SURGERICAL PROCEDURE	N/A		N/A
267	REQ-ICD9-SURGICAL-CD	REVENUE CODE 490 REQUIRES VALID ICD-9 SURGICAL PROCEDURE	N/A		N/A

268	INVALID-TREATMENT-PL	TREATMENT PLACE IS INCORRECT	N/A		N/A
269	ANEST-CPT-NOT-COVERED	ANESTHESIOLOGIST CPT NOT COVERED FOR MEDICAID ONLY-BILL SURG+MOD	D		
270	90-DAY-FILING-LIMIT	CLAIM EXCEEDS 90-DAY FILING LIMIT (PHARMACY)	N/A		N/A
271	SER HOSPICE RELATED	HOSPICE RELATED/SUB BILL TO HOSPICE 30 DAYS TO APPEAL	N/A		N/A
272	1-YR-FILING-LIMIT	CLAIM EXCEEDS 1 YEAR FILING LIMIT	E		N/A
273	PURSUE-THIRD-PARTY-EOB	3RD PARTY CARRIER CODE MISSING; REFER TO CARRIER CODE LIST	D		Y
274	PURSUE-THIRD-PARTY	POSSIBLE THIRD PARTY LIABILITY	N/A		N/A
275	RECIPIENT-MEDICARE-ELIG	RECIPIENT IS MEDICARE ELIGIBLE	N/A		N/A
276	HIGH-VARIANCE-ERROR	HIGH VARIANCE ERROR	N/A		N/A
277	LOW-VARIANCE-ERROR	LOW VARIANCE ERROR	N/A		N/A
278	RECIP-POSS-MEDICARE-ELIG	RECIPIENT POSSIBLY ELIGIBLE FOR MEDICARE	N/A		N/A
279	PROF-COMP-INVALID-POT	INVALID PLACE OF TREATMENT FOR PROF COMP	E		N/A
280	MANUAL-PRICE-PEND	MANUAL PRICING REQUIRED/HARD COPY BILL	N/A		N/A
281	VISIT INC. SURG CHGS	OFFICE VISIT CONS. BILLED SEP. FROM SURG FEE	N/A		N/A
282	PRE-OP INC IN SURG.	PRE-OP INCLUDED IN TOTAL SURGICAL FEE	N/A		N/A
283	POST-OP INC IN SURG	POST-OP INCLUDED IN TOTAL SURGERY FEE	N/A		N/A
284	MANUAL-PRICE-GR-BILLED	MANUAL PRICE EXCEEDS BILLED CHARGES	N/A		N/A
285	PAYMENT-GR-BILL-CHARGE	PAYMENT EXCEEDS BILLED CHARGES/REQUIRES REVIEW	N/A		N/A
286	REF MISS/REQ-DEVELOP	REFERRAL MISSING AND REQUIRED FOR DEVELOPMENTAL	N/A		N/A
287	PAT LIAB EXCEEDS CHG	PATIENT LIABILITY EXCEEDS BILLED CHARGES	N/A		N/A
288	PROC/DESC CONFLICT	PROCEDURE CODE/DESCRIPTION CONFLICT	N/A		N/A
289	REJ-DENY-INV-PROV	INVALID PROVIDER NUMBER WHEN DENY APPLIED	D		Y
290	TPL RESOURCE REQ EOB	NO EOB ATTACHED FOR RECIP WITH OTHER RESOURCE INDICATED	N/A		N/A
291	FOUND MULT RESOURCES	CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCES	N/A		N/A
292	FOUND NO TPL AMOUNT	NO TPL AMOUNT INDICATED ON CLAIM/REQUIRES REVIEW	N/A		N/A
293	RECYCLED-RECIP-INELIG	RECYCLED RECIPIENT INELIGIBLE ON DOS	D		N
294	RECYCLED-RECIP-NOF-DENY	RECIPIENT NOT ON FILE RECYCLED 3 TIMES	E		N/A
295	RECYCLED-RECIP-INELIG-DENY	RECIPIENT INELIGIBLE RECYCLED THREE TIMES	E		N/A
296	CAR-CODE REQ REVIEW	CARRIER CODE REQUIRES REVIEW/POSS NO MATCH	N/A		N/A
297	BANKRUPT.FILE W/CARR	DECLARED BANKRUPTCY.FILE W/CARRIER FOR POSSIBLE PMTS.	E		N/A
298	INVALID-PROC-CODE	INVALID PROCEDURE CODE FOR DATE-OF-SERVICE	N/A		N/A
299	PROC-NOT-COVERED	PROCEDURE/DRUG NOT COVERED BY MEDICAID	D		N

300	CLM-OVRLPS-FISCAL-YR	CLAIM SPANS FISCAL YEAR	D		Y
301	EMER-ACCESS-NATURE-ERR	EMERGENCY ACCESS HOSPITAL - NATURE OF ADMISSION MUST BE EMERGENCY	D		Y
302	REF MISS/REQ-AB/NEGL	REFERRAL MISSING AND REQUIRED FOR ABUSE/NEGLECT	N/A		N/A
303	HOSPICE-DAYS-GT-5	HOSPICE DAYS GREATER THAN 5 (INPATIENT RESPITE DAYS GREATER THAN FIVE)	N/A		N/A
304	INV BABY/MTHR ADMISN	BABY AND MOTHER - NATURE OF ADMISN MUST BE NEWBORN	N/A		N/A
305	INV BABY/MTHR PROC	BABY AND MOTHER - SURGICAL PROCEDURE MUST BE DELIVERY	N/A		N/A
306	NURS-ONLY-PND-REVIEW	NURSERY ONLY PENDING REVIEW (BABY ONLY / PENDING FOR REVIEW)	N/A		N/A
307	SURG PROC MISSING	SURGICAL PROCEDURE MISSING	D		Y
308	REF MISS/REQ-PSY/SOC	REFERRAL MISSING AND REQUIRED FOR PSYCHOLOGICAL/SOCIAL	N/A		N/A
309	SURG DATE MISSING	DATE OF SURGERY MISSING	D		Y
310	SURG DTE LT SRV FROM	DATE OF SURGERY LESS THAN SERVICE FROM DATE	D		Y
311	SURG DTE GT SRV THRU	DATE OF SURGERY GREATER THAN SERVICE THRU DATE	D		Y
312	REF MISS/REQ-SPEECH	REFERRAL MISSING AND REQUIRED FOR SPEECH/LANGUAGE	N/A		N/A
313	AMB-SURG-COV-DAYS-ERR	AMBULATORY SURGICAL CENTER - DAYS/DATES DO NOT EQUAL 1	N/A		N/A
314	SUSP-COND-MISS-REF1	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
315	PROSTHESIS NOT PA	PROSTHESIS MUST BE PRIOR AUTHORIZED	N/A		N/A
316	COVERED-DAYS-ERR	COVERED DAYS DO NOT EQUAL ACCOMMODATION DAYS	D		Situational
317	STMT-DAYS-CONFLICT-ERR	STATEMENT DATES CONFLICT WITH ACCOMMODATION DAYS	D		Situational
318	SUSP-COND-MISS-REF2	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL 2	N/A		N/A
319	SUSP-COND-MISS-REF3	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFERRAL 3	N/A		N/A
320	REF ASST MIS/REQ-RF1	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
320	REF-ASSIST-MISS-REF1	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
321	PSRO-FROM-DATE-MIN-ERR	PSRO FROM DATE LESS THAN STATEMENT FROM DATE	N/A		N/A
323	REF ASST MIS/REQ-RF2	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 2	N/A		N/A
323	REF-ASSIST-MISS-REF2	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 2	N/A		N/A
324	REF ASST MIS/REQ-RF3	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 3	N/A		N/A
324	REF-ASSIST-MISS-REF3	REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 3	N/A		N/A
326	APPT-DATE-MISS-REF1	APPOINTMENT DATE MISSING AND REQUIRED FOR REFERRAL #1	N/A		N/A
328	PROVIDER-NOT-CERTIFIED	PROVIDER NOT CERTIFIED FOR SERVICE	N/A		N/A
329	PROV-NOT-CLIA-CERT-DOS	CLIA NUMBER DOES NOT COVER DATE OF SERVICE	N/A		N/A
330	RECIP-NOT-MCAID-ELIG	QUALIFIED MEDICARE BENEFICIARY NOT MEDICAID ELIGIBLE	E		N/A
331	ABORTION-REVIEW	DOES NOT MEET PROGRAM CRITERIA FOR ABORTION	N/A		N/A

332	STERILIZATION-LESS-THAN-21	STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21	N/A		N/A
333	AUTH MINOR UNM MO	FOUND NO DOCUMENT/OVERRIDE CODE MINOR UNM MOTHER/UNBORN	N/A		N/A
334	CONSENT-30-180-DAYS	CONSENT MUST BE AT LEAST 30 BUT NO MORE THAN 180 DAYS	N/A		N/A
335	HH-SFL-REVIEW-FOR-PA	HH SFL REVIEW FOR PA	N/A		N/A
336	ABORTION-REQUIRES-REVIEW	ABORTION REQUIRES REVIEW	N/A		N/A
337	STERILIZATION-REQUIRES-REVIEW	STERILIZATION OFS FORM 96 REQUIRES REVIEW	N/A		N/A
338	HYSTERECTOMY-REQUIRES-REVIEW	HYSTERECTOMY REQUIRES REVIEW	N/A		N/A
339	CODES-DATE-CONFLICT	OCCURRENCE CODES/DATES CONFLICT	D		Situational
340	SPAN-NON-COV-DAYS-CONFLICT	SPAN DAYS/NON COVERED DAYS CONFLICT	D		Situational
341	DENY TO BE REBILLED	DENY TO BE REBILLED TO MEDICARE	N/A		N/A
343	APPT-DATE-MISS-REF2	APPOINTMENT DATE MISSING AND REQUIRED FOR REFERRAL #2	N/A		N/A
343	APP DATE MIS/REQ RF2	APPOINTMENT DATE MISSING AND REQUIRED FOR REFERRAL #2	N/A		N/A
344	SPAN-FROM-THRU-INVALID	SPAN FROM THRU DATES CONFLICT	D		Situational
345	INVALID-DAYS-BILLED	INVALID ZERO BILLED DAYS (DAYS ZERO, PATIENT STATUS NOT 9)	N/A		N/A
346	INVALID-WAIVED-LOC	INVALID WAIVED LEVEL OF CARE	N/A		N/A
347	EXCEEDS-MAX-DAYS	EXCEEDS MAX - 23 DAYS (EXCEEDS MAXIMUM MONTHLY DAYS)	N/A		N/A
348	CHARGE-EXCEEDS-MAX	SERVICE CHARGE EXCEEDS 80% OF COMPARABLE CARE	N/A		N/A
349	RECIP-NOT-COVRD-FOR-SERVICE	RECIPIENT NOT COVERED FOR THIS SERVICE	N/A		N/A
349	INVALID-TYPE-CASE	INVALID TYPE CASE (RECIPIENT NOT COVERED FOR THIS SERVICE)	N/A		N/A
350	LOC-AGE-CONFLICT	LOC AGE CONFLICT (LTC SNF THRU DATE IN ERROR)	N/A		N/A
351	SPAN-DATE-INVALID	SPAN DATE NOT ALLOWED; MUST BILL PER DAY	D		Y
352	INVALID-LTC-CERT-DATE	LTC CERTIFICATION DATE INVALID	N/A		N/A
353	LTC-CERT-DTE-GT-SERV-DTE	SERVICE DATE IS PRIOR TO LTC CERTIFICATION DATE	N/A		N/A
354	SERV-DTE-BEFORE-PROV-ELIG	SERVICE DATE IS PRIOR TO PROVIDER LICENSING EFFECTIVE DATE	N/A		N/A
355	MISSING-51NH	NO '51 NH' NURSING HOME FORM ATTACHED OR ADMIT CODE MUST BE A '6'	N/A		N/A
356	TOT-DAYS-LOC-DAYS-CONFL	TOTAL DAYS LEVEL OF CARE DAYS CONFLICT	N/A		N/A
357	LTC-DAYS-LTC-DATES-CONFL	LTC LOC DAYS CONFLICT WITH LTC LOC FROM AND THRU DATES	N/A		N/A
358	LTC-COST-ERROR	NO VALID RATE WAS FOUND FOR LTC LEVEL OF CARE	N/A		N/A

