BAYOU HEALTH

Medicaid Managed Care Organizations System Companion Guide

Version 15
April 2016

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

Change Control Table

Author of Change	Section Changed	Description	Reason	Date
Darlene White	**2**	**Added sub-section for Identifying Encounters for EPSDT Non-covered Services**	**To provide instructions to MCO's for identifying these services in their encounters**	**10/2014**
Darlene White	**Appendix D**	**Added sequential column range for Taxonomy to reflect 10-digit length – 56-65**	**Correction**	**10/2014**
Darlene White	**Appendix R**	**Added Prior Authorization Data Elements Instructions and File Layout**	**To provide directions to MCO for submitting files**	**10/2014**
Darlene White	**Appendix G**	**Added list of Network Providers by Specialty Type and Taxonomy**	**To provide direction to MCO for coding of provider specialty and taxonomy for network providers**	**10/2014**
Darlene White	**Appendix S**	**Added Supplement to Fee Schedule File - includes Extract Record Layout, Sample Fee Schedule Extract, and DED**	**To provide information from DHH's Procedure Formulary that is not included in the Department's Fee Schedule**	**10/2014**
Darlene White	**Appendix G**	**Updated Error Codes for MCO Batch Electronic File Layout for PCP Linkage**		**11/2014**
Darlene White	**Appendix G**	**Added Provider Supplemental Record Layout**	**Correction – removed from Appendix J**	**11/2014**
Darlene White	**Appendix J**	**Removed Provider Supplemental Record Layout**	**Correction – added to Appendix G**	**11/2014**
Darlene White	**Appendix L**	**Added: New Region Codes; Region Code Crosswalk; and Revised MCO Capitation Codes**	**To provide new Rate Cell Codes, description, and CAP codes to MCOs.**	**11/2014**

Author of Change	Section Changed	Description	Reason	Date
Darlene White	Appendix R	Added instructions for Submitter ID's Usage Notes		11/2014
Darlene White	Section 2	Added instructions for Billing Provider's Patient Control Number		12/2014
Darlene White	Section 2	Corrected Loop and Reference for billing MCO Line Item Control Number (LICN)		12/2014
Darlene White	Section 2	Re-added naming convention for NCPDP Batch Pharmacy		12/2014
Darlene White	Section 2	Added loop for billing value code 54 for New Birth Weight.		12/2014
Darlene White	Appendix D	Added E-CP-O-90-D Report AND E-CP-O-90-E Report		12/2014
Darlene White	Appendix E	Removed expired link for 416 Reports; added current link		12/2014
Darlene White	Appendix E	Removed obsolete Report 174 FQHC/RHC Encounter File		12/2014
Darlene White	Appendix H	Added Phase to each Tier of the EDI Test Plan explanation.		12/2014
Darlene White	Appendix H	Added EDI Test Plan		12/2014
Darlene White	Appendix H	Added Schedules for Outbound files from Molina to MCO and Inbound files from MCO to Molina		12/2014
Darlene White	Appendix K	Added CCN TPL Carrier File Layout		12/2014
Dianne Griffin	Appendix F	Updated disposition of Edits 410, 414,416,417, and 860 to Deny		1/2015

Author of Change	Section Changed	Description	Reason	Date
Dianne Griffin	Cover Page	Changed version to 2.0 March 2015		2/2015
Dianne Griffin	Appendix H	Added Item 5i – Test Provider Supplemental File to EDI Test Plan		2/2015
Dianne Griffin	Section 2	Added Guidelines for submitting encounters for NEMT providers		2/2015
Dianne Griffin	Appendix D	Added PA Type 67 for NEMT to Prior Authorization File		2/2015
Dianne Griffin	Appendix K	Replaced TPL Batch Electronic File Layout. Updated document provides TPL Initiator Code Values for Field Number 9 for MCOs including Aetna and UHC		2/2015
Dianne Griffin	Appendix L	Expanded explanation of Capitation Fee Payments. Added Member Parish to Region Code Crosswalk		2/2015
Dianne Griffin	Appendix T	Added Hospice Enrollment File Layout (FI to MCO)		2/2015
Dianne Griffin	Appendix U	Added verbiage: MCO is not required to submit weekly Hospice file to FI at this time.		2/2015
Dianne Griffin	Section 2	Added instructions for submitting receive date for Historical Encounter Data		2/2015
Dianne Griffin	Appendix V	Added file layout for submitting Receive Date in Historical Encounter Data		2/2015

