CCN-P Systems Companion Guide

April 11, 2011

CCN-P Systems Companion Guide

DHH will provide maintenance of all documentation changes to this Guide using the Change Control Table as shown below.

Change Control Table

Author of Change	Sections Changed	Descriptions	Reason	DATE

CCN –P Systems Companion Guide

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Overview

Introduction

Beginning November 2011, DHH will phase-in implementation of member enrollment services into Medicaid's Coordinated Care Network (CCN) Program. Member enrollment into the Coordinated Care Program will be phased in based on DHH's GSAs. Services will begin January 1, 2012 for GSA A; March 1, 2012 for GSA B; and May 1, 2012 for GSA C.

A CCN differs from the current CommunityCARE 2.0 Program in that it assumes risk for the cost of the services covered under the Contract and incurs a loss if the cost of furnishing the services exceeds the payment received.

DHH will require CCNs to report encounters. Encounters include paid services provided to Medicaid enrollees. CCNs will be required to submit encounters to the Fiscal Intermediary (FI) using HIPAA compliant Provider-to-Payer-to-Payer COB 837I (Institutional) and 837P (Professional) transactions.

Encounter Definition

Encounters are records of medically related services rendered by a CCN provider to DHH Medicaid enrollees enrolled as members with a Prepaid CCN on the date of service. It includes all services for which the CCN has any financial liability to a provider. An encounter is comprised of the procedures(s) and/or service(s) rendered during the contract. Encounters include services paid as Fee-for-Service (FFS), as well as services paid under a capitated provider arrangement. CCNs must report all paid services covered under the CCN Contract. Encounter services include, but are not limited to the following:

- Hospital services
- Physician visits
- Nursing visits
- Surgical services
- Anesthesia services
- Laboratory tests

- Radiology services
- DME
- Dialysis center services
- Physical therapy services
- EPSDT services
- Case management services
- Home health services

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contract Requirements

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

Rate Setting

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

Quality Management and Improvement

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

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

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

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

Implementation Date

Within sixty (60) days of operation in the applicable geographic service area (GSA), the CCN's Systems shall be ready to submit encounter data to DHH's FI in a HIPAA compliant provider-to-payer-to-payer COB format.

DHH Responsibilities

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

Ruth Kennedy	
Telephone	225 342 9240
Fax	225 342 9508
E-mail	Ruth.Kennedy@la.gov

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

Fiscal Intermediary (FI) Responsibilities

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

Accepting and Storing Encounters

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

X12 Reporting

If the file contains syntactical errors, the segments and elements where the error occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

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

Proprietary Reports

The FI will also provide CCNs with proprietary MMIS encounter adjudication edit reports following the weekly claims payment cycle.

Enrollment Broker Responsibilities

The Enrollment Broker shall make available to the CCN via a daily and weekly 834 X12 transaction, updates on members newly enrolled, disenrolled or with demographic changes. At the end of each month, the Enrollment Broker shall reconcile enrollment/disenrollment with a full 834 X12 reconciliation file.

CCN Responsibilities

It is the CCNs responsibility to ensure accurate and complete encounter reporting from their providers.

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

CCNs are expected to investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified data quality issue(s). As data issues are discussed, CCNs must incorporate corrective action steps into the encounter quality improvement plan. Any issues that are not fully addressed on a timely basis may be escalated into a corrective action plan (CAP). The CAP will include a listing of issues, responsible parties, and projected resolution dates.

File Transfer

The CCN shall be able to transmit, receive and process data in HIPAA compliant or DHH specific formats and/or methods, including, but not limited to secure File Transfer Protocol (FTP) over a secure connection such as Virtual Private Network (VPN), that are in use at the start of the Systems readiness review activities. CCN generated reports are described 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). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

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

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

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

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

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

Molina Companion Guides and Billing Instructions

Molina, as DHHs FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and

elements where the error(s) occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

DHH Supplemental Instructions

DHH requires CCNs to submit the Provider-to-Payer-to-Payer COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2430 (Service Line Adjudication Information) and 2330B (Other Payer information). In the first COB loop, the CCN will be required to include information about CCN provider claim adjudication. In the first loop, the CCN shall place their unique DHH carrier code in loop 2300B, NM109. In subsequent loops, the CCN shall provide DHH with any third-party payments. In these loops, the CCN must include the DHH carrier code of the other payer. There can be only one single subsequent loop per unique payer.

Financial Fields

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

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

Header and Line Item Submitted Charge Amount — CCNs shall report the provider's charge or billed amount. The value may be "$0.00" if the CCN contract with the provider is capitated and the CCN 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 Approved (Allowed) Amount — CCNs shall report their fee schedule amount or maximum allowed amount. If the CCN does not cover the specific service reported, the Approved Amount may be "$0.00." Historically, the MMIS did not store approved amount in claims history.

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

Header and Line Item Adjustment Amount — If the Paid Amount reflects any adjustments to the Submitted Line Item Charge Amount, the adjustment amounts must be reported. Any time the charge amount does not equal the paid amount, the CCN is required to report both the Adjustment Amount and the adjustment reason code. The adjustment amounts and reason codes are critical to the correct pricing of the encounter in the MMIS.

Professional Identifiers

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

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, CCNs must obtain valid medical records to supplement the UB-04 or use logic from the paper claim to derive the required additional information for the 837 transactions.

Newborn Birth Weight

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

Newborn ID Usage

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

Category II CPT Codes

DHH requires the use of applicable Category II CPT Codes 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. Please note that this guidance is subject to change. 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
07	Case Mgmt - Infants & Toddlers
08	Case Mgmt - Elderly
09	Hospice Services
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
23	Independent Lab
24	Personal Care Services (LTC/PCS/PAS)
25	Mobile X-Ray/Radiation Therapy Center
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services (EarlySteps)
30	Chiropractor and Chiropractor Group

Provider Type	Description
31	Psychologist
32	Podiatrist and Podiatrist Group
34	Audiologist
35	Physical Therapist
37	Occupational Therapist
39	Speech Therapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother
46	Case Mgmt – HIV
51	Ambulance Transportation
61	Venereal Disease Clinic
62	Tuberculosis Clinic
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital - Distinct Part Psychiatric Unit
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
73	Social Worker
74	Mental Health Clinic
75	Optical Supplier
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
81	Case Mgmt - Ventilator Assisted Care Program
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home
90	Nurse-Midwife
91	CRNA or CRNA Group
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan

Provider Type	Description
	"638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care