359	APPT-DATE-MISS-REF3	APPOINTMENT DATE MISSING AND REQUIRED FOR REFERRAL #3	N/A		N/A
359	APP DATE MIS/REQ-RF3	APPOINTMENT DATE MISSING AND REQUIRED FOR REFERRAL #3	N/A		N/A
360	LTC-PROV-NOT-CERT	PROVIDER CERTIFICATION EXPIRED AS OF DOS	N/A		N/A
363	OFS-24-NOT-ON-FILE	OFS 24 NOT ON FILE	N/A		N/A
364	RECIPIENT-INELIGIBLE-DECEASED	RECIPIENT INELIGIBLE DECEASED	D		Situational
365	ANESTH-REPT-REQ	ANESTHESIOLOGY REPORT REQUESTED	N/A		N/A
366	OPER-PATH-REQ	SEND BOTH OPERATIVE AND PATHOLOGY REPORT	N/A		N/A
367	ADJ. DENY	ADJUSTMENT DENIED/ORIG CLAIM PAID CORRECTLY	D		N
368	REASON-REF-MISS-REF1	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
368	REF REAS MIS/REQ-RF1	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
370	INVALID-CAT-SERV	UNABLE TO CALCULATE COS (CLAIM IN PROCESS)	N/A		N/A
371	TIME-FILE-REVIEW	TIME FILE REVIEW (ATTACHMENT REQUIRES REVIEW/FILING DEADLINE)	N/A		N/A
372	INVALID-LEAVE-CODE	ABSENT DAY TYPE MUST BE AN 'A' OR 'B'	N/A		N/A
373	INVALID-LEAVE-DATE	ABSENT DAY AND/OR TOTAL DAYS CONFLICT	N/A		N/A
374	INSUFFICIENT-DATA	UNABLE TO PROCESS/RE-BILL/ATTENTION UNISYS PA DEPT. PEGGY MISNER	N/A		N/A
375	REQUIRES-HOSP-LEAVE	REQUIRES HOSPITAL LEAVE	N/A		N/A
376	ADJ DAYS CONFL HIST	ADJUSTMENT DAYS CONFLICT WITH HISTORY DAYS	D		Y
377	PAYABLE-FOR-QMB-ONLY	PAYABLE ONLY FOR QUALIFIED MEDICARE BENEFICARY RECIPIENT	N/A		N/A
378	NO-MEDICARE-PAID-DTE	MEDICARE PAYMENT DATE IS MISSING OR INVALID	N/A		N/A
379	HOME-DAYS-REDUCED	HOME LEAVE DAYS REDUCED TO ONE/HALF PER DIEM	N/A		N/A
380	AMBUL-REQ-ATTACH	CLAIM REQUIRES MD CERTIFICATION ATTACHED AFTER 2/14/87	N/A		N/A
381	LTC-MED-LOA-OVER-5	LTC LEAVE DAYS EXCEED LIMIT - 5 PER HOSPITAL STAY	N/A		N/A
382	HOSPICE-MUST-BILL	HOSPICE CLIENT - ONLY HOSPICE PROVIDER CAN BILL	N/A		N/A
383	SERV. IN MED SCREEN.	SERVICE INCLUDED IN MED SCREENING	N/A		N/A
384	NOT-COVRD-NH-RESIDENT	NOT COVERED FOR NURSING HOME RESIDENT	N/A		N/A
385	DIABETIC-NOT-COVRD-NH-RECIP	DIABETIC SUPPLIES NOT COVERED FOR LTC RECIPIENT	N/A		N/A
386	NO-PAY-WITH-CLIA-CERT	NOT PAYABLE WITH CLIA CERTIFICATION TYPE	N/A		N/A
387	PROV-NOT-ON-CLIA-FILE	PROVIDER NOT ON CLIA FILE (NO CLIA NUMBER ON OUR FILE)	N/A		N/A
388	RECIP-NOT-COVRD-FOR-DRUG	RECIPIENT NOT COVERED FOR THIS DRUG	N/A		N/A
389	RECIPIENT-PHARM-RESTRICT	RECIPIENT IS MD, PHARMACY RESTRICTED -PHARMACY INVALID	N/A		N/A
390	SERV MAX 1 PER MO	SERVICE EXCEEDS MAXIMUM ALLOWABLE OF 1 PER MONTH	N/A		N/A
391	LTC LV DAYS OVER MAX	LTC HOSP LEAVE DAYS IN EXCESS OF MAXIMUM-5-BUDGET CUT	N/A		N/A

392	ICF-MR LV OVER MAX	ICF-MR HOME LEAVE IN EXCESS OF MAXIMUM 22/30 BUDGET CUT	N/A		N/A
393	NF LV DAYS OVER MAX	NF HOME LEAVE DAYS IN EXCESS OF MAXIMUM-4-BUDGET CUT	N/A		N/A
394	REHAB-NOT-COVRD-NH	REHAB CENTER SERVICES NOT COVERED -NURSING HOME RESIDENT	N/A		N/A
395	HOSP LEAVE DAYS > 7	HOSPITAL LEAVE DAYS EXCEED 7	N/A		N/A
396	HOME LEAVE DAYS > 15	HOME LEAVE DAYS EXCEED 15	N/A		N/A
397	CLAIM-NEEDS-80-MOD	APPEARS TO BE ASSISTANT--REBILL WITH 80 MODIFIER	N/A		N/A
398	BIL LOCAL/PRENAT LAB	BILL LOCAL ASSIGNED FOR PRENATAL LAB PANEL	N/A		N/A
399	REASON-REF-MISS-REF2	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 2	N/A		N/A
400	REFER-PHYS-REQD	REFERRING/ATTENDING PHYSICIAN REQUIRED	N/A		n/a
401	CONCURRENT-CARE	CONCURRENT CARE IS NOT COVERED BY THE PROGRAM	N/A		N/A
402	NO-SERV-EXCEEDS-MAX	NUMBER OF SERVICES EXCEEDS STATE MAX/ CUTBACK APPLIED	N/A		N/A
403	MULTIPLE-SURGERY	MULTIPLE SURGERY - PENDED FOR MANUAL PRICING	N/A		N/A
404	NON-EMER TRANS OUTPT	NON-EMERGENCY TRANSPORTATION BILLED ON OUTPATIENT FORM	N/A		N/A
405	OUTSIDE-LAB-NOT-COVERED	OUTSIDE LABORATORY SERVICES NOT COVERED	N/A		N/A
406	MANUAL-MANIP-OF-SPINE-ONLY	MANUAL MANIPULATION OF SPINE ONLY (EXCEEDS THREE CHIROPRACTIC TREATMENTS SAME DAY)	N/A		N/A
407	NON-EMER-TRANS-REQ-PA	NON-EMERGENCY TRANSPORTATION REQUIRES PRIOR AUTHORIZATION	N/A		N/A
408	NON-EMER-MILES-GR-400	NON-EMERGENCY MILES EXCEED 400-STATE AUTHORIZATION REQUIRED	N/A		N/A
409	EMERG-MILES-GR-25	EMERGENCY MILES EXCEEDS 25	N/A		N/A
410	REASON-REF-MISS-REF3	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 3	N/A		N/A
410	REF REAS MIS/REQ-RF3	REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 3	N/A		N/A
411	REF-NAME-MISS-REF1	REFERRED TO NAME IS MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
411	REF NAME MIS/REQ-RF1	REFERRED TO NAME IS MISSING AND REQUIRED FOR REFERRAL 1	N/A		N/A
412	REF-NAME-MISS-REF2	REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #2	N/A		N/A
412	REF NAME MIS/REQ-RF2	REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #2	N/A		N/A
413	DME-REQUIRES-PRIOR-AUTH	DME REQUIRES PRIOR AUTHORIZATION	N/A		N/A
414	REF-NAME-MISS-REF3	REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #3	N/A		N/A
414	REF NAME MIS/REQ-RF3	REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #3	N/A		N/A
415	PA AMOUNT GR LEVEL3	PRIOR AUTHORIZED AMOUNT GREATER THAN LEVEL 3 CHARGE	N/A		N/A
416	REF-PHONE-MISS-REF1	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #1	N/A		N/A
417	REF-PHONE-MISS-REF2	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #2	N/A		N/A
417	REF PHON MIS/REQ-RF2	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #2	N/A		N/A
418	REF-PHONE-MISS-REF3	REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #3	N/A		N/A

419	OFS REV PA DT GT DOS	OFS TO REVIEW-PA DATE GREATER THAN SERVICE DATE	N/A		N/A
420	SPECIALTY-RESTRICTED	PROVIDER IS RESTRICTED TO DESIGNATED PROCEDURES PER OFS	N/A		N/A
421	OFS REV INV PA DATE	OFS TO REVIEW INVALID PA DATE/SIGNATURE	N/A		N/A
422	ONE H.HLTH NURSE/DAY	ONLY ONE HOME HEALTH NURSE VISIT ALLOWED PER DAY	N/A		N/A
423	ONE H.HLTH AIDE/DAY	ONLY ONE HOME HEALTH AIDE VISIT ALLOWED PER DAY	N/A		N/A
424	BILL-PROV-NOT-DESIG	BILLING PROVIDER IS NOT THE DESIGNTED PROVIDER OF RECORD	N/A		N/A
425	ONE DOT PER RECIP/DY	ONLY ONE DOT PER RECIPIENT ALLOWED PER DAY	N/A		N/A
426	BILL HR CD PRE 15MIN	BILL CM HOUR CODE BEFORE 15 MIN CODE	N/A		N/A
427	PSYCH-NOT-HH-COVERED	PSYCHIATRIC SERVICES NOT COVERED UNDER HOME HEALTH	E		N/A
428	ADMINISTRATIVE-PEND	ADMINISTRATIVE PEND	N/A		N/A
429	NOT-PAYABLE-FOR-MNP	NOT PAYABLE FOR MEDICAL NEEDY PROGRAM	N/A		N/A
430	NO-NEED-FOR-MODIFIER	MODIFIER NOT NEEDED-REMOVE AND RESUBMIT	D		Y
431	M/I PROF SERV CODE	MISSING/INVALID PROFESSIONAL SERVICE CODE	N/A		N/A
432	QTY-EXCEEDS-PACKAGE-SIZE	QUANTITY EXCEEDS PACKAGE SIZE	N/A		N/A
433	INVALID-DIAGNOSIS	MISSING/INVALID DIAGNOSIS CODE	D		Y
434	BILL-MEDICARE-NEBULIZER	BILL MEDICARE NEBULIZER MEDICAL	N/A		N/A
435	60-DAY-FILING-LIMIT	CLAIM EXCEPTION FOR 60-DAY TIMELY FILING	N/A		N/A
436	DAYS SUPPLY OVER MAX	DAYS SUPPLY >100 EXCEEDS PROGRAM MAXIMUM	N/A		N/A
436	DAYS-SUPPLY-EXCEEDS-100	DAYS SUPPLY > 100 EXCEEDS PROGRAM MAXIMUM	N/A		N/A
437	OVER-VIAL-LIMIT	OVER VIAL LIMIT (DRUG IS A VIAL. QUANTITY OF 1 = 1 VIAL)	N/A		N/A
438	MFG-NDC-OBSOLETE	MANUFACTURER NOTIFIED US THAT NDC IS OBSOLETE	N/A		N/A
439	MFG-IDENTIFIED-FOOD-SUPPLMT	MANUFACTURER HAS IDENTIFIED PRODUCT AS FOOD SUPPLEMENT	N/A		N/A
440	SITE N/ALLW BILL/DOS	PROV SITE NOT ALLWD TO BILL SCR TYPE ON DATE OF SERVICE	N/A		N/A
440	PROV-SITE-NOT-SCREEN-TYPE-DOS	PROVIDER SITE NOT ALLOWED TO BILL SCREEN TYPE ON DATE OF SERVICE	N/A		N/A
441	RX-NOT-FILLED	RX NOT FILLED (OUTCOME 2A OR 2B - RX NOT FILLED - TRANSACTION REPORTING)	N/A		N/A
442	DRUG/DRUG INTERACT	DRUG/DRUG INTERACTION	N/A		N/A
443	THERAPEUTIC OVERLAY	THERAPEUTIC OVERLAY	N/A		N/A
444	M/I SERVICE PROVIDER	MISSING/INVALID SERVICE PROVIDER	D		Y
445	DUP DRUG THERAPY	DUPLICATE DRUG THERAPY	N/A		N/A
446	PREGNANCY PRECAUTION	PREGNANCY PRECAUTION	N/A		N/A
447	MON.EARLY/LATE REFIL	COMPLIANCE MONITORING/EARLY OR LATE REFILL	N/A		N/A
448	NEED-TRANSPLANT-DATE	TRANSPLANT DISCHARGE DATE OR OTHER DX NEEDED	N/A		N/A