Author of Change	Section Changed	Description	Reason	Date
Dianne Griffin	**Appendix W**	**Added Retro Enrollment Disenrollment File Layout**		**2/2015**
Dianne Griffin	**Appendix G**	**Added Provider Type 27 (Dentist) and Provider Type 38 (School-Based Health Center)**		**3/2015**
Dianne Griffin	**Appendix X**	**Added Magellan-Provider Registry**	**To provide directive for submission of Magellan provider listing and/or any changes/updates**	**3/2015**
Dianne Griffin	**Appendix D**	**820 file – Added REF-Reference Information (5th Occurrence)**	**Directive to MCOs for reporting FMP amount.**	**3/2015**
Dianne Griffin	**Appendix Y**	**Added SRI Chisholm PA Extract Layout**	**To provide comprehensive data captured by the MCO and the FI**	**3/2015**
Dianne Griffin	**Appendix H**	**Added file exchange information for SRI Chisholm PA data to Outbound File Exchange Schedule**		**3/2015**
Dianne Griffin	**Section 2**	**Added indicators Q, F, and V to identify Value Added services in Character 1 of MCO ICN prefix**	**Directive to MCOs for submitting encounters for Value Added services**	**4/2015**
Dianne Griffin	**Appendix G Appendix J**	**Added Behavioral Health Provider Types: AC-AH; AJ-AK; Added Behavioral Health Provider Specialty/Type Codes: 5J/1; 5V/1; 5X thru 5Z/1; 8E/1,2; 8P/1; Updated description for Provider Types:**		**5/2015**

Author of Change	Section Changed	Description	Reason	Date
		08 – OAAS Case Management; 11 – Shared Living (Waiver); 13 – Pre-Vocation Habilitation – (Waiver); 21 – Third Party Billing Agent/Submitter; 22 – Personal Care Attendant Waiver; 29 – Early Steps; 39 – Speech/Language Therapist; 58 – Not Assigned; 90 – Certified Nurse-Midwife The following existing Provider types are now in use: 53 – Self-Directed/Direct Support; 56 – Prescriber ONLY for MCO; 57 – OPH Registered Nurse; 99 – Greater New Orleans Community Health Connections Added the following Provider Types: AA thru AB AI; AL thru AN; AQ thru AS; AU thru AY; BC; BI; IP; MI; MW; SP; XX	**Provided complete updated list of Provider Types and Specialties**	
Dianne Griffin	**Appendix G Appendix J**	**Added the following Provider Specialties,**		**05/2015**

Author of Change	Section Changed	Description	Reason	Date
		Sub-Specialty/Type Codes **1Q thru 1R/2** **1U/2;** **2Q/1;** **3D thru 3H/2;** **3J thru 3N/2;** **3P/1; 3Q-3S/2; 3T/1;** **3U/2;** **3W thru 3Y/1;** **4G thru 4H/1;** **4J thru 4L/1; 4M/2;** **4P/1;** **4U/1;** **4W/1;** **4Y/2;** **5I;** **5K thru 5N/1;** **5T thru 5U/1;** **5W/2;** **6T/2;** **6U thru 6W/1** **7G – 7H/2;** **7P/1;** **7R/1;** **7T/1** **7U/2** **7V/1** **7X thru 7Z/1;** **8D/1;** **8F thru 8J/2;** **8K thru 8M/1;** **8N/2;** **8O/1;** **8Q/2;** **8S/2** **9A/2;** **9F thru 9G/1;**		