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

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

Specialty	Description	Associated Provider Types
24	Plastic Surgery	19,20
25	Physical Medicine Rehabilitation	19,20
26	Psychiatry	19,20,93
27	Psychiatry; Neurology (DO only)	19
28	Proctology	19,20
29	Pulmonary Diseases	19,20
30	Radiology	19,20
31	Roentgenology, Radiology (DO only)	19
32	Radiation Therapy (DO only)	19
33	Thoracic Surgery	19,20
34	Urology	19,20
35	Chiropractor	30,35
36	Pre-Vocational Habilitation	13
37	Pediatrics	19,20,93
38	Geriatrics	19,20
39	Nephrology	19,20
40	Hand Surgery	19,20
41	Internal Medicine	19,20
42	Federally Qualified Health Centers	72
44	Public Health	66,70
45	NEMT - Non-profit	42
46	NEMT - Profit	42
47	NEMT - F+F	42
48	Podiatry - Surgical Chiropody	20,32
49	Miscellaneous (Admin. Medicine)	20
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included	40

Specialty	Description	Associated Provider Types
	in 51, 52, 53	
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	61,62,66,67
62	Psychologist Crossovers only	29,31
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27
69	Independent Laboratory (Billing Independently)	23
70	Clinic or Other Group Practice	19,20,68,74,76
71	Speech Therapy	29
72	Diagnostic Laboratory	23
73	Social Worker Enrollment	73
74	Occupational Therapy	29,37
75	Other Medical Care	65
76	Adult Day Care	85
77	Habilitation	85
78	Mental Health Rehab	77
79	Nurse Practitioner	78
81	Case Management	07,08,43,46,81
83	Respite Care	83
85	Extended Care Hospital	60
86	Hospitals and Nursing Homes	55,59,60,64,69, 80,88

Specialty	Description	Associated Provider Types
87	All Other	26,40,44
88	Optician / Optometrist	28,75
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
1T	Emergency Medicine	19,20
2R	Physician Assistant	94
2T	American Indian/Native Alaskan	95
4R	Registered Dietician	41
5B	PCS-EPSDT	24
5C	PAS	24
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5M	Multi-Systemic Therapy	12
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6N	Endodontist	27
6P	Periodontist	27
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38
7C	SBHC - MD - Part Time - less than 20 hrs week	38
7D	SBHC - MD - Full Time - 20 or more hrs week	38

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

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Repairable Denial Edit Codes and Descriptions

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 CCN is to repair as many edit codes as possible. The table below represents the edit codes that must be corrected by the CCNs. For a complete list of edit codes, see Appendix F of this Guide.

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
041	ADMISN-DTE-GT-SERV-FROM-DTE
042	INVALID-TYP-HOSP-BILL
044	INVALID-NATURE-OF-ADMISN-ERR
049	INVALID-CONFLICT-SURG-DATE
200	PROVIDER-NOT-ON-FILE
216	RECIPIENT-NOT-ELIGIBLE
224	INVALID-BIRTHDATE
235	PF-SEX-RESTRICT
254	DIAG-AGE-RESTRICT
255	DIAG-SEX-RESTRICT
258	SPANNING-DATES-QUANT-DIFF
263	PROCEDURE-AGE-RESTRT
313	AMB-SURG-COV-DAYS-ERR
316	COVERED-DAYS-ERR

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

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
317	STMT-DAYS-CONFLICT-ERR
339	CODES-DATE-CONFLICT
340	SPAN-NON-COV-DAYS-CONFLICT
344	SPAN-FROM-THRU-INVALID
364	RECIPIENT-INELIGIBLE-DECEASED
545	REV-NDC-INVALID

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
002	INVALID-PROV-NO
003	INVALID-RECIP-NO
005	INVALID-STMT-FROM-DTE
006	INVALID-STMT-THRU-DTE
007	SERV THRU LT SERV FM
008	SERV FRM GT ENTR DTE
009	SRV-THRU-GT-ENTRY
012	ORG CLM W/ADJ/VD CDE
013	ORG CLM W ADJ/VD ICN
015	INVALID ACCIDENT IND
016	INVALID ACCID IND
017	INVALID EPSDT IND
020	DIAG-MISSING
021	INVALID FORMER REFNO
022	BILLED-CHRGS-ERR
023	INV PARTIAL RECIP
024	INV BILLING PROV NO
040	INVALID-ADMISSION-DTE-ERR
043	INVALID-ATTEND-PHYS
045	INV PATIENT STATUS
046	INV PATIENT STAT DTE
047	PAT STAT DTE GT THRU
052	BLOOD-CHG-ERR
055	INVALID-ANCILLARY-ACCOM-CHRG
060	MISSING-OR-INVALID-COV-DAYS
063	INVALID TOTAL CHARGE

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
064	INVALID NET AMOUNT
065	INVALID-SIGNATURE-INDICATOR
068	INVALID-SOURCE-ADMISN
069	INVALID-OCUR-DATE
071	INV STMT COVERS FROM
072	INV STMT COVER THRU
073	STMT FRM LT SERV FRM
074	STMT THRU GT SRV THR
080	INVALID LAB INDICATR
081	INVALID STATUS DATE
082	INVALID STATUS CODE
085	INVALID UNITS/VISITS
090	REFER-PROV-NOT-ON-FILE
092	INVALID-PROC-MODIFIER
093	REV-CODE-MISSING
094	MISSING-PTS-BLOOD
095	FROM-THRU-NOT-EQUAL
096	REV-CHG-MISSING
097	NON-COV-GT-BILLED
101	INVALID EMER IND
120	QTY-INVALID-MISSING
130	DENY-PROV-9999999
136	NO ELIG SERVICE PAID
180	INVALID ADMIT DATE
182	PROC-CLAIM-TYP-CONFLICT
186	CRNA-MUST-BILL-CORRECT-MOD
206	BILL PROV NOT ON FIL
211	DOS-LESS-THAN-DOB
212	NO-SERVICING-PROV-NO
215	RECIPIENT-NOT-ON-FILE
260	ANESTHESIA-UNITS-NOF
266	INVALID-AMB-SURG-REV
267	REQ-ICD9-SURGICAL-CD
289	REJ-DENY-INV-PROV
301	EMER-ACCESS-NATURE-ERR
304	INV BABY/MTHR ADMISN