449	WITHIN-TRANSPLANT-WINDOW	WITHIN TRANSPLANT WINDOW (BILL MEDICARE FIRST BASED ON DISCHARG DATE)	N/A		N/A
450	PRESC-PROVNO-NOT-ON-FILE	PRESCRIBING PROVIDER NOT ON FILE	N/A		N/A
451	DENT-PRESC-NOT-EPSDT	DENTAL PRESCRIBER NOT EPSDT (DENTAL PRESCRIBER, RECIPIENT 21 OR OVER)	N/A		N/A
452	SCH2-NARC-CANNOT-REFILL	SCHEDULE 2 NARCOTIC CANNOT BE REFILLED	N/A		N/A
453	SCH2-NARC-FILL-GR-DA	SCHEDULE 2 NARCOTIC NOT FILLED WITHIN 5 DAYS	N/A		N/A
454	NEW PRESC OVER 6 MOS	NEW PRESCRIPTION NOT FILLED WITHIN 6 MOS. OF DATE PRESC	N/A		N/A
455	REFILL-FILL-GR-6-MO	REFILL NOT FILLED WITHIN 6 MONTHS	N/A		N/A
456	DRUG-IS-NOT-MAC	DRUG IS NOT MAXIMUM ALLOWABLE CHARGE	N/A		N/A
457	QTY-EXCEEDS-MAXIMUM	QUANTITY AND/OR DAYS SUPPLY EXCEEDS PROGRAM MAXIMUM	N/A		N/A
458	MAC-COST-ZEROES	MAXIMUM ALLOWABLE CHARGE/FEDERAL UPPERL LIMIT COST IS ZERO/CALL HELP DESK	N/A		N/A
459	DENY FOR FILE REVIEW	DENY FOR REVIEW / CALL POS HELP DESK	N/A		N/A
460	NDC MAY BE OBSOLETE	NDC POSSIBLY OBSOLETE	N/A		N/A
461	REFILL-NOT-PAYABLE	REFILLS NOT PAYABLE	N/A		N/A
462	NDC TERMINATED/CMS	CMS NOTIFIED US THAT NDC IS TERMINATED	N/A		N/A
463	MAC-OVERRIDE-NOT-VALID	DRUG DOES NOT NEED MAXIMUM ALLOWABLE CHARGE OVERRIDE	N/A		N/A
464	OVER-KIT-LIMIT	OVER KIT LIMIT (DRUG UNIT OF MEASUREMENT IS A KIT. PLEASE VERIFY QUANTITY)	N/A		N/A
465	INVALID NDC	INVALID NDC - NOT AVAILABLE	N/A		N/A
466	FERTILITY-PREP-HARDCOPY-REQ	HARD COPY REQUIRED-FERTILITY PREPARATION	N/A		N/A
467	COV MDCARE IF INSULI	ITEM COVERED BY MEDICARE IF REC IS INSULIN TREATED	N/A		N/A
468	JUSTIFY EYEGLASSES	SEND DOCUMENTATION FOR MORE THAN 3 EYEGLASSES PER YEAR	N/A		N/A
469	EYEWEAR DENIED	LIMITATION MET - SUBMIT JUSTIFICATION FOR ADD'L EYEWEAR	N/A		N/A
470	SUBMIT-ANESTH-DOC	ATTACH ANESTHESIA RECORD AND DOCUMENT MEDICAL NECESSITY	N/A		N/A
471	DRUG-DRUG INTERACTIO	DRUG TO DRUG INTERACTION-DENY	N/A		N/A
472	MFCTR NOT IN REBATE	MANUFACTURER HAS NOT ENTERED INTO HCFA REBATE AGREEMENT	N/A		N/A
473	EDITED FOR MEDICARE	EDITED FOR MEDICARE -SERV. PAYABLE	N/A		N/A
474	EDITED FOR INSURANCE	EDITED FOR INSURANCE SERV. PAYABLE	N/A		N/A
475	QW-MODIFIER-NEEDED	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE	N/A		N/A
476	BILL VISITS--SEE CPT	SEE CPT-MEDICAL TREATMENT OF ABORTION USE E AND M CODES	N/A		N/A
477	JUSTIFY OVER 1/A/YR	SEND DOC TO JUSTIFY OVER ONE PROCEDURE PER YEAR	N/A		N/A
478	SONOGRAM-AND REPORTS	SEND WRITTEN SONOGRAM RESULTS WITH OP PATH AND HISTORY	N/A		N/A

479	DUR DATA UNNECESSARY	DUR DATA UNNECESSARY FOR CONFLICT INTERVENTION OUTCOME	N/A		N/A
480	DEDUCTIBLE-EXCEEDS-MAX	DEDUCTIBLE EXCEEDS MAXIMUM	N/A		N/A
481	SEND-LAB-TEST-DOC	SEND DOCUMENTS TO JUSTIFY SPECIFIC LAB TEST	N/A		N/A
482	THERAPEUTIC DUP DENY	THERAPEUTIC DUPLICATION DENIAL-LIMITED TO SPECIFIC CLAS	N/A		N/A
483	PREGNANCY DENIAL	PREGNANCY PRECAUTION-DENIAL-FDA CATEGORY X	N/A		N/A
484	NEW RX REQUIRES PA	NEW RX WILL REQUIRE PA	N/A		N/A
485	PA REQUIRED	MD MUST CALL ULM-PA OPERATIONS STAFF	N/A		N/A
486	PA EXPIRED	MD MUST CALL ULM-PA OPERATIONS STAFF	N/A		N/A
487	PA-EMERGENCY-OVERRID	EMERGENCY OVERRIDE OF DRUG THAT REQUIRES PA	N/A		N/A
488	ONLY-1ST DIAG VS PD	KELOID TREATMENT-ONLY FIRST DIAGNOSTIC VISIT IS PAID	n/a		N/A
489	INVALID-PRESCRIBER-NO	INVALID PRESCRIBER NUMBER (PROVIDER TYPE NOT AUTHORIZED TO PRESCRIBE)	N/A		N/A
490	UTILIZE HMO	MUST UTILIZE HMO SERVICES	N/A		N/A
491	PRESCRIBER-IS-GROUP	PRESCRIBER IS GROUP (PRESCRIBER NUMBER NOT FOR INDIVIDUAL PRESCRIBER)	N/A		N/A
492	HMO REVIEW	HMO EOB REQUIRES REVIEW	N/A		N/A
493	NOT-HOSPICE-PROVIDER	NOT HOSPICE PROVIDER (SUBMIT JUSTIFICATION FOR SERVICES)	N/A		N/A
494	INVALID-MSA-CODE	INVALID MSA (METROPOLITAN STATISTICAL AREA) CODE	N/A		N/A
495	NOT-HOSPICE-ELIGIBLE	NOT HOSPICE ELIGIBLE	N/A		N/A
496	DOC MEDICA NECESSITY	SUBMIT DOCUMENTATION TO WARRANT MEDICAL NECESSITY	N/A		N/A
497	INV PRESCRIB ID QUAL	INVALID PRESCRIBER ID QUALIFIER MUST BE 01 OR 05	N/A		N/A
498	NO OF RX GR THAN LIM	NUMBER OF PRESCRIPTIONS GREATER THAN LIMIT	N/A		N/A
499	JUSTIFY-PATH-CONSULT	JUSTIFY PATHOLOGY CONSULT (SEND DOCUMENT TO JUSTIFY PATHOLOGY CONSULT)	N/A		N/A
500	USE 62/66 MOD RESUB	USE OF 62/66 MOD INDICATED BY REPORT;RESUB &/OR ADJUST	N/A	Surgery codes issue, not applicable to LBHP	N/A
503	EXACT DUPE 16 TO 16	EXACT DUPE: IDENTICAL ADULT DAY CARE CLAIMS	N/A		N/A
505	CLM RECD NO CC EDITS	CLAIM DID NOT RECEIVE CLAIMCHECK EDITS	N/A		N/A
506	SUB PROV NON PAR BYU	SUBMIT TO RECIPIENTS SHARED PLAN	D		Y
508	NON WAIVER PAY IP	WAIVER SVC NOT PAYABLE WHILE IP	D		N
509	M/I SERV PRV ID QUAL	MISSING/INVALID SERVICE PROVIDER ID QUALIFIER	N/A		N/A
510	ALLOW 1 PER 7 YEARS	ONLY 1 OF THESE PROCS IN 7 YEARS PER RECIP/PROVIDER	N/A		N/A
511	PROV-NOT-MATCH-HOSPICE	PROVIDER ID NUMBER ON CLAIM MUST MATCH PROVIDER ID NUMBER ON RECIPIENT FILE	N/A		N/A