Author of Change	Section Changed	Description	Reason	Date
		9M/1; 9P/1; 9R/2 9S/1; 9T/2; 9Y/1; XX/1		
Dianne Griffin	Appendix Z	Added the LEERS file Layout	Provides list of deliveries for enrollees linked to MCO	06/20/15
Dianne Griffin	Appendix AA	Psychiatric Residential Treatment Facility File Layout	Provides list of members in facility	06/20/2015
Dianne Griffin	Section 2	Updated hyperlink for 5010 transactions		06/2015
Dianne Griffin	Appendix H	Updated File Exchange Schedule – Outbound Files to include the LEERS File		06/2015
Dianne Griffin	Appendix H	Updated File Exchange Schedule – Outbound Files to include the Psychiatric Residential Treatment Facility		06/2015
Dianne Griffin	Appendix K	Removed MCO's individual Plan ID numbers from the TPL Batch Submission File Layout		06/2015
Dianne Griffin	Appendix H	Updated File Transfer Schedule – Outbound Files – to include Third Party Liability (TPL) Batch Full Reconciliation File	To provide file transfer information to the MCOs	06/15
Dianne Griffin	Appendix AB	Added Third Party Liability (TPL) Batch Full Reconciliation File Layout	To provide directive to MCOs for reconciliation of TPL information between the MCOs and DHH/FI	06/2015
Dianne Griffin	Cover Page	Updated to Version 6 for July 2015		07/2015

Author of Change	Section Changed	Description	Reason	Date
Dianne Griffin	**Appendix G**	**Updated Provider Registry File Layout to reflect changes to Prescriber Information for Columns 777-780**	**Directive for submitting Prescriber information in Registry**	**07/2015**
Dianne Griffin	**Appendix G**	**Added updated Look Up Taxonomy Table (LTX) which includes Provider Types 78 & 94; Provider Specialty 26 (for both provider types)**		**7/2015**
Dianne Griffin	**Cover Page**	**Updated version to 7.0 August 2015**		**08/2015**
Dianne Griffin	**Section 2**	**Added instructions for submitting Value Added Services – Dental - on the 837P when DX not submitted by the provider**		**08/2015**
Dianne Griffin	**Section 2**	**Added instructions for Value Added Services – Dental- on the 837 P when submitting Tooth Numbers**		**08/2015**
Dianne Griffin	**Appendix F**	**Added Encounter Edits 133, 227, 228, 229, & 555 – Disposition "O" for Behavioral Health** **Added Encounter Edit 556 with disposition "E" for Behavioral Health (NOTE: Disposition to be changed to "D" effective 10-20-2015)**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Appendix F**	**Added Behavioral Health Encounter Edits 133, 227, 228, 229, & 555 to Non-Repairable Edits Table**	**Effective 12-1-2015 for Behavioral Health**	**08/20/15**

Author of Change	Section Changed	Description	Reason	Date
Dianne Griffin	**Appendix F**	**Updated disposition for Edit 735 from "D" to "O"**		**08/2015**
Dianne Griffin	**Appendix W**	**Corrected file name to BYU Retro Cancellations/Closures File Layout**		**08/2015**
Dianne Griffin	**Appendix H**	**Added BYU Cancellations/Closures File to Outbound File Exchange Schedule**		**08/2015**
Dianne Griffin	**Appendix H**	**Added Magellan Prior Authorization File from FI to MCO to Outbound File Exchange Schedule NOTE: Frequency TBD**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Appendix H**	**Added Magellan Prior Authorization File from Magellan to FI to Inbound File Exchange Schedule NOTE: Frequency TBD**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Appendix AC**	**Added Behavioral Health Provider Types, Provider Specialties, and Taxonomy** **Includes NEW Provider Types "AT" – Therapeutic Group Home; and "AZ" – Substance Use Residential**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Appendix AD**	**Added Magellan Prior Authorization (PA) File Layout and instructions**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**
Dianne Griffin	**Section 2**	**Added MCO and Medicare Unique DHH Carrier Code Assignments**	**Effective 12-1-2015 for Behavioral Health**	**08/2015**