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
305	INV BABY/MTHR PROC
307	SURG PROC MISSING
309	SURG DATE MISSING
310	SURG DTE LT SRV FROM
311	SURG DTE GT SRV THRU
314	SUSP-COND-MISS-REF1
318	SUSP-COND-MISS-REF2
319	SUSP-COND-MISS-REF3
328	PROVIDER-NOT-CERTIFIED
376	ADJ DAYS CONFL HIST
400	REFER-PHYS-REQD
430	NO-NEED-FOR-MODIFIER
444	M/I SERVICE PROVIDER
513	HCPCS-REQUIRED
520	MUST-BILL-ZERO
522	MOTHER-BABY-CLAIM-ERR
523	CANNOT BE ADJUSTED
539	CLAIM REQ DETAIL
563	ADJ-ADD-ON-WITH-51
614	HEMA.COMP/IND/BILLED
615	REBIL W/APP PRIM CDE
632	ADJUST UB82 MISMATCH
663	NO ABORTION DONE
676	PRIMARY CODE DENIED
702	NEW PT/EST PT CD CON
706	FOLLOW-UP-NB-CARE-BILLED
720	TO BE BILLED BY PROV
753	REBILL-DELIVERY
755	BILL AS ADJ/CNT STAY
757	ADJ PD LINE 51 MOD
781	INAPPROPRIATE-MODIFIER
796	ORIG/ADJ PROV DIFF
799	NO ADJ HISTORY
914	UNITS NOT=SVC DAY
934	MOD-51-REQUIRED
938	MOD-51-INVALID

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
949	ANESTH-TIME-MISSING
970	INAPPROPRIATE CODE
983	TOTAL-CHRG-CHANGED
TBD	PROV-NOT-CCN

Encounter Correction Process

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

Resubmissions

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

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

4

Transaction Testing and EDI Certification

Introduction

The intake of encounter data from each of the CCNs is treated as HIPAA compliant transactions by DHH and its FI. As such, CCNs are required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, CCNs are requested to send real transmission data. The FI does not define the number of encounters in the transmission; however, DHH will require a minimum set of encounters for each transaction type based on testing needs.

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

Prior to testing, CCNs 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 CCNs with a list of provider types and specialties. CCNs are to provide the provider type and specialty in addition to the data elements available through NPPES.

Test Process

The Electronic Data Interchange (EDI) protocols are available at:
http://www.lamedicaid.com/provweb1/billing_information/medicaid_billing_index.htm or
www.lmmis.com/provweb1/default.htm and choosing Electronic Claims Submission (EMC).
Below are the required steps of the testing process.

Electronic Data Interchange (EDI)

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

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

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

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

- Upon receipt of the submission, the FI's EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
- If the certification form is complete, the EDI Department enters the submitted 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.

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

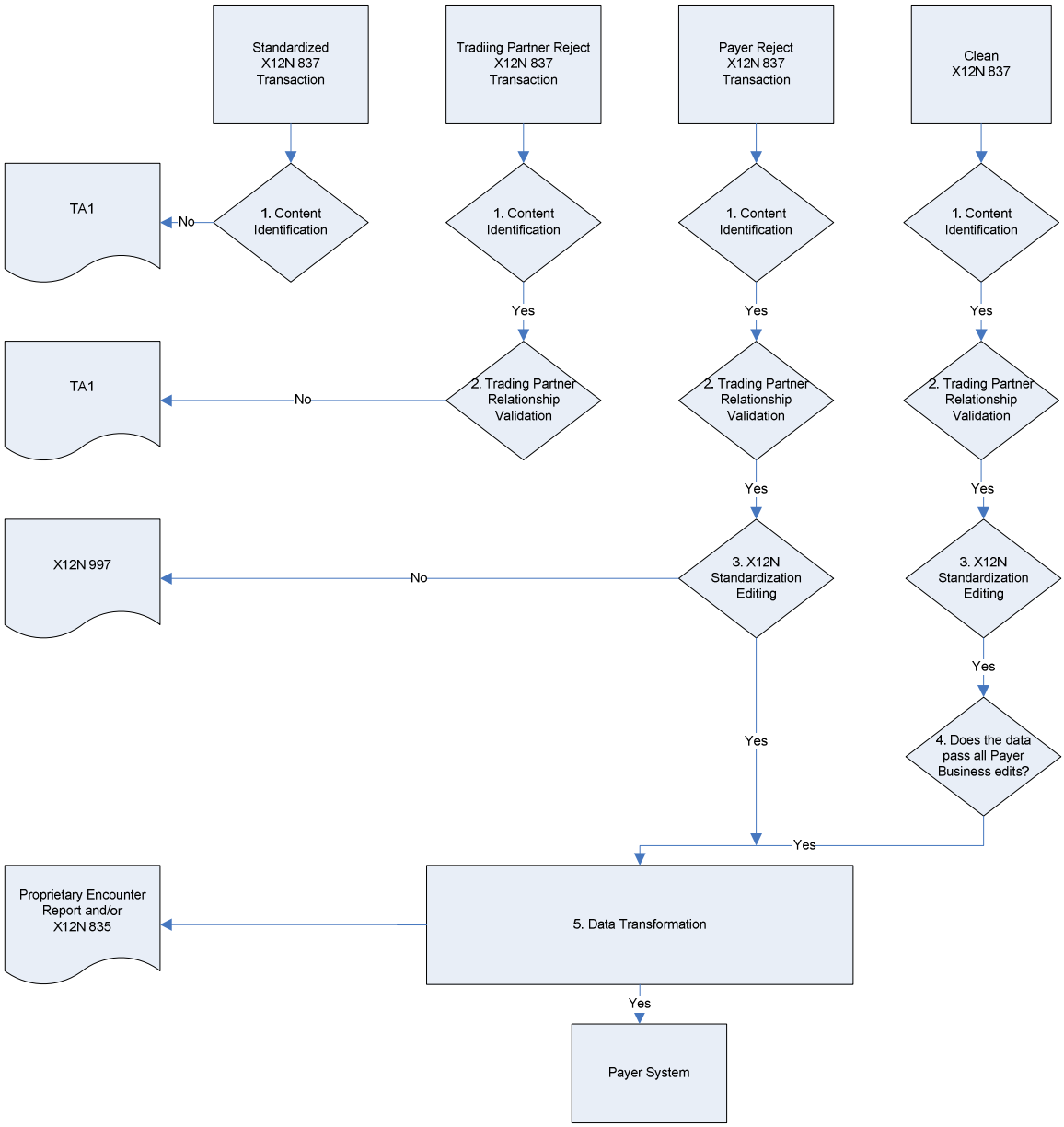
Timing

CCNs may initiate EDIFECS testing at any time. DHH's FI Business Support Analysts are ready to answer technical questions and to arrange testing schedules and EDIFECS enrollment.
Please refer to the FI Companion Guides 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



Data Certification[2]

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

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

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

Certification shall be submitted concurrently with the certified data.

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 CCNs 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 997 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.[3]

Error Correction Process

CCNs are required to correct and resubmit any transactions or encounters that are rejected in their entirety. For service line rejections, CCNs are 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.

Entire File

CCNs will receive either a TA1 or X12N 997 error report. CCNs are required to work with the FI's Business Support Analysts to determine the cause of the error.