512	VNS REPROGRAMMING	SUBMIT MEDICAL DOCUMENTATION TO JUSTIFY REPROGRAMMING	N/A		N/A
513	HCPCS-REQUIRED	HCPCS REQUIRED	D		Y
514	NO PRESCRIPTIVE AUTH	PRESCRIBING PROVIDER DOES NOT HAVE PRESCRIPTIVE AUTHORI	N/A		N/A
515	O/R REQ-SEND TO PA	OVERRIDE REQUIRED-SEND TO DENTAL PA UNIT	N/A		N/A
517	KIDMED-FORMAT-REQ	CLAIM MUST BE SUBMITTED IN KIDMED FORMAT	N/A		N/A
518	KIDMED INFO MISSING	IMMUNIZATION AND SUSPECTED CONDITION INFO REQUIRED	N/A		N/A
519	WELL-BABY-CLAIM-ZERO-PD	NEWBORN CLAIM ZERO PAID	N/A		N/A
520	MUST-BILL-ZERO	VACCINES FROM VFC (VACCINES FOR CHILDREN PROGRAM) AT NO COST - BILLED AMOUNT MUST BE 0	N/A		N/A
521	USE INDIV PRESC NO	PRESCRIBING PRVI BILLED IS GROUP USE INDIVIDUAL PRES NO	N/A		N/A
522	MOTHER-BABY-CLAIM-ERR	MOTHER/NEWBORN MUST BE BILLED SEPARATE	N/A		N/A
523	CANNOT BE ADJUSTED	ADJUSTMENT IS INVALID VOID AND REBILL	n/a		Y
524	PACE-PROC-CONFLICT	CAPITATED-SERVICE MUST BE AUTHORIZED/PAID BY A PACE PROVIDER	N/A		N/A
525	NO-LON-ON-RECIP-FILE	NO LEVEL OF NEED ON RECIPIENT FILE	N/A		N/A
526	KATRINA-AID-CAT11	HURRICANE KATRINA EVACUEE/AID CATEGORY 11	N/A		N/A
527	KATRINA-OTHER	HURRICANE KATRINA EVACUEE/PARISH	N/A		N/A
528	LACHIP-ELIGIBLE	LACHIP AFFORDABLE PLAN - SUBMIT CLAIM TO LOUISIANA OFFICE OF GROUP BENEFITS	D		N
529	EXCEEDS MAX DOSE	EXCEEDS MAXIMUM DAILY DOSE	N/A		N/A
530	SERVICE ALREADY PAID	RECIPIENT WAS REIMBURSED FOR THIS SERVICE	D		N
531	UNNESCESSARY DRUG	DRUG USE NOT WARRANTED - COX-2 INHIBITOR	N/A		N/A
532	OOS-SERVICE-REQ-APPROVAL	OUT OF STATE SERVICES REQUIRE DHH APPROVAL LETTER	N/A		N/A
533	EXCEEDS MAX ER REVS	EXCEEDS MAXIMUM ER REVENUE CODES PER VISIT	N/A		N/A
534	PA-APRVD-PROC-DELETED	PRIOR AUTHORIZATION APPROVED PRIOR TO DELETION OF PROCEDURE CODE	N/A		N/A
535	BILL MEDICARE PART D	BILL MEDICARE PART D	N/A		N/A
536	BILL MEDICARE PART B	BILL MEDICARE PART B	N/A	Research -- will any of services be covered by Medicare. Not applicable to Molina encounter edits since SMO will receive the crossover claims.	N/A
537	OBRA 90 EXCLUDED DRU	OBRA 90 EXCUDED DRUG PAID BY MEDICAID	N/A		N/A
538	REVIEW-DIAG-MED	REVIEW DIAGNOSIS AND/OR ATTACHMENT FOR MEDICAL NECESSITY	N/A		N/A

539	CLAIM REQ DETAIL	CLAIM REQUIRES DETAILED BILLING	D		Y
540	FPW OVER MAX	FPW VISIT EXCEEDS ANNUAL MAXIMUM ALLOWED	N/A		N/A
541	INPAT-SERV-NOT-COVERED-FPW	INPATIENT SERVICES ARE NOT COVERED BY THE FAMILY PLANNING WAIVER PROGRAM	N/A		N/A
542	LT-PCS-DAILY-MAX-EXCEEDED	LONG TERM PERSONAL CARE SERVICES DAILY MAXIMUM EXCEEDED (UNITS EXCEED MAXIMUM DAILY ALLOWED LIMIT)	N/A		N/A
543	LT-PCS-DAILY-33-47	LONG TERM PERSONAL CARE SERVICES DAILY 33- 47 (UNITS PAID BETWEEN 33 AND 47)	N/A		N/A
544	SERV-NOT-COVERED-FPW	CLAIM TYPE/FORMAT NOT COVERED BY THE FAMILY PLANNING WAIVER PROGRAM	N/A		N/A
545	REV-NDC-INVALID	REVENUE CODE INVALID FOR REPORTING NDC INFORMATION	D		Situational
546		Code added due to a REB of a current code only	E		N/A
547	PROC-REB-REL-TO-CURR	CURRENT PROCEDURE HAS BEEN REBUNDLED TO A GLOBAL PROCEDURE THAT WAS SUBMITTED ON THE CURRENT CLAIM	N/A		N/A
548	PROC-REB-REL-TO-HIST	CURRENT PROCEDURE HAS BEEN REBUNDLED TO A GLOBAL PROCEDURE CODE IN HISTORY	N/A		N/A
549	HIST-PROC-VOIDED-REB	HISTORICAL PROCEDURE HAS BEEN REBUNDLED TO A GLOBA PROCEDURE ON THE CURRENT CLAIM	N/A		N/A
550	NO MULTI - PROVIDERS	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCEDURE	E		N/A
552	SUSPCT DUPE 16 TO 02	SUSPCT DUPE: ADULT DAY CARE AND LTC	N/A		N/A
553	SUSPCT DUPE 16 TO 16	SUSPCT DUPE: IDENTICAL ADULT DAY CARE CLAIMS	N/A		N/A
554	DUPLICATE-SERVICES	CURRENT PROCEDURE HAS BEEN DENIED AS A DUPLICATE UNILATERAL OR BILATERAL PROCEDURE CODE DUE TO ANOTHER CURRENT PROCEDURE	N/A		N/A
556	ATND PRV NOT LNK BYU	ATTENDING/SERVICING PROVIDER NOT LINKED TO BYU PLAN	D		Y
558	ASSIST-SURG-INVALID	CURRENT PROCEDURE DENIED BECAUSE IT NEVER ALLOWS AN ASSISTANT SURGEON	N/A		N/A
559	HOME LEAVE DAYS ADJ	HOME LEAVE DAYS AT 75%	N/A		N/A
560	ALL BUT MAJ. NEED 51	CANNOT PAY MAJOR UNTIL SECONDARY IS PAID AT 50%	N/A		N/A
561	ADJ SEC 51 AND 62/66	ADJUST SECONDARY PROC WITH 51 MOD AND WITH 62 OR 66	N/A	Surgical procedures issue. Not applicable to LBHP.	N/A
562	EDC ON 96 AND NOTES	LESS THAN 30 DAYS NEED EDC ON 96 AND RECORDS TO SUPPORT	N/A		N/A
563	ADJ-ADD-ON-WITH-51	ADJ ADD-ON CODE WITH 51 MOD THEN REBILL PRIMARY PROC	N/A		N/A
564	MAX-SERVICE-LIFETIME	CURRENT PROCEDURE HAS BEEN DENIED AS A DUPLICATE BECAUSE THE MAXIMUM ALLOWED LIFETIME OCCURRENCES OF THIS PROCEDURE WAS EXCEEDED DUE TO CURRENT CODES	N/A		N/A

565	MAX-SERVICE-SAME-DAY	Added procedure has been denied as a duplicate procedure because the maximum allowed daily occurrences of this procedure was exceeded due to current codes.	E		N/A
566	ADJ MAJOR WITH 62/66	ADJ MAJOR WITH 62 OR 66 THEN SECONDARY (S) WILL BE PAID	N/A	Surgical procedures issue. Not applicable to LBHP.	N/A
567	INCIDENTAL-PROC-CURR	CURRENT PROCEDURE WAS FOUND INCIDENTAL TO ANOTHER CURRENT PROCEDURE	N/A		N/A
568	NOT-LTC-ELIGIBLE	NOT LTC ELIGIBLE	N/A		N/A
569	HOSP LEAVE DAY ADJ.	HOSP LEAVE DAY ADJ. REL TO MEDICAID SPENDING RED PLAN	N/A		N/A
570	ADJ. REL BUDGET CUTS	ADJUSTMENT RELATED TO MEDICAID SPENDING REDUCTION PLAN	N/A		N/A
571	NH OFFSET	NH OFFSET ADJ. REL TO M'CAID SPEND REDUCT PLAN $1.11	N/A		N/A
572	ER TRANSPORT OFFSET	ER TRANSPORT OFFSET REL TO M'CAID SPEND RED PLAN	N/A		N/A
573	INCIDENTAL-PROC-HIST	CURRENT PROCEDURE WAS FOUND INCIDENTAL TO A PROCEDURE IN HISTORY	N/A		N/A
574	HIST-PROC-VOIDED-INC	HISTORICAL PROCEDURE WAS FOUND INCIDENTAL TO A CURRENT PROCEDURE	N/A		N/A
575	MISS/INVLD ICD9 RXOV	MISSING OR INVALID ICD-9 DIAGNOSIS CODE FOR RX OVERRIDE	N/A		N/A
576	MISS/INVLD PA/MC COD	MISSING OR INVALID PA/MC CODE OR NUMBER FOR RX OVERRIDE	N/A		N/A
577	OVERRIDE OF RX LIMIT	OVERRIDE OF MONTHLY PRESCRIPTION LIMIT	N/A		N/A
578	INVALID-POS-MODIFIER-COMB	INVALID PLACE OF SERVICE/PROCEDURE MODIFIER COMBINATION	N/A		N/A
579	MUTUALLY-EXCLU-CURR	CURRENT PROCEDURE IS MUTUALLY EXCLUSIVE TO ANOTHER CURRENT PROCEDURE	N/A		N/A
581	HURRICANE-REL WO ATT	HURRICANE RELATED CLAIMS ALLOWED TO PROCESS W/O ATTACHM	N/A		N/A
582	MUTUALLY-EXCLU-HIST	CURRENT PROCEDURE IS MUTUALLY EXCLUSIVE TO A PROCEDURE IN HISTORY	N/A		N/A
583	HIST-PROC-VOIDED-ME	HISTORIACL PROCEDURE IS MUTUALY EXCLUSIVE TO A CURRENT PROCEDURE	N/A		N/A
584	PROC-SEX-CONFLICT	Current procedure is flagged because the indicated procedure is inappropriate for patient's sex.	E		N/A
585	PRE-OP-PROC-CURR	CURRENT PREOPERATIVE PROCEDURE OCCURRED WITHIN 1 DAY OF AN ASSOCIATED SURGICAL PROCEDURE INCLUDED IN THE CURRENT CLAIM	N/A		N/A
586	PRE-OP-PROC-HIST	CURRENT PREOPERATIVE PROCEDURE OCCURRRED WITHIN 1 DAY OF AN ASSOCIATED SURGICAL PROCEDURES RETRIEVED FROM HISTORY	N/A		N/A
587	HIST-PROC-VOIDED-PRE	HISTORICAL PROCEDURE OCCURRRED WITHIN 1 DAY OF AN ASSOCIATED SURGICAL PROCEDURE INCLUDED ON THE CURRENT CLAIM	N/A		N/A

588	POST-OP-PROC-CURR	CURRENT POSTOPERATIVE PROCEDURE OCCURRED WITHIN 90 DAYS OF AN ASSOCIATED SURGICAL PROCEDURE INCLUDED ON THE CURRENT CLAIM	N/A		N/A
589	POST-OP-PROC-HIST	CURRENT POSTOPERATIVE PROCEDURE OCCURRED WITHIN 90 DAYS OF AN ASSOCIATED SURGICAL PROCEDURE RETRIEVED FROM HISTORY	N/A		N/A
590	RECI IS MEDCARETCHOI	RECIPIENT IS MEDICARETCHOICE	N/A	Not applicable to Molina encounter edits since the SMO will receive the crossover claims.	N/A
591	HIST-PROC-VOIDED-PST	HISTORICAL POSTOPERATIVE PROCEDURE OCCURRED WITHIN 90 DAYS OF AN ASSOCIATED SURGICAL PROCEDURE INCLUDED ON THE CURRENT CLAIM	N/A		N/A
592	E&M-NOT-PAYABLE-CURR	CURRENT MEDICAL VISIT SHOULD NOT HAVE BEEN BILLED SEPARATELY FROM AN ASSOCIATED PROCEDURE INCLUDED ON THE CURRENT CLAIM	N/A		N/A
593	E&M-NOT-PAYABLE-HIST	CURRENT MEDICAL VISIT SHOULD NOT HAVE BEEN BILLED SEPARATELY FROM AN ASSOCIATED PROCEDURE RETRIEVED FROM HISTORY	N/A		N/A
594	HIST-PROC-VOIDED-VIS	HISTORICAL MEDICAL VISIT SHOULD NOT HAVE BEEN BILLED SEPARATELY FROM AN ASSOCIATED PROCEDURE INCLUDED ON THE CURRENT CLAIM	N/A		N/A
595	PROC SPL REL TO CURR	Current multi-unit line contains units, which have been denied for more than one reason. (Split-Decision)	E		N/A
596	LINE ADDED-SPL	Code added due to SPL claim	E		N/A
597	PA-MODIFIER-NO-MATCH	PA MODIFIER DOES NOT MATCH CLAIM MODIFIER	N/A		N/A
598	PA-TOOTH-OCD-NO-MATCH	PA TOOTH/ORAL CAVITY CODE NOT SAME AS CLAIM	N/A		N/A
599	SONOS NOT JUSTIFIED	DOCUMENTATION DOES NOT JUSTIFY ADDITIONAL SONOGRAMS	N/A		N/A
600	10-MO-PAST-PA-DATE	10-MONTH PASTE PRIOR AUTHORIZATION DATE	N/A		N/A
601	ADULT-DENT-AGE-LS21	ADULT DENTAL CLAIM FILED FOR RECIPIENT UNDER 21	N/A		N/A
602	DA-SURF-CODE	CLAIM DOES NOT INDICATE CORRECT NUMBER OF SURFACES	N/A		N/A
603	DA-TOOTH-REQD	TOOTH CODE/ORAL CAVITY DESIGNATOR REQUIRED	N/A		N/A
604	EPSDT-DENT-AGE-GR21	EPSDT DENTAL CLAIM - RECIPIENT AGE GREATER THAN 21	N/A		N/A
605	OVER LMT PER PREG	EXCEEDS LIMIT PER PREGNANCY	N/A		N/A
606	ADULT DENTAL REQ PA	ADULT DENTAL CLAIM MUST BE PRIOR AUTHORIZED	N/A		N/A
607	PA-DATE-GR-SERV-DT	PRIOR AUTHORIZATION DATE GREATER THAN SERVICE DATE	N/A		N/A
608	INVALID-TOOTH-NUMBER	INVALID TOOTH NUMBER (SEALANT NOT PAYABLE FOR THIS TOOTH)	N/A		N/A
609	DENTAL-AGE-RESTRICT	DENTAL AGE RESTRICTION (RESTORATION NOT ALLOWABLE DUE TO PATIENT AGE)	N/A		N/A

610	PULP CAP NO PAY DECI	PULP CAP NOT PAYABLE FOR DECIDUOUS TOOTH	N/A		N/A
611	PULPOTOMY NO PAY-PER	PULPOTOMY NOT PAYABLE FOR PERMANENT TOOTH	N/A		N/A
612	PIN-NOT-PAYABLE	PIN NOT PAYABLE FOR THIS TOOTH	N/A		N/A
613	INVALID-TOOTH-CODE	INVALID TOOTH CODE/ORAL CAVITY DESIGNATOR	N/A		N/A
614	HEMA.COMP/IND/BILLED	HEMATOLOGY COMPONENT/INDICE/PROFILE BILLED INCORRECTLY	N/A		N/A
615	REBIL W/APP PRIM CDE	MUST BE BILLED WITH APPROPRITATE PRIMARY CODE	N/A		N/A
616	ONE PANEL/PREGNANCY	ONLY ONE PRENATAL LAB PANEL PER PREGNANCY	N/A		N/A
617	PYMNT INCDL DELV FEE	PAYMENT INCLUDED IN DELIVERY FEE	N/A		N/A
619	PAN & IND CODE/ PANE	BILLED PANEL AND INDIVIDUAL CODE WITHIN PANEL	N/A		N/A
620	PAN & IND CODE/ PANE	ONE URINALYSIS PER PREGNANCY PAYABLE	N/A		N/A
621	RESUBMIT-WITH-REPORTS	RESUBMIT WITH OPERATIVE AND PATHOLOGY REPORTS AND HISTORY	N/A		N/A
622	EXACT DUPE 01 TO 03	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY	E		N/A
623	EXCEEDS ONE PER YEAR	SEND DOCUMENTAION TO JUSTIFY MORE THAN ONE PER YEAR	N/A		N/A
624	CHIRO-NOT-PAYABLE	THIS CHIROPRACTIC SERVICE IS NO LONGER PAYABLE	N/A		N/A
625	DOCU-INSUFFICIENT	DOCUMENTATION OF MEDICAL NECESSITY INSUFFICIENT	N/A		N/A
626	SEND EPSDT REFERRAL	SEND EPSDT REFERRAL AND PROOF OF MEDICAL NECESSITY	N/A		N/A
627	SEND MED NECESSITY	SEND PROOF OF MEDICAL NECESSITY AND EPSDT REFERRAL	N/A		N/A
628	RESUBMIT-WITH-REFERRAL	NEED EPSDT REFERRAL AND PROOF OF MEDICAL NECESSITY	N/A		N/A
629	ALLOW 1 PER 8 YEARS	ONLY 1 OF THESE PROCES IN 8 YEARS PER RECIP/PROVIDER	N/A		N/A
631	EPSDT-AGE-ERROR	EPSDT AGE OVER 21	D		N/A
632	ADJUST UB82 MISMATCH	ADJUSTMENT UB82 INDICATOR MISMATCH	N/A		N/A
633	VOID COMPON REBILL	VOID COMPONENTS REBILL PANEL CODE	N/A		N/A
634	VOID REBILL HIGH COD	VOID PAID CODE; REBILL HIGHER CODE IN TRIAD	N/A		N/A
635	HIGH CODE TRIAD PAID	HIGHER CODE IN TRIAD ALREADY PAID	N/A		N/A
636	REBILL VISIT CODE	CRITICAL CARE/CONSULT NOT DOCUMENTED-BILL CORRECT VISIT	N/A		N/A
637	SEE MED SERV MANUAL	MATERNITY ANES. SEE PG. 10-5 OF MEDICAL SERVICES MANUAL	N/A		N/A
638	ONLY LO-LEVEL OFFICE	ONLY LOW LEVEL OFF VISIT ALLOWED	N/A		N/A
640	EXCEEDS MAX PHYS YRS	EXCEEDS MAXIMUM ALLOWED BY SAME PHYSICIAN W/I 3 YEARS	N/A		N/A
641	EXCEEDS MAX/HOSPITAL	EXCEEDS MAXIMUM ALLOWED PER HOSPITALIZATION	N/A		N/A
642	1 CONSLT/PHYS/HOSP	ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION	D		N
643	EXCEEDS DAY MAX VISI	EXCEEDS DAILY MAXIMUM ALLOWED VISITS	N/A		N/A
644	VISIT CODE PD/DOS	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE	D		N
645	NEW/EST PT CONFLICT	NEW/ESTABLISHED PATIENT CONFLICT-CC	N/A		N/A
646	EXCEEDS DAY MAX VISI	EXCEEDS DAILY MAXIMUM VISITS PER PROVIDER/SPECIALTY	N/A		N/A
648	DOC REQ CONCUR CARE	RESUBMIT W/DOCUMENTATION SUBSTANTIATING CONCURRENT	N/A		N/A

		CARE			
649	VFC-PAYMENT-CUTBACK	VACCINES FOR CHILDREN PAYMENT CUTBACK (ADMINISTRATION ONLY IS REIMBURSABLE)	N/A		N/A
650	PAY-RED-TO-STATE-MAX	PAYMENT MADE AT STATE MAXIMUM	N/A		N/A
651	HOSPITAL-CUTBACK-APPLIED	HOSPITAL CUTBACK APPLIED	E	SMO should operate under same claim edits defined in state plan that are implemented in MMIS FFS claims processing.	N
656	OVER MAX DURATION	EXCEEDS MAXIMUM DURATION OF THERAPY	N/A		N/A
658	UNABLE PRICE CLAIM	PROC CODE/DESCRIPTION CONFLICT-UNABLE TO PRICE CLAIM	N/A		N/A
659	REBIL W/ONE PRIM CDE	REBILL.ONLY ONE PRIMARY VACCINE ADMIN CODE ALLOWED/DAY	N/A		N/A
660	PAY-RED-TO-LMAC-MAX	PAYMENT REDUCED TO LMAC MAXIMUM	N/A		N/A
661	MEDICARE-COVERAGE	CLM VOID/ADJ BY STATE**RECIPIENT HAS MEDICARE COVERAGE	N/A	Not applicable to Molina encounter edits since SMO will receive the crossover claims	N/A
662	COPAY-REDUCED	PAYMENT REDUCED BY CO-PAY	N/A		N/A
663	NO ABORTION DONE	ABORTION NOT DONE-FETUS NOT ALIVE AT TIME OF PROCEDURE	n/a		n/a
664	1 PAYABLE/180 DAYS	ONLY ONE (1) PAYABLE PER 180 DAYS	N/A		N/A
665	RESUB HRDCPY ADJ/VOI	MEDICARE ADJ/VOID;RESUBMIT HARDCOPY ADJ OR VOID CLAIM	N/A		N/A
666	NO OF RX GR THAN 5	NUMBER OF PRESCRIPTIONS GREATER THAN FIVE	N/A		N/A
667	RX>5 MED NEC DX REQU	RX GREATER THAN 5 MEDICALLY NECESSARY AND DX REQUIRED	N/A		N/A
668	NO HIST.INSULIN REQ.	NO PATIENT HISTORY OF INSULIN REQUIREMENTS	N/A		N/A
670	VOID REBILL VISIT	VOID PAID URINALYSIS REBILL VISIT	N/A		N/A
671	PAID. DO NOT REBILL	INCLUDED IN PAID PRE/POSTNATAL CAREVISIT. DO NOT REBILL	N/A		N/A
672	SERVICE IN PD 77427	SERVICE INCLUDED IN PAID 77427	N/A		N/A
673	EVAL & MGT PD DOS	EVAL AND MGT CODE PAID FOR THIS DOS	D		N
674	DOCUMENT NAME CHANGE	96/96A--DOC.NAME CHANGE-PG28 PROF SERV 2000 TRAIN PACK	N/A		N/A
675	VACCINE/ADM CONFLICT	VACC & ADM MUST PAY/AGREE;IF ONLY ONE PAYS TOTAL DENIES	N/A		N/A
676	PRIMARY CODE DENIED	PAYABLE ONLY IF PRIMARY CODE IS PAID	N/A		N/A
677	RESTORATIVE/SURG REQ	RESTORATIVE AND/OR SURGICAL SERVICE REQ ON SAME DOS	N/A		N/A
678	GLOBAL CODE PD	GLOBAL CODE PD THIS DOS THIS RECIP	N/A		N/A
679	COMPONENT CODE PD	COMPONENT CODE PD THIS DOS RECIP	N/A		N/A