Claim

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

CCNs 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

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

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

Dispute Resolution

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

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

The FI will review the CCN’s notification and may ask the CCN to research the issue and provide additional substantiating documentation, or the FI may disagree with the CCN’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 CCN will be required to make corrections to the encounter, if appropriate, and resubmit during the next billing cycle.

6

Continuous Quality Improvement

Introduction

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

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

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

Minimum Standards

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

Repairable Denials

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

Data Volume Assessment

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

7

Adjustment Process

Introduction

In the case of adjustments, CCNs are to follow the detailed, payer-specific instructions provided in the FI's Companion Guides found at:

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

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

Line Adjustment Process

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

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

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.
997 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 997 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
Agent	Any person or entity with delegated authority to obligate or act on behalf of another party.

Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc).
Benefits or Covered Services	Those health care services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan.
CAS Segment	Used to report claims or line level adjustments.
Case Management	Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources, to promote high quality, cost-effective outcomes. Case Management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).
Claim adjustment	A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by adjustment reason codes.
Claim denial	When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under health plan rules.
Claims adjudication	In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim.

CommunityCARE 2.0	Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home.
Contract	As it pertains to the Louisiana Department of Health and Hospitals (DHH) and the CCNs, the contract signed by or on behalf of the CCN entity and those things established or provided for in R.S. 46:437.11 - 437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the CCN program. It includes the signed Contract, together with any and all future addendums issued thereto by DHH.
Coordinated Care Network (CCN)	An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.
Coordinated Care Network – Prepaid (CCN-P)	The private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid CCN Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22 of the Louisiana Revised Statues, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.
Coordinated Care Network – Shared Savings (CCN-S)	An entity that serves as a primary care case manager by providing enhanced primary care case management in addition to contracting with primary care providers (PCPs) for primary care management.
Coordination of Benefits (COB)	Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
Co-payment	Any cost sharing payment for which the Medicaid CCN member is responsible for in accordance with 42 CFR § 447.50 and

	Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.
Core Benefits and Services	A schedule of health care benefits and services required to be provided by the CCN to Medicaid CCN members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan.
Corrective Action Plan (CAP)	A plan developed by the CCN that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.
Corrupt data	Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption.
Covered Services	Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to a CCN are based on data that is submitted by the CCN, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State.
Department (DHH)	The Louisiana Department of Health and Hospitals, referred to as DHH.
Department of Health and Human Services (DHHS; also HHS)	The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes

	more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.
Dispute	An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”.
Edit Code Report	A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the encounter has denied. Other edit codes are informational only.
EDI Certification	EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to encounters being submitted to the Fiscal Intermediary.
Eligible	An individual determined eligible for

	assistance in accordance with the Medicaid State Plan(s) under the Title XIX or Title XXI of the Social Security Act.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention.
Enrollee	Louisiana Medicaid or CHIP recipient who is currently enrolled in a CCN or other managed care program.
Enrollment	The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a CCN.
Enrollment Broker	The states contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees and enrollees into a CCN.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both.
Federally Qualified Health Center (FQHC)	An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.
Fee for Service (FFS)	A method of provider reimbursement based

	on payments for specific services rendered to an individual enrolled in Louisiana Medicaid.
File Transfer Protocol (FTP)	Software protocol for transferring data files from one computer to another with added encryption.
Fiscal Intermediary (FI)	DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fiscal Year (FY)	Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY).
Fraud	As it relates to the Medicaid Program Integrity; means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.
Health Care Professional	A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.
Health Care Provider	A health care professional or entity who

	provides health care services or goods.
Healthcare Effectiveness Data and Information Set (HEDIS)	A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (i.e., CCN) performance.
HIPAA – Health Insurance Portability Administration Act	The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient.
Immediate	In an immediate manner; instant; instantly or without delay, but not more than 24 hours.
Implementation Date	The date DHH notifies the CCN of on-site Readiness Review completion and approval. It differs from the service start-up or “go live” date (which should be roughly five months from the implementation date). At implementation, a CCN can begin the process of establishing all systems for the subsequent enrollment of Medicaid eligibles and service start-up date, and preparing for DHH’s on-site Readiness Review. Enrollment of members will not begin until the CCN has signed a Contract with DHH and passed the Readiness Review or at the “go live” date.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e.* structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group

	Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.
KIDMED	Louisiana's screening component for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).
Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.
Medicaid FFS Provider	An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.
Medicaid Management Information System (MMIS)	A mechanized claims processing and information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of

	payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.
Medical Vendor Administration (MVA)	Refers to the name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana's single state Medicaid Agency).
Medically Necessary Services	Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on

	a case-by-case basis.
Medicare	The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.
Member	As it relates to the Louisiana Medicaid Program and the Contract, refers to a Medicaid eligible who enrolls in a CCN under the provisions of the Contract and also refers to "enrollee" as defined in 42 CFR 438.10(a).
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Network	As utilized in the Contract, "network" may be defined as a group of participating providers linked through contractual arrangements to a CCN to supply a range of primary and acute health care services. Also referred to as Provider Network.
Newborn	A live infant born to a CCN member.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the CCN.
Non-Covered Services	Services not covered under the Title XIX Louisiana State Medicaid Plan.
Non-Emergency	An encounter by a CCN member who has presentation of medical signs and symptoms,

	to a health care provider, and not requiring immediate medical attention.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.
Primary Care Case Management (PCCM)	A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.
Primary Care Provider (PCP)	An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Primary Care Services	Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Prospective Review	Utilization review conducted prior to an admission or a course of treatment.
Protected Health Information (PHI)	Individually identifiable health information that

	is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.
Provider Specialty	A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.).
Provider Type	A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.).
Quality	As it pertains to external quality, review means the degree to which a CCN increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Assessment and Performance Improvement Program (QAPI Program)	Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.
Quality Assessment and Performance Improvement Plan (QAIP Plan)	A written plan, required of all CCN-P entities, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees.

Quality Management (QM)	The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.
Readiness Review	Refers to DHH's assessment of the CCN's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of CCN standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the CCN's ability and readiness to render services.
Recipient	An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.
Reject	Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the CCN, payments for maternity, and adjustments.
Repairable Edit Code	An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying "repairable edit code "code" to indicate that the encounter is repairable.
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized

	representative.
Risk	The chance or possibility of loss. The member is at risk only for pharmacy co-payments as allowed in the Medicaid State Plan and the cost of non-covered services. The CCN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.
Rural Health Clinic (RHC)	A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Area	Referred to as geographic service area (GSA) in the Contract. The designated geographical service area(s) within which the CCN is authorized to furnish covered services to enrollees. A service area shall not be less than one GSA.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Shall	Denotes a mandatory requirement.
Should	Denotes a preference but not a mandatory requirement.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Span of Control	Information systems and telecommunications capabilities that the CCN itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN.
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Start-Up Date	The date CCN providers begin providing medical care to their Medicaid members. Also referred to as “go-live date”.
State	The state of Louisiana.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Surveillance and Utilization Review Subsystems (SURS) Reporting	Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.
Syntactical Error	Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement**)** will be returned to the submitter. The 997 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Function Response Time	Based on the specific sub function being performed: • *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. • *Record Retrieval Time*-the time elapsed after the retrieve command is

	entered until the record data begin to appear on the monitor. • *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. • *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the CCN from the provider and/or switch vendor until the CCN hands-off a response to the provider and/or switch vendor.
System Unavailability	Measured within the CCN's information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "enter" or other function key.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Utilization Management (UM)	Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization

	review and service authorization.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.
Will	Denotes a mandatory requirement.

Appendix B

Frequently Asked Questions (FAQs)

What is HIPAA and how does it pertain to CCNs?

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 CCN encounter data reporting.

What is Molina and what is their role with CCNs?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yes, that is correct. Effective with claims and 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 CCNs submit encounter data?

The reasons why CCNs are required to submit encounter data are as follows:

1. Encounter Data: Section 17.5.4 of the CCN-P RFP details the requirements for encounter submission.

2. Rate Setting: The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are

considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the Contract.

3. Utilization Review and Clinical Quality Improvement: DHH's CCN program is partially funded by CMS. Encounter data is analyzed and used by CMS and DHH to evaluate program effectiveness and monitor quality of care, utilization levels and patterns, access to care, and to evaluate CCN performance. The utilization data from encounter data provides DHH with performance data and indicators. DHH will use this information to evaluate the performance of each CCN 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 CCNs to adhere to HIPAA standards governing Medical data code sets. Specifically, CCNs must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. CCNs are also required to use the non-medical data code sets, as described in the IGs that are valid at the time the transaction is initiated.

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

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

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

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

- Treatment; and
- Management.

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

- Drugs; and
- Biologics.

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

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

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

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

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

- Medical supplies,
- Orthotic and prosthetic devices, and
- Durable medical equipment.

Appendix D

System Generated Reports

The over arching purpose of this set of reports is to enhance the quality of the encounter data by providing DHH and the submitting CCN 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 FIs 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 CCN are found in Section 6 of this Guide.

The following reports are generated by the MMIS system and have been selected specifically to provide each CCN with useful information that, when compared with the 835 Remittance Advice for the specific encounter, will provide a complete explanation for the edit code. A second set of reports that focus more closely on the overall quality of the data will also be created from the encounter data. These reports and the process for Data Quality Assessment are discussed in Section 6 of this Guide. These quality reports will also depict accuracy and completeness at a volume and utilization level. Please refer to these reports, as outlined in Section 6.

ASC X12N 835

As discussed above, and in Section 5, CCNs 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.

Encounter Claims Summary — Molina Report CCN-W-001

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

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-001"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is "Claims Summary"	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-001"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the	8	Numeric

Column(s)	Item	Notes	Length	Format
		detail record. The detail portion of the file is sorted by this number		
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services. 14=Medicare Crossover Instit. 15=Medicare Crossover Prof	2	Numeric
25	Delimiter		1	Uses the ^ character value
26-33	Number of claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Number of claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				character value
44-51	Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Character
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-001"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Not Used		8	Character value is spaces.
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-33	Total Number of Claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Total Number of Claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Overall Percentage		8	Numeric, with decimal point.

Column(s)	Item	Notes	Length	Format
	of Denied Claims			For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

Encounter Edit Disposition Summary — Molina Report CCN-W-005

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

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

Column(s)	Item	Notes	Length	Format
		The detail portion of the file is sorted by this number.		
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services 14=Medicare Crossover Instit. 15=Medicare Crossover Prof.	2	Numeric
25	Delimiter		1	Uses the ^ character value
26-29	Error Code		4	Numeric
30	Delimiter		1	Uses the ^ character value
31-38	Number of claim records having this error code		8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.
TRAILER		There is only		

Column(s)	Item	Notes	Length	Format
(TOTALS) RECORD		one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-005"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^ character value
26-29	Unused		4	Value is spaces
30	Delimiter		1	Uses the ^ character value
31-38	Total Number of Claim records denied	This value should match that of the CCN-W-001 file. It may not equal the total of all detail lines in the CCN-W-005 file because one claim may have several edits.	8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.

Edit Code Detail — Molina Report CCN-W-010

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

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-010"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Report Date	Date that the report was created by Molina.	8	Numeric, format YYYYMMDD
22	Delimiter		1	Uses the ^ character value
23-72	Report Description	Value is "Claim Detail"	50	Character
73	Delimiter		1	Uses the ^ character value
74-80	CCN Provider ID	Medicaid Provider ID associated with the CCN.	7	Numeric
81	Delimiter		1	Uses the ^ character value
82-321	End of Record		240	Value is spaces.
DETAIL RECORD		There may be multiple detail		

Column(s)	Item	Notes	Length	Format
		records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-010"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail portion of the file is sorted by this number	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-35	Claim ICN	Internal Claim Number, assigned by Molina. Unique per claim line.	13	Numeric
36	Delimiter		1	Uses the ^ character value
37-66	Medical Record Number	Submitted on the claim by the CCN.	30	Character
67	Delimiter		1	Uses the ^ character value
68-87	Patient Control Number	Submitted on the claim by the CCN	20	Character
88	Delimiter		1	Uses the ^ character value
89-118	Line Control Number	Submitted on the claim by the CCN	30	Character

Column(s)	Item	Notes	Length	Format
119	Delimiter		1	Uses the ^ character value
120-128	Remittance Advice Number	Assigned by Molina	9	Numeric
129	Delimiter		1	Uses the ^ character value
130-133	Error Code 1	First error code, if claim was denied.	4	Numeric
134	Delimiter		1	Uses the ^ character value
135-138	Error Code 2 (if necessary)	2nd error code, if claim was denied and if available.	4	Numeric
139	Delimiter		1	Uses the ^ character value
140-143	Error Code 3 (if necessary)	3rd error code, if claim was denied and if available.	4	Numeric
144	Delimiter		1	Uses the ^ character value
145-148	Error Code 4 (if necessary)	4th error code, if claim was denied and if available.	4	Numeric
149	Delimiter		1	Uses the ^ character value
150-153	Error Code 5 (if necessary)	5th error code, if claim was denied and if available.	4	Numeric
154	Delimiter		1	Uses the ^ character value
155-158	Error Code 6 (if necessary)	6th error code, if	4	Numeric