688	ICFDD-RESP	INTERMEDIATE CARE FACILITY/DEVELOPMENTAL DISABILITY FACILITY IS REQUIRED TO PROVIDE THIS SERVICE	N/A		N/A
689	MHR SERV PD THIS DOS	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE	D		N
690	PAYMENT IN SURG FEE	PAYMENT INCLUDED IN SURGERY FEE	N/A		N/A
691	REBILL SURGERY	VISIT PAID IN GSP.VOID VISIT;REBILL SURGERY	N/A		N/A
692	SEND-VFTEST-AND-RESULTS	VISUAL FIELD TEST AND RESULTS NEEDED FOR REVIEW	N/A		N/A
693	ADJUST PAID LINE	ONLY A PAID LINE/THE CORRECT PAID LINE CAN BE ADJUSTED	N/A		N/A
694	DID NOT SUB REQ DOC	REQUESTED DOCUMENTS WERE NOT SUBMITTED/SEE PREVIOUS RA	N/A		N/A
695	HOSP DISCHARGE PAID	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION	D		N/A
696	PROBLEM CODE PD 2YRS	PROBLEM ORIENTED CODE PAID WITHIN 2 YEARS	N/A		N/A
697	REQ OVERRIDE >3650	REQUEST OVERRIDE FOR ELDERLY WVR PCA UNITS OVER 3650	N/A		N/A
698	CUTBACK-SERV 1 YEAR	CUTBACK-REPAIR MUST YIELD DENTURE SERVICEABLE FOR 1 YR	N/A		N/A
699	REPR DENIED 1 YEAR	REPAIR DENIED FOR 1 YR POST INSERTION	N/A		N/A
701	FOLLOW UP VS CHG	CONSULT FOLLOW-UP VISITS NOT ALLOWED.	E		N/A
702	NEW PT/EST PT CD CON	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT	D		Y
703	SEPARATE CHGS EPIS.	EPISIOTOMY INCLUDED IN DELIVERY CHARGE	N/A		N/A
704	ER VISIT/INP HOS SER	ER VISIT ON DATE OF INP HOS SERVICES	D		N
705	AID/RN/PT NO SAME DY	AIDE/RN/PT VISIT SAME DAY NOT ALLOWED/H.HEALTH	N/A		N/A
706	FOLLOW-UP-NB-CARE-BILLED	FOLLOWUP NEWBORN CARE BILLED SEPARATELY	n/a		n/a
709	STERILIZATION-REVIEW	STERILIZATION CONSENT FORM INCORRECT/ILLEGIBLE	N/A		N/A
711	SAME SPEC/SUBSP PAID	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF SERV	E		N/A
712	INITIAL HOSP INPT PD	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS	D		N
713	MULTI-CHANN TEST SEP	PANEL AUTOMATED MULTICHANNEL TEST	N/A		N/A
714	MULTI-URINE TEST SEP	MUTLI-URINE TESTS BILLED; TO BE COMBINED TO PANEL	N/A		N/A
715	2ND. VISIT SAME DAY	FOUND DUPLICATE VISIT SAME DAY	E		N/A
716	PROC-INCLUDED-IN-OV	PROCEDURE INCLUDED IN THE PHYSICIAN OFFICE VISIT	D		N
717	FOUND TWO PANEL CODE	MAX ALLOW ONE PANEL A DAY/BILLING PROVIDER	N/A		N/A
718	CODE INC FRAMES/LENS	CD 00089 INCL FRAME&LENS-HIST INDIC COMP PMT	N/A		N/A
719	EMERG COMB XRAY ONLY	EMERGENCY CAN BE COMBINED WITH X-RAY ONLY	N/A		N/A
720	TO BE BILLED BY PROV	MUST BE BILLED BY PROVIDER OF SERVICE	n/a		n/a
721	SUR ASST NOT NEEDED	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST	n/a		N/A
722	BILL EMERG OV/XRAY	EMERGENCY CANNOT BE COMBINED WITH CODES OTHER THAN XRAY	N/A		N/A
723	PROV RESPONSIBLE/SVC	PROVIDER RESPONSIBLE FOR THIS SERVICE	n/a		N/A
724	EXCEEDS MAX DOLLAR	EXCEEDS MAXIMUM DOLLAR AMOUNT PER TOOTH	N/A		N/A
725	D&C/BIOP-CERVIX CRG	SEE CPT-CODE 57520 INCLUDES D&C/DO NOT BILL CODE 58120	N/A		N/A

726	MULTIPLE SURGERY	MULTIPLE SURGERY-PENDED FOR REVIEW	N/A		N/A
727	EXCEEDS DAILY MAX	EXCEEDS DAILY SERVICE MAXIMUM	E		N/A
728	BLOOD COMP + PANEL	BLOOD COMPONENT BILLED ALONG WITH PANEL CODE	N/A		N/A
729	URINE COMP + PANEL	URINE COMPONENT BILLED ALONG WITH PANEL CODE	N/A		N/A
730	1 INP HSP VST PER DA	ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY	E		N/A
732	ATTACH DETAIL.DESCR.	ATTACH DETAILED DESCRIPTION OF PROCEDURE	N/A		N/A
733	95165-90 DAYS	95165-90 DAYS	N/A		N/A
734	EXCEEDS-MAX-UNITS-AL	RECIPIENT HAS EXCEEDED MAXIMUM ALLOWED SERVICES PER 6MO	N/A		N/A
735	PREV PD ANES-SAME RE	PREVIOUSLY PAID ANES.OR SUPERVISING ANES SAME RECI/DOS	D		N
737	FEE IN SCREEN. FEE	FEE INCLUDED IN SCREENING FEE	N/A		N/A
738	ONLY ONE D0111/12 MO	RECIPIENT NOT ELIGIBLE FOR THIS SERVICE ON DATE OF SER	N/A		N/A
739	EXCEEDS-MAX-UNITS-AL	RECIPIENT HAS EXCEEDED MAXIMUM ALLOWED SERVICES PER YR	N/A		N/A
740	1-INTRAOCULAR-LEN-AL	ONLY ONE PROCEDURE V2630 V2631 V2632 ALLOWED PER RECIP	N/A		N/A
741	ONLY 1 PER YEAR/RECI	ONLY 1 D0120/D0272/D1110/D1120/D1203/D1204 PER YR/RECI	N/A		N/A
742	ALLOW 1 PER 5 YEARS	ONLY 1 OF THESE PROCS ALLOWED IN 5 YEARS PER RECIP/PROV	N/A		N/A
743	PREG EXCEEDED	MAX PER PREGNANCY EXCEEDED	N/A		N/A
745	1/PREG-158A NEEDED	ONE ALLOWED/PREG.;158-A NEEDED FOR UNUSUAL SITUATIONS	N/A		N/A
746	SAME ATTD PD IP CONS	SAME ATTENDING PROV PAID INPT CONSULTATION SAME STAY	D		N
747	PROVIDE-SPEC-RADIONU	RESUBMIT WITH SPECIFIC NUCLIDE/AMOUNT USED PER PT (PATIENT)/AMOUNT PAID/INVOICE	N/A		N/A
748	1 DEL.ALLOW. 6MTH.SP	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN	n/a		n/a
749	DEL HYST/STER CONFLI	DELIVERY BILLED AFTER HYSTERECTOMY/STERLIZ WAS DONE	n/a		n/a
750	STERILIZATION INDIC	FOUND PROC. 2 X INDICATES STERILIZATION	n/a		N/A
751	HYSTERECTOMY-REVIEW	HYSTERECTOMY REQUIRED ACKNOWLEDGEMENT OR PROOF PREVIOUSLY STERILE	N/A		N/A
752	STER-REQ-ATTACH	STERILIZATION REQUIRES OFS FORM 96	N/A		N/A
753	REBILL-DELIVERY	REBILL DELIVERY (DELIVERY-SURGERY) CODE & OFFICE VISIT	n/a		n/a
754	RVW READMIT/DSCHG DX	PEND FOR REVIEW OF READMIT/DISCHARGE DIAGNOSIS	N/A		N/A
755	BILL AS ADJ/CNT STAY	THIS SHOULD BE BILLED AS ADJUST.FOR CNT STAY	n/a		N/A
756	DOC/READMIT SAME DAY	RESUBMIT WITH DOCUMENTATION OF DISC/READMIT SAME DATE	N/A		N/A
757	ADJ PD LINE 51 MOD	ADJUST PAID LINE WITH 51 MODIFIER THEN RESUBMIT MAJOR	n/a		n/a
758	FND DUP SERV SM DAY	FOUND DUPLICATE SERVICE SAME DAY	D		N
760	RESUBMIT-WITH-AUTH-LETTER	AIR TRANSPORTATION REQUIRES PRIOR AUTHORIZATION (AIR TRANSPORTATION CLAIMS REQUIRE STATE APPROVAL)	N/A		N/A
761	SEND DATED OP REPORT	SEND DATED OPERATIVE REPORT FOR DATE BILLED	N/A		N/A
762	SEND-DATED-NOTES	SEND SPECIFIC DATED NOTES FOR EACH DATE BILLED	N/A		N/A
768	RESUB/CORRECT MOD	NO DOCUMENTATION FOR 62/66;CORRECT/RESUBMIT	N/A		N/A

769	REFERRED TO P.A.	TO BE REVIEWED BY PRIOR AUTHORIZATION;DO NOT RESUBMIT	N/A		N/A
770	RESUBMIT-WITH-HISTORY	PERTINENT HISTORY REQUIRED (RESUBMIT WITH PERTINENT HISTORY)	N/A		N/A
771	SEND L & D RECORDS	RESUBMIT WITH LABOR AND DELIVERY RECORDS	N/A		N/A
772	JUSTIFY/#UNITS	SEND NOTES JUSTIFYING # OF UNITS BILLED	N/A		N/A
773	IN TRANSPLANT FEE	INCLUDED IN GLOBAL FEE FOR TRANSPLANT	N/A		N/A
774	INC IN RELATED SERV	INCLUDED IN RELATED SERVICE	n/a		N/A
775	PAY CUT SAME TOOTH	PAYMENT CUTBACK SAME TOOTH	N/A		N/A
776	ONGOING CM PRIOR TO	ONGOING CM PRIOR TO INITIAL CM ~	n/a		N/A
778	ATTACH-PROCDESC-UNDERLINE	CIRCLE UNLISTED DESCRIPTION (CIRCLE UNLISTED CODE DESCRIPTION IN-OPERATIVE REPORT)	N/A		N/A
779	PROC:EXTRCT NOT PAY	PROCEDURE ON EXTRACTED TOOTH NOT PAYABLE	N/A		N/A
780	REBILL CORRECT UNITS	UNITS AVAILABLE FOR CODE--REBILL USING UNITS	N/A		N/A
781	INAPPROPRIATE-MODIFIER	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL	D		Y
782	SEND DATED NOTES	EXCEEDS SONOGRAMS/PREGNANCY IN 270 DAYS	N/A		N/A
783	EXCEEDS SONOS/270DAY	JUSTIFY ADDITIONAL SONOGRAMS W PERTINENT DATED NOTES	N/A		N/A
784	EXCEEDS MO LIMIT	EXCEEDS MONTHLY LIMIT	N/A		N/A
785	SERV REV/CHIRO CNSLT	SERVICE LIMIT REVIEW BY CHIROPRACTIC CONSULTANT	N/A		N/A
786	UNKNOWN ABBREVATION	RESUBMIT WITH ABBREVATION LEGEND	N/A		N/A
787	SEND ALL DOCUMENTS	INADEQUATE DOCUMENTATION-SEE FEB 94 & AUG 93 UPDATES	N/A		N/A
788	DAILY-NOTES-NEEDED	DAILY NOTES (TREATMENT, PROGRESS) NEEDED	N/A		N/A
790	3 HOSP VISIT SERV PD	3 HOSPITAL INPATIENT SERV PAID FOR SAME DATE OF SERVICE	E		N/A
791	CODE CONFLICT	BILLED CODE CONFLICTS WITH CODE ALREADY PAID	D		N
792	CLM BYPASS CC EDITS	Bypass ClaimCheck edits	E		N/A
793	PCA SERV LIMIT EXCEE	PCA SERVICE LIMIT EXCEEDED	N/A		N/A
794	INPT SER PD SAME ATT	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING PROV	D		N
795	CLM BYPASS PAM EDITS	Bypass PAM edits	E		N/A
796	ORIG/ADJ PROV DIFF	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT	D		Y
797	DUP ADJ. RECORD	DUPLICATE ADJUSTMENT RECORDS ENTERED	D		N
798	HIST ALREADY ADJSTED	HISTORY RECORD ALREADY ADJUSTED	D		N
799	NO ADJ HISTORY	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT	D		Y
800	ON-LINE DUPE DENY	DUPLICATE OF PREVIOUSLY PAID CLAIM	D		N
801	EXACT DUPE 01 TO 01	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS	D		N
802	EXACT DUPE 01 TO 14	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION	D		N
803	EXACT DUPE 02 TO 02	EXACT DUPLICATE ERROR: IDENTICAL LTC CLAIMS	n/a		n/a
804	EXACT DUPE 02 TO 14	EXACT DUPLICATE ERROR: LTC AND TITLE18-INSTITUTIONAL	n/a		n/a
805	EXACT DUPE 03 TO 03	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS	D		N

806	EXACT DUPE 03 TO 05	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVICES	D		N
807	EXACT DUPE 03 TO 06	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH	n/a		N/A
808	EXACT DUPE 03 TO 07	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE	n/a		N/A
809	EXACT DUPE 03 TO 08	EXACT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULANCE	n/a		N/A
810	EXACT DUPE 03 TO 09	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUIPMENT	n/a		N/A
811	EXACT DUPE 03 TO 13	EXACT DUPLICATE ERROR: OUTPATIENT AND EPSDT	n/a		N/A
812	EXACT DUPE 03 TO 15	EXACT DUPLICATE ERROR: OUTPATIENT AND TITLE18	n/a		N/A
813	EXACT DUPE 04 TO 04	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS	D		N
814	EXACT DUPE 04 TO 15	EXACT DUPLICATE ERROR: PHYSICIAN AND TITLE18	D		N
815	EXACT DUPE 05 TO 05	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS	n/a		n/a
816	EXACT DUPE 05 TO 06	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH	n/a		N/A
817	EXACT DUPE 05 TO 07	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE	n/a		N/A
818	EXACT DUPE 05 TO 08	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANCE	n/a		N/A
819	EXACT DUPE 05 TO 09	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE EQUIP	n/a		N/A
820	EXACT DUPE 05 TO 13	EXACT DUPLICATE ERROR: REHAB-SERVICES AND EPSDT	n/a		N/A
821	EXACT DUPE 05-14	EXACT DUPE ERROR-REHAB SERVICES & TITLE 18	n/a		N/A
822	EXACT DUPE 06 TO 06	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS	n/a		N/A
823	EXACT DUPE 06 TO 07	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE	n/a		N/A
824	EXACT DUPE 06 TO 08	EXACT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULANCE	n/a		N/A
825	EXACT DUPE 06 TO 09	EXACT DUPLICATE ERROR: HOME HEALTH AND DURABLE-EQUIP	n/a		N/A
826	EXACT DUPE 06 TO 13	EXACT DUPLICATE ERROR: HOME HEALTH AND EPSDT	n/a		N/A
827	EXACT DUPE 06-14	EXACT DUPE ERROR-HOME HEALTH & TITLE 18	n/a		N/A
828	EXACT DUPE 07 TO 07	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS	n/a		N/A
829	EXACT DUPE 07 TO 08	EXACT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANCE	n/a		N/A
830	EXACT DUPE 07 TO 09	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP	n/a		N/A
831	EXACT DUPE 07 TO 13	EXACT DUPLICATE ERROR: AMBULANCE AND EPSDT	n/a		N/A
832	EXACT DUPE 07 TO 15	EXACT DUPLICATE ERROR: AMBULANCE AND TITLE18	n/a		N/A
833	EXACT DUPE 08 TO 08	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLAIMS	N/A		N
834	EXACT DUPE 08 TO 09	EXACT DUPLICATE ERROR: NON-AMBULANCE AND DURABLE-EQUIP	n/a		N/A
835	EXACT DUPE 08 TO 13	EXACT DUPLICATE ERRORS: NON-AMBULANCE AND EPSDT	n/a		N/A
836	EXACT DUPE 08 TO 15	EXACT DUPLICATE ERROR: NON-AMBULANCE AND TITLE18	n/a		N/A
837	EXACT DUPE 09 TO 09	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS	n/a		N/A
838	EXACT DUPE 09 TO 13	EXACT DUPLICATE ERROR: DURABLE-EQUIPMENT AND EPSDT	n/a		N/A
839	EXACT DUPE 09 TO 15	EXACT DUPLICATE ERROR: DURABLE-EQUIPMENT AND TITLE18	n/a		N/A
840	EXACT DUPE 10 TO 10	EXACT DUPLICATE ERROR: IDENTICAL DENTAL-EPSDT CLAIMS	n/a		N/A
841	EXACT DUPE 10 TO 11	EXACT DUPLICATE ERROR: DENTAL-EPSDT AND DENTAL-ADULT	n/a		N/A

842	EXACT DUPE 11 TO 11	EXACT DUPLICATE ERROR: IDENTICAL DENTAL-ADULT CLAIMS	n/a		N/A
843	EXACT DUPE 12 TO 12	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS	n/a		N/A
844	EXACT DUPE 13 TO 13	EXACT DUPLICATE ERROR: IDENTICAL EPSDT CLAIMS	n/a		N/A
845	EXACT DUPE 13 TO 15	EXACT DUPLICATE ERROR: EPSDT AND TITLE18	n/a		N/A
846	EXACT DUPE 14 TO 14	EXACT DUPLICATE ERROR: IDENTICAL TITLE18 INST CLAIMS	n/a		N/A
847	EXACT DUPE 15 TO 15	EXACT DUPLICATE ERROR: IDENTICAL TITLE18 PROF CLAIMS	n/a		N/A
848	EXACT DUPE 12 TO 15	EXACT DUPLICATE ERROR:IDENTICAL DRUG & PARTB MC CLAIMS	n/a		N/A
849	PD SAME ATTEN/DIF BL	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROVIDER	D		N
851	SUSPCT DUPE 01 TO 01	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS	E		N/A
852	SUSPCT DUPE 01 TO 14	SUSPT DUPLICATE ERROR: HOSPITAL AND TITLE18	n/a		N/A
853	SUSPCT DUPE 02 TO 02	SUSPCT DUPLICATE ERROR: IDENTICAL LTC CLAIMS	n/a		N/A
855	SUSPCT DUPE 03 TO 03	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS	E		N/A
856	SUSPCT DUPE 03 TO 05	SUSPCT DUPLICATE ERROR: OUTPATIENT AND REHAB	n/a		N/A
857	SUSPCT DUPE 01 TO 06	SUSPCT DUPLICATE ERROR: OUTPATIENT AND HOME-HEALTH	n/a		N/A
858	SUSPCT DUPE 03 TO 07	SUSPCT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE	n/a		N/A
859	SUSPCT DUPE 03 TO 08	SUSPCT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULANCE	n/a		N/A
860	SUSPCT DUPE 03 TO 09	SUSPCT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUIPMT	n/a		N/A
861	SUSPCT DUPE 03 TO 13	SUSPCT DUPLICATE ERROR: OUTPATIENT AND EPSDT	n/a		N/A
862	SUSPCT DUPE 03 TO 15	SUSPCT DUPLICATE ERROR: OUTPATIENT AND TITLE18-PROF	n/a		N/A
863	SUSPCT DUPE 04 TO 04	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS	E		N/A
864	SUSPCT DUPE 04 TO 15	SUSPCT DUPLICATE ERROR: PHYSICIAN AND TITLE18-PROF	n/a		N/A
865	SUSPCT DUPE 05 TO 05	SUSPEC DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CLAIMS	n/a		N/A
866	SUSPCT DUPE 05 TO 06	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEALTH	n/a		N/A
867	SUSPCT DUPE 05 TO 07	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANCE	n/a		N/A
868	SUSPCT DUPE 05 TO 08	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBULANC	n/a		N/A
869	SUSPCT DUPE 05 TO 09	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND DME	n/a		N/A
870	SUSPCT DUPE 05 TO 13	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND EPSDT	n/a		N/A
871	SUSPECT DUPE 05-14	SUSPECT DUPE ERROR-REHAB SERVICES & TITLE 18	n/a		N/A
872	SUSPCT DUPE 06 TO 06	SUSPCT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIMS	n/a		N/A
873	SUSPCT DUPE 06 TO 07	SUSPCT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE	n/a		N/A
874	SUSPCT DUPE 06 TO 08	SUSPCT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULANCE	n/a		N/A
875	SUSPCT DUPE 06 TO 09	SUSPCT DUPLICATE ERROR: HOME HEALTH AND DURABLE EQUIPMT	n/a		N/A
876	SUSPCT DUPE 06 TO 13	SUSPCT DUPLICATE ERROR: HOME HEALTH AND EPSDT	n/a		N/A
877	SUSPECT DUPE 06-14	SUSPECT DUPE ERROR-HOME HEALTH & TILE 18	n/a		N/A
878	SUSPCT DUPE 07 TO 07	SUSPCT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS	n/a		N/A
879	SUSPCT DUPE 07 TO 08	SUSPCT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANCE	n/a		N/A

880	SUSPCT DUPE 07 TO 09	SUSPCT DUPLICATE ERROR: AMBULANCE AND DURABLE EQUIPMENT	n/a		N/A
881	SUSPCT DUPE 07 TO 13	SUSPCT DUPLICATE ERROR: AMBULANCE AND EPSDT	n/a		N/A
882	SUSPCT DUPE 07 TO 15	SUSPECT DUPLICATE ERROR: AMBULANCE AND TITLE18	n/a		N/A
884	SUSPCT DUPE 08 TO 09	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND DME CLAIMS	n/a		N/A
885	SUSPCT DUPE 08 TO 13	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND EPSDT CLAIMS	n/a		N/A
886	SUSPCT DUPE 08 TO 15	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND TITLE18	n/a		N/A
887	SUSPCT DUPE 09 TO 09	SUSPECT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLAIMS	n/a		N/A
888	SUSPCT DUPE 09 TO 13	SUSPECT DUPLICATE ERROR: DURABLE-EQUIPMENT AND EPSDT	n/a		N/A
889	SUSPCT DUPE 09 TO 15	SUSPECT DUPLICATE ERROR: DME AND TITLE18 CLAIMS	n/a		N/A
890	SUSPCT DUPE 10 TO 10	SUSPECT DUPLICATE ERROR: IDENTICAL DENTAL-EPSDT CLAIMS	n/a		N/A
891	SUSPCT DUPE 10 TO 11	SUSPECT DUPLICATE ERROR: DENTAL-EPSDT AND DENTAL-ADULT	n/a		N/A
893	SUSPCT DUPE 12 TO 12	SUSPECT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS	n/a		N/A
895	SUSPCT DUPE 13 TO 15	SUSPECT DUPLICATE ERROR: EPSDT AND TITLE18 CLAIMS	n/a		N/A
896	SUSPCT DUPE 14 TO 14	SUSPECT DUPLICATE ERROR: IDENTICAL TITLE18-INST CLAIMS	n/a		N/A
897	SUSPCT DUPE 15 TO 15	SUSPECT DUPLICATE ERROR: IDENTICAL TITLE18-PROF CLAIMS	n/a		N/A
898	EXACT DUPE SAME ICN	EXACT DUPE SAME ICN - DROPPED	D		N
899	SUSPCT DUPE 12 TO 15	SUSPECT DUPLICATE ERROR:DRUG & PARTB MC CLAIMS	n/a		N/A
900	LIFETIME LIMITS-ONE	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED	n/a		n/a
902	LTC HOME LV OVER MAX	LTC LEAVE DAYS EXCEED LIMIT	N/A		N/A
904	SVC BEYOND TIME LIM	SERVICE PERFORMED BEYOND REQUIRED TIME SPECIFICATIONS	N/A		N/A
905	LTC-MED-LOA-OVER-15	LTC LEAVE DAYS EXCEED LIMIT - 15 PER HOSPITAL STAY	N/A		N/A
906	EXCEEDS MAX ALLOWED	EXCEEDS MAMIMUM ALLOWED	N/A		N/A
907	PHY/CLINIC OVER MAX	PHYSICIAN/CLINIC VISITS EXCEEDS ANNUAL MAXIMUM	N/A	Robert to research. See resolution in Section 1.11.3	N/A
908	HH VISITS OVER 50	HOME HEALTH VISITS EXCEEDS ANNUAL MAXIMUM ALLOWED (50)	N/A		N/A
909	LTC HOME LVD OVER 9	LTC HOME LEAVE EXCEEDS ANNUAL MAXIMUM ALLOWED (9)	N/A		N/A
910	ICF-MR LIMIT OVER 45	ICF-MR HOME LEAVE EXCEEDS ANNUAL MAXIMUM ALLOWED (45)	N/A		N/A
911	HOSP DAYS OVER MAX	HOSPITAL DAYS EXCEED ANNUAL MAXIMUM ALLOWED	N/A	Robert to research. See resolution in Section 1.11.3	N/A
912	PENICL INJ OVER 12	PENICILLIN/BICILLIN INJCTNS EXCEED ANNUAL ALLOWED (12)	N/A		N/A
913	PHY/HOSP VIS OVER MX	PHYSICIAN HOSPITAL VISITS EXCEED ANNUAL MAXIMUM	N/A	Robert to research. See resolution in Section 1.11.3	N/A
914	UNITS NOT=SVC DAY	UNITS DO NOT MATCH DATES OF SERVICE/CLAIMCHECK	D		Y
915	EMERG OP OVER 3	EMERGENCY OUTPATIENT VISITS EXCEED ANNUAL MAXIMUM (3)	N/A		N/A