Column(s)	Item	Notes	Length	Format
		claim was denied and if available.		
159	Delimiter		1	Uses the ^ character value
160-163	Error Code 7 (if necessary)	7th error code, if claim was denied and if available.	4	Numeric
164	Delimiter		1	Uses the ^ character value
165-168	Error Code 8 (if necessary)	8th error code, if claim was denied and if available.	4	Numeric
169	Delimiter		1	Uses the ^ character value
170-173	Error Code 9 (if necessary)	9th error code, if claim was denied and if available.		
174	Delimiter		1	Uses the ^ character value
175-178	Error Code 10 (if necessary)	10th error code, if claim was denied and if available.		
179	Delimiter		1	Uses the ^ character value
180	Not used		1	Character
181	Delimiter		1	Uses the ^ character value
182-195	Not used		14	Numeric with decimal point, left zero-fill.
196	Delimiter		1	Uses the ^ character value.
197-204	DOS-From		8	Numeric,

Column(s)	Item	Notes	Length	Format
				YYYYMMDD
205	Delimiter		1	Uses the ^ character value.
206-213	DOS-Through		8	Numeric, YYYYMMDD
214	Delimiter		1	Uses the ^ character value.
215-227	Medicaid Recipient ID	Recipient's current Medicaid ID number	13	Character
228	Delimiter		1	Uses the ^ character value.
229-242	Provider Billed Charges	Billed charges from provider as submitted by CCN on claim	14	Numeric with decimal point, left zero-fill.
243	Delimiter		1	Uses the ^ character value.
244-248	Procedure Code	As submitted by CCN on claim, for all claim types except inpatient hospital.		Character
249	Delimiter		1	Uses the ^ character value.
250-259	Provider Billed Units	As submitted by CCN on claim	10	Numeric with decimal point, left zero-fill.
260	Delimiter		1	Uses the ^ character value.

Column(s)	Item	Notes	Length	Format
261-274	Medicaid Payment	Amount Louisiana Medicaid paid on the claim	14	Numeric with decimal point, left zero-fill.
275	Delimiter		1	Uses the ^ character value.
276-286	NDC	If Rx claim, then this is the NDC on the claim	11	
287	Delimiter		1	Uses the ^ character value.
288-290	Therapeutic Class	If Rx claim	3	
291	Delimiter		1	Uses the ^ character value.
292	Rx refill code	If Rx claim: 0=1st script, 1-5=refill number	1	
293	Delimiter		1	Uses the ^ character value.
294	Diagnosis Code	ICD-9-CM diag code, if available	5	Character, does not include the decimal.
299	Delimiter		1	Uses the ^ character value.
300	Admit Date		8	Numeric, YYYYMMDD For inpatient hospital claims
308	Delimiter		1	Uses the ^ character value.
309	Discharge Date		8	Numeric, YYYYMMDD

Column(s)	Item	Notes	Length	Format
				For inpatient hospital claims
317	Delimiter		1	Uses the ^ character value.
318,319	Servicing Provider Specialty		2	Numeric with leading zero if necessary.
320	Delimiter		1	Uses the ^ character value.
321	End of Record		1	Character, value is space.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is "CCN-W-010"	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Total Detail Lines in the file	This is a number that represents the total detail lines submitted in the file. It is equivalent to the total number of claim lines that denied.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Totals Line Indicator		2	Numeric, value is 99.
25	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				character value
26-33	Total Number of claim records denied.	This value represents the count of unique claim lines that appear in the detail portion of this file and have been denied.	8	Numeric
34	Delimiter		1	Uses the ^ character value
35-321	End of Record		287	Value is spaces.

Appendix E

CCN 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.

416 Reports

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

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

Instructions for the 416 report may be found at

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

Denied Claims Report

DHH 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 CCN

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

In the interim, CCNs are to submit to DHH an electronic report monthly on the number and type of denied claims referenced above. 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 CCN
- 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 CCN shall submit on a quarterly basis by date of service, a report of encounter/claim data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. The report shall be submitted based on timeframes established in Section 18.13 of the CCN-P RFP. The report shall include the following information:

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

Appendix F

Encounter Edit Codes

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 CCN.

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (PAY) EDIT DESCRIPTION
TBD	PROV-NOT-LINKED-CCN
014	IMM COMPL MISS/INVLD
020	PRIM-OR-SEC-DIAG-REQD
025	IMM NOT COMP RSN MIS
028	INVALID-MISSING-PROC-CODE
029	SERV MORE THAN 12 MO
030	SERV-THRU-DATE-TOO-OLD
034	22 MOD.NOT JUSTIFIED
038	MOD52-REDUCED-PAY
039	PROC-MOD-NOT-APPLICABLE
048	INVALID-SURGICAL-PROC
084	TREATMENT-PLACE-INVALID

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (PAY) EDIT DESCRIPTION
105	REFER-BY-CASE-MANAGER
108	PROV-TYPE-AGE-RESTRICT
114	INVALID-HCPCS-CODE
115	HCPCS-CODE-NOF
119	INVEST EXPER OR NOT
127	NDC-INVALID-MISSING
131	PRIM-DIAG-NOT-ON-FILE
132	SEC-DIAG-NOT-ON-FILE
183	SURG-PROC-NOF
201	PROVIDER-NOT-ELIGIBLE
203	PROVIDER-ON-REVIEW
207	BILL-PROV-NOT-ELIG
217	RECIP-NAME-MISMATCH
231	NDC-NOT-ON-FILE
252	DIAGNOSIS-NOT-ON-FILE
268	INVALID-TREATMENT-PL
275	RECIPIENT-MEDICARE-ELIG
278	RECIP-POSS-MEDICARE-ELIG
279	PROF-COMP-INVALID-POT
281	VISIT INC. SURG CHGS
282	PRE-OP INC IN SURG.
283	POST-OP INC IN SURG
298	INVALID-PROC-CODE
299	PROC-NOT-COVERED
330	RECIP-NOT-MCAID-ELIG
331	ABORTION-REVIEW
332	STERILIZATION-LESS-THAN-21
377	PAYABLE-FOR-QMB-ONLY
397	CLAIM-NEEDS-80-MOD
401	CONCURRENT-CARE
402	NO-SERV-EXCEEDS-MAX
403	MULTIPLE-SURGERY
404	NON-EMER TRANS OUTPT
405	OUTSIDE-LAB-NOT-COVERED
431	M/I PROF SERV CODE
433	INVALID-DIAGNOSIS
488	ONLY-1ST DIAG VS PD
505	CLM RECD NO CC EDITS
519	WELL-BABY-CLAIM-ZERO-PD
547	PROC-REB-REL-TO-CURR
548	PROC-REB-REL-TO-HIST
549	HIST-PROC-VOIDED-REB
550	NO MULTI - PROVIDERS
558	ASSIST-SURG-INVALID
567	INCIDENTAL-PROC-CURR