916	NON-EMER OP OVER 12	NON-EMERGENCY OUTPATIENT VISITS EXCEED MAXIMUM (12)	N/A		N/A
917	OVER LIFETIME LIMIT	LIFETIME LIMITS FOR THIS SERVICE HAVE BEEN EXCEEDED	n/a		N/A
918	PAYMENT-REDUCED-BY-TPL	MEDICAID ALLOWABLE AMOUNT REDUCED BY OTHER INSURANCE	E		N/A
919	REDUCED BY SPENDDOWN	MEDICAID ALLOWABLE AMOUNT REDUCED BY RECIPIENT SPENDOWN	E		N/A
920	OVER 5 REFILLS	MORE THAN 5 REFILLS PER PRESCRIPTION NOT REIMBURSABLE	N/A		N/A
921	UNITS NOT=SITE MOD	UNITS DON'T MATCH THE SITE SPECIFIC MODIFIERS	E		N/A
922	EOMB MUST ATTACH	MEDICARE EOMB INVALID/OR MISSING.	N/A		N/A
923	CHIROP E&M VISIT MAX	CHIROPRACTIC E & M VISIT MAX REACHED	N/A		N/A
925	SEND-RECORDS-FOR-DOS	SEND OFFICE RECORDS FOR DATE OF SERVICE	N/A		N/A
926	EXACT DUPLICATE.	EXACT DUPLICATE OF ANOTHER ADJUSTMENT.	D		N
927	OFS FORMS MISSING	OFS FORMS 158B & ACKNOWLEDGEMENT REQUIRED	N/A		N/A
928	PD PATIENT RESP AMT	PAID PATIENT RESPONSIBILITY AMT PER THE EOB	N/A		N/A
929	PD MEDICAID AMT	PD MEDICAID AMT TPL DENIED CLAIM	N/A		N/A
930	BILL ONE PROC.PER L	BILL ONE PROCEDURE PER LINE FOR EACH DATE OF SERVICE	D		Y
931	DENIED PER TPL EOB	DENIED PER THE TPL EOB INFORMATION	D		Y
932	BILL-THIRD-PARTY	BILL THIRD PARTY CARRIER FIRST	N/A		N/A
933	INVALID PROC-MOD	INVALID/MODIFIER/PROCEDURE CODE COMBINATION	D		Y
934	MOD-51-REQUIRED	PAY PERCENT = 50 BUT NO MODIFIER 50 OR 51 WAS INPUT	n/a		n/a
935	BATCHED INCORRECTLY	BATCHED INCORRECTLY/RE-ENTER	N/A	Paper claims edit	n/a
936	PROCESSING-ERROR	PROCESSING ERROR	N/A		Jeff to research
938	MOD-51-INVALID	PAY PERCENT = 100 BUT NO MODIFIER 50 OR 51 WAS INPUT	n/a		N/A
939	CUTBACK PER SURS	CUTBACK PER SURS GUIDELINES	N/A		N/A
940	DENY TO BE REBILLED	MEDICARE DENIED IF COVERED BILL WITH PROVIDER EOB	N/A		N/A
941	DENIED-PER-SURS	DENIED PER SURS GUIDELINES	N/A		N/A
942	DENY NOT TO REBILL	DENIED BY MEDICARE NOT COVERED BY MEDICAID	D		N
943	SPEND DOWN FORM	SPEND DOWN FORM 110MNP INVALID/MISSING	N/A	Robert to research. As a result of 7/26/11 meeting, spend-down is the responsibility of the SMO for LBHP services	N/A
944	NOT PAID BY MEDICARE	NOT PAID BY MEDICARE	N/A		N/A
945	INVALID W/O PRIMARY	ADD-ON PROCEDURE INVALID WITHOUT PRIMARY/CLAIMCHECK	n/a		N/A
946	SPLIT BILL FOR PART.	SPLIT BILL FOR PARTIAL ELIGIBILITY.	D		Y

947	MAX # CLM LINES EXC	E305 – MAXIMUM EXCEEEDED FOR ADDED CLAIM LINES. PLEASE SPLIT CLAIM AND RESUBMIT.	E		Y
948	INC IN MAJ SUR PROC	INCLUDED IN MAJOR SURGICAL PROCEDURE	D		N
949	ANESTH-TIME-MISSING	ANESTHESIA MINUTES INVALID OR MISSING	D		Y
950	OPERATIVE-REQUESTED	ATTACH BOTH OPERATIVE AND HISTORY REPORT	N/A		N/A
951	DISCH DATE NOT COV	DATE OF DISCHARGE NOT COVERED	D		N
952	INC IN OV/RELAT PROC	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE	D		N
953	JUSTIFY-MOD22	RESUBMIT WITH JUSTIFICATION FOR USE OF 22 MODIFIER	N/A		N/A
954	PROC INAPPROPRIATE	INAPPROPRIATE PROCEDURE - SEE CPT FOR VALID CODE	D		N
955	PAID ACC TO MED REV	PAID ACCORDING TO MEDICAL REVIEW	N/A		N/A
956	PROC/DX AGE RESTRICT	PROC/DX NOT COVERED FOR RECIPIENT THIS AGE	N/A		N/A
957	PROC-DIAG-REQ-REVIEW	PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY	n/a		N/A
958	DENY BY MED REVIEW	DENIED ACCORDING TO MED REVIEW GUIDELINES	N/A		N/A
959	RESUB SURGEONS CODE	RESUBMIT CLAIM USING CODE SURGEON BILLED	N/A		N/A
960	AUTHORIZE-TRANSPLANT	ATTACH BHSF AUTHORIZATION LETTER AND OPERATIVE REPORT	N/A		N/A
961	INVALID PROC/MOD	INVALID PROCEDURE-MODIFIER COMBINATION/CLAIMCHECK	E		N/A
962	MAX SERVICE SAME DAY	MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK	E		N/A
963	PROC./DIAG. DESP.REQ	PROCEDURE/DIAGNOSIS DESCRIPTION REQUIRED.	N/A		N/A
964	CLAIMCHECK RESERVED	Integration Wizard Defined AUDIT-RESULT	E		N/A
965	NOT-COVERED-BY-HH	SERVICE NOT COVERED BY HOME HEALTH PROGRAM	N/A		N/A
966	SUBMIT-HARD-COPY	SUBMIT HARD COPY OF CLAIM	N/A		N/A
967	CLAIMCHECK RESERVED	Integration Wizard Defined AUDIT-RESULT	E		N/A
968	PROC/SERV REND CONF	PROCEDURE CODE DOES NOT REFLECT SERVICES RENDERED	N/A		N/A
969	CLAIMCHECK RESERVED	Integration Wizard Defined AUDIT-RESULT	E		N/A
970	INAPPROPRIATE CODE	INAPPROPRIATE CODE BILL LAB OR SPECIFIC HANDLING.	N/A		N/A
971	CLAIM-EXCEEDS-6MO	MEDICARE CLAIM > 6 MONTHS (CLAIM EXCEEDS FILLING LIMIT CO-INSURANCE/DEDUCTIBLE)	N/A		N/A
972	MEDICARE PAID 100%	ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE	D		N
973	NO SURGERY MODIFIER	CLAIM DESCRIPT INDICATES PROC CODE SHOULD HAVE MODIFIER	n/a		N/A
974	DIA CODE/DESC CONF	DIAGNOSIS CODE/DESCRIPTION CONFLICT	N/A		N/A
977	CLAIMCHECK RESERVED	Integration Wizard Defined AUDIT-RESULT	E		N/A
978	PAY-AMOUNT-ZERO	CALCULATED PRICING IS ZERO/CALL HELP DESK	E		N/A
979	CLAIM-IN-PROCESS	CLAIM IN PROCESS	N/A		N/A
980	INVALID ADJ REASON	INVALID ADJUSTMENT REASON	D		Y
981	CLAIMCHECK RESERVED	Integration Wizard Defined AUDIT-RESULT	E		N/A
983	TOTAL-CHRG-CHANGED	SYSTEM CALCULATED TOTAL - NET BILLED NOT IN BALANCE	D		Y

985	REBILL-MOTHERS INFO	REBILL UNDER MOTHERS NAME & MID NUMBER	N/A		N/A
986	REBILL-BABYS INFO	REBILL-BABYS MID & MOTHERS D/C DATE AS BABYS ADMIT DATE	N/A		N/A
987	DENIED TO REBILL/ADJ	DENIED TO BE REBILLED ON ADJUSTMENT FORM.	N/A		N/A
988	COVERED-BY-MEDICARE	ITEM COVERED BY MEDICARE	N/A		N/A
990	2 PROC SAME TOTH/DAY	EMERGENCY/DEFINITIVE NOT PAYABLE ON SAME TOOTH/SAME DAY	N/A		N/A
991	PROCEDURE IN PANEL	PROCEDURE INCLUDED IN PANEL	n/a		N/A
993	MID CORRECTED.	MID HAS BEEN CORRECTED/PLEASE UPDATE YOUR FILES.	n/a		N/A
994	DOCUMENT NOT LEGIBLE	DOCUMENTS NOT LEGIBLE PLEASE RESUBMIT	N/A		N/A
996	MC-PAYMENT-REDUCED	DEDUCTIBLE AND/OR CO-INSURANCE REDUCED TO MAXIMUM ALLOWABLE	N/A		N/A
997	COMP A-MODE ECHOENCH	COMPLETE A-MODE ECHOENCHEPHALOGRAPHY-BILL HCPC Z9100	N/A		N/A