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (PAY) EDIT DESCRIPTION
573	INCIDENTAL-PROC-HIST
574	HIST-PROC-VOIDED-INC
578	INVALID-POS-MODIFIER-COMB
579	MUTUALLY-EXCLU-CURR
582	MUTUALLY-EXCLU-HIST
583	HIST-PROC-VOIDED-ME
585	PRE-OP-PROC-CURR
586	PRE-OP-PROC-HIST
587	HIST-PROC-VOIDED-PRE
588	POST-OP-PROC-CURR
589	POST-OP-PROC-HIST
591	HIST-PROC-VOIDED-PST
592	E&M-NOT-PAYABLE-CURR
593	E&M-NOT-PAYABLE-HIST
594	HIST-PROC-VOIDED-VIS
650	PAY-RED-TO-STATE-MAX
678	GLOBAL CODE PD
679	COMPONENT CODE PD
689	MHR SERV PD THIS DOS
701	FOLLOW UP VS CHG
711	SAME SPEC/SUBSP PAID
715	2ND. VISIT SAME DAY
721	SUR ASST NOT NEEDED
750	STERILIZATION INDIC
851	SUSPCT DUPE 01 TO 01
852	SUSPCT DUPE 01 TO 14
853	SUSPCT DUPE 02 TO 02
855	SUSPCT DUPE 03 TO 03
856	SUSPCT DUPE 03 TO 05
857	SUSPCT DUPE 01 TO 06
858	SUSPCT DUPE 03 TO 07
859	SUSPCT DUPE 03 TO 08
860	SUSPCT DUPE 03 TO 09
861	SUSPCT DUPE 03 TO 13
862	SUSPCT DUPE 03 TO 15
863	SUSPCT DUPE 04 TO 04
864	SUSPCT DUPE 04 TO 15
865	SUSPCT DUPE 05 TO 05
866	SUSPCT DUPE 05 TO 06
867	SUSPCT DUPE 05 TO 07
868	SUSPCT DUPE 05 TO 08
869	SUSPCT DUPE 05 TO 09
870	SUSPCT DUPE 05 TO 13
871	SUSPECT DUPE 05-14
872	SUSPCT DUPE 06 TO 06

EDIT CODE	EDIT DISPOSITION – INFORMATION ONLY (PAY) EDIT DESCRIPTION
873	SUSPCT DUPE 06 TO 07
874	SUSPCT DUPE 06 TO 08
875	SUSPCT DUPE 06 TO 09
876	SUSPCT DUPE 06 TO 13
877	SUSPECT DUPE 06-14
878	SUSPCT DUPE 07 TO 07
879	SUSPCT DUPE 07 TO 08
880	SUSPCT DUPE 07 TO 09
881	SUSPCT DUPE 07 TO 13
882	SUSPCT DUPE 07 TO 15
884	SUSPCT DUPE 08 TO 09
885	SUSPCT DUPE 08 TO 13
886	SUSPCT DUPE 08 TO 15
887	SUSPCT DUPE 09 TO 09
888	SUSPCT DUPE 09 TO 13
889	SUSPCT DUPE 09 TO 15
890	SUSPCT DUPE 10 TO 10
891	SUSPCT DUPE 10 TO 11
893	SUSPCT DUPE 12 TO 12
895	SUSPCT DUPE 13 TO 15
896	SUSPCT DUPE 14 TO 14
897	SUSPCT DUPE 15 TO 15
899	SUSPCT DUPE 12 TO 15
921	UNITS NOT=SITE MOD
930	BILL ONE PROC.PER L
933	INVALID PROC-MOD
945	INVALID W/O PRIMARY
946	SPLIT BILL FOR PART.
948	INC IN MAJ SUR PROC
951	DISCH DATE NOT COV
952	INC IN OV/RELAT PROC
954	PROC INAPPROPRIATE
957	PROC-DIAG-REQ-REVIEW
973	NO SURGERY MODIFIER
980	INVALID ADJ REASON
991	PROCEDURE IN PANEL
993	MID CORRECTED.

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
035	REBILL CORRECT HCPC
202	SVC NOT COVERED, MORAL/RELIG
219	EPSDT-REFER-AGE-ERR

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
222	RECIP-ELIG-DATE-OVERLAP
508	NON WAIVER PAY IP
530	SERVICE ALREADY PAID
554	DUPLICATE-SERVICES
564	MAX-SERVICE-LIFETIME
631	EPSDT-AGE-ERROR
642	1 CONSLT/PHYS/HOSP
644	VISIT CODE PD/DOS
673	EVAL & MGT PD DOS
695	HOSP DISCHARGE PAID
704	ER VISIT/INP HOS SER
712	INITIAL HOSP INPT PD
716	PROC-INCLUDED-IN-OV
735	PREV PD ANES-SAME RE
746	SAME ATTD PD IP CONS
748	1 DEL.ALLOW. 6MTH.SP
749	DEL HYST/STER CONFLI
758	FND DUP SERV SM DAY
774	INC IN RELATED SERV
776	ONGOING CM PRIOR TO
794	INPT SER PD SAME ATT
797	DUP ADJ. RECORD
798	HIST ALREADY ADJSTED
800	ON-LINE DUPE DENY
801	EXACT DUPE 01 TO 01
802	EXACT DUPE 01 TO 14
803	EXACT DUPE 02 TO 02
804	EXACT DUPE 02 TO 14
805	EXACT DUPE 03 TO 03
806	EXACT DUPE 03 TO 05
807	EXACT DUPE 03 TO 06
808	EXACT DUPE 03 TO 07
809	EXACT DUPE 03 TO 08
810	EXACT DUPE 03 TO 09
811	EXACT DUPE 03 TO 13
812	EXACT DUPE 03 TO 15
813	EXACT DUPE 04 TO 04
814	EXACT DUPE 04 TO 15
815	EXACT DUPE 05 TO 05
816	EXACT DUPE 05 TO 06
817	EXACT DUPE 05 TO 07
818	EXACT DUPE 05 TO 08
819	EXACT DUPE 05 TO 09
820	EXACT DUPE 05 TO 13
821	EXACT DUPE 05-14

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
822	EXACT DUPE 06 TO 06
823	EXACT DUPE 06 TO 07
824	EXACT DUPE 06 TO 08
825	EXACT DUPE 06 TO 09
826	EXACT DUPE 06 TO 13
827	EXACT DUPE 06-14
828	EXACT DUPE 07 TO 07
829	EXACT DUPE 07 TO 08
830	EXACT DUPE 07 TO 09
831	EXACT DUPE 07 TO 13
832	EXACT DUPE 07 TO 15
833	EXACT DUPE 08 TO 08
834	EXACT DUPE 08 TO 09
835	EXACT DUPE 08 TO 13
836	EXACT DUPE 08 TO 15
837	EXACT DUPE 09 TO 09
838	EXACT DUPE 09 TO 13
839	EXACT DUPE 09 TO 15
840	EXACT DUPE 10 TO 10
841	EXACT DUPE 10 TO 11
842	EXACT DUPE 11 TO 11
843	EXACT DUPE 12 TO 12
844	EXACT DUPE 13 TO 13
845	EXACT DUPE 13 TO 15
846	EXACT DUPE 14 TO 14
847	EXACT DUPE 15 TO 15
848	EXACT DUPE 12 TO 15
849	PD SAME ATTEN/DIF BL
898	EXACT DUPE SAME ICN
900	LIFETIME LIMITS-ONE
917	OVER LIFETIME LIMIT
926	EXACT DUPLICATE.

Appendix G

Provider Directory/Network Provider and Subcontractor Registry

CCNs will be required to provide DHH with a list of contracted providers including various data elements that are publicly available from NPPES through the Freedom of Information Act (FOIA). DHH 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.

The provider directory must include the following information:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), or the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, or 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code[4], and Country Code if outside U.S., Telephone Number, Fax Number)

[4] 9-digit Postal Code

- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)
- Panel Open (Y/N)
- Language
- Age Restriction
- PCP Linkage Maximum
- PCP Linkages with Others
- CCN Enrollment Indicator
- CCN Enrollment Indicator Effective Date
- Family Only Indicator
- Provider Sub-Specialty
- CCN Contract Name or Number
- CCN Contract Begin Date

- CCN Contract Termination Date
- Provider Parish

CCNs are required to populate the Other Provider Type Code to a DHH valid provider type code as shown in the list below:

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

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

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

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

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

Provider Specialty	Description	Associated Provider Types
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	19
18	Ophthalmology	20
19	Orthodontist	19,20
20	Orthopedic Surgery	19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	19
22	Pathology	20
23	Peripheral Vascular Disease or Surgery (DO only)	19
24	Plastic Surgery	19,20
25	Physical Medicine Rehabilitation	19,20
26	Psychiatry	19,20,93
27	Psychiatry; Neurology (DO only)	19
28	Proctology	19,20
29	Pulmonary Diseases	19,20
30	Radiology	19,20
31	Roentgenology, Radiology (DO only)	19
32	Radiation Therapy (DO only)	19
33	Thoracic Surgery	19,20
34	Urology	19,20
35	Chiropractor	30,35
36	Pre-Vocational Habilitation	13
37	Pediatrics	19,20,93
38	Geriatrics	19,20
39	Nephrology	19,20
40	Hand Surgery	19,20
41	Internal Medicine	19,20
42	Federally Qualified Health	72

Provider Specialty	Description	Associated Provider Types
	Centers	
44	Public Health	66,70
45	NEMT - Non-profit	42
46	NEMT - Profit	42
47	NEMT - F+F	42
48	Podiatry - Surgical Chiropody	20,32
49	Miscellaneous (Admin. Medicine)	20
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included in 51, 52, 53	40
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	61,62,66,67
62	Psychologist Crossovers only	29,31
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27

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

Provider Specialty	Description	Associated Provider Types
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5M	Multi-Systemic Therapy	12
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6N	Endodontist	27
6P	Periodontist	27
7A	SBHC - NP - Part Time - less than 20 hrs week	38
7B	SBHC - NP - Full Time - 20 or more hrs week	38
7C	SBHC - MD - Part Time - less than 20 hrs week	38
7D	SBHC - MD - Full Time - 20 or more hrs week	38
7E	SBHC - NP + MD - Part Time - combined less than 20 hrs week	38
7F	SBHC - NP + MD - Full Time - combined less than 20 hrs week	38
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97

CCNs must submit this information in a file layout shown below.

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

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				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	
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		10	Character	R Note: if a single NPI is

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Code 1				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 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	7	Numeric, left-fill with zeroes.	R, if provider is already

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		provider's Louisiana Medicaid Provider ID			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
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	NPPES	20	Left justify,	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Deactivation Reason Code	deactivation reason; leave blank if appropriate.		right-fill with spaces.	
440	Delimiter		1	Character, use the ^ character value	
441-448	NPI Deactivation Date	NPPES deactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
449	Delimiter		1	Character, use the ^ character value	
450-457	NPI Reactivation Date	NPPES reactivation date; leave all zeros if not appropriate.	8	Numeric, format YYYYMMDD	O
458	Delimiter		1	Character, use the ^ character value	
459	Provider Gender Code	**M**=Male, **F**=Female, **N**=Not applicable	1	Character .	R
460	Delimiter		1	Character, use the ^ character value	
461-480	Provider License Number		20	Character, left-justified, right-fill with spaces.	R
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider	2-character	2	Character	R

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients			
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	0=no other language	1	Character	O

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		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 CCN	Numeric	5	Numeric, left fill with zeroes. This number represents the maximum	R for PCPs; otherwise optional.

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				number of CCN enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a 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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
611	Delimiter		1	Character, use the ^ character value	
612-619	CCN Enrollment Indicator Effective Date	Effective date of Enrollment Indicator above.	8	Numeric, format YYYYMMDD	R
620	Delimiter		1	Character, use the ^ character value	
621	Family Only Indicator	**0**=no restrictions **1**=family members only	1		R for PCPs; otherwise optional.
622	Delimiter		1	Character, use the ^ character value	
623-624	Provider Sub-Specialty 1	Value set is determined by DHH and is available in 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	2		O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		determined by DHH and is available in CCN 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	Parish code value that	2	2-digit parish code value.	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	– 1st or primary	represents the primary parish that the provider serves		See the CCN 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 other parish that	2	2-digit parish code value. See the CCN Companion	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		the provider serves. Use only if necessary; otherwise enter 00.		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 the ^ character value	
699-700	Provider Parish served	Parish code value that	2	2-digit parish code value.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	– 7th	represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.		See the CCN Companion Guide.	
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. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the CCN Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	

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

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		otherwise enter 00.			
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	

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 CCN must enroll with EDI to receive a Trading Partner ID in order to submit electronic encounter data. In most cases, the CCNs will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the CCNs to be able to both transmit and receive.

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

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

Testing Tier II

Once each CCN has successfully passed more than 50% of their 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 CCNs via IDEX. Each CCN 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 CCNs and DHH/Mercer for evaluation as well as a MMIS edit code explanation document which details the conditions under which each edit code will post to an encounter data claim in order to assist them with their research. Molina is available to answer any questions that any CCN may have concerning the edit codes.

Testing Tier III

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

Appendix I

Websites

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

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.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

Website Address	Website Contents
	care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	This links to the **Washington Publishing Company website**. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996. They may be downloaded for free.
http://www.ansi.org	This is the **American National Standards Institute website** that 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

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