Author of Change	Section Changed	Description	Reason	Date
Dianne Griffin	**Cover Page**	**Updated version to: v8.0 September 2015**		**09/2015**
Dianne Griffin	**Section 1**	**Updated Medicaid Deputy Director and contact information**		**09/2015**
Dianne Griffin	**Appendix F**	**Changed BH edit codes from 227, 228, & 229 to 425,426 & 456 respectively.** **Added Edit Code 507 Submit Claim to BYU Plan**	**Effective 12-1-2015 for Behavioral Health**	**09/2015**
Dianne Griffin	**Appendix F**	**Added Edit Code 507 to (Submit Claim to BYU Plan) to Non-Repairable Edits List**	**Effective 12-1-2015 for Behavioral Health**	
Dianne Griffin	**Appendix F**	**Added Edit 556 (Attending Servicing Provider Not Linked to Bayou Health Plan) to Edits Repairable Under Limited Circumstances Table**	**Effective 12-1-2015 for Behavioral Health**	**09/2015**
Dianne Griffin	**Appendix J**	**Added Claim Type Table**		**09/2015**
Dianne Griffin	**Section 3**	**Added statement from discussion with CMS regarding their agreement to/for reporting encounter files on the Encounter Data Certification Form based on CFR**§438.606		**09/2015**
Dianne Griffin	**Appendix L**	**Added Member Border Cities by Zip Code to Parish/Region Code Crosswalk**		**09/2015**
Dianne Griffin	**Appendix W**	**Updated naming convention for Retro Cancellation/Closure**		**09/2015**

Author of Change	Section Changed	Description	Reason	Date
		File to PPLANID_YYYYMM.TXT		
Dianne Griffin	Section 2	Added instructions for submitting CMS approved modifiers for NEMT Services	Implementation date TBD	09/2015
Dianne Griffin	Appendix H	Updated File Naming Convention for Retro Cancellation/Closure File to PPLANID_YYYYMM.TXT on Out Bound File Exchange Schedule		09/2015
Dianne Griffin	Appendix AA	Removed spaces between item numbers in Psychiatric Residential Treatment Facility File Layout		09/2015
Dianne Griffin	Appendix J	Added Parish 65 to Parish Codes		09/2015
Andrea Hollins	Appendix AD	Updated Magellan PA File Layout		10/2015
Andrea Hollins	Appendix H	Updated Schedules for Outbound files from Molina to MCO and Inbound files from MCO to Molina		10/2015
Andrea Hollins	Appendix K	Updated TPL Batch electronic file layout	Removed field numbers 55 and 56	10/2015
Andrea Hollins	Section 2	Added instructions for Value Added Services – Dental- when submitting Tooth Numbers		10/2015
Andrea Hollins	Cover Page	Updated Version to 9.0 October 2015		10/2015
Andrea Hollins	Appendix F	Removed BH edit codes 425,426 & 456		10/2015
Andrea Hollins	Appendix F	Removed Edit Code 507 (Submit Claim to BYU Plan)		10/2015
Andrea Hollins	Appendix F	Changed the Effective date for		10/2015

Author of Change	Section Changed	Description	Reason	Date
		Edit 556 (Attending Servicing Provider Not Linked to Bayou Health Plan) to 11/3/2015		
Andrea Hollins	**Appendix D**	**Added Provider Type 17 indicator to Prior Authorization File FI to MCO layout**	**Molina sends PA type 17 in the weekly MCO PA file but it was not reflected in the layout**	**11/2015**
Yolanda Chanet	**Appendix Y**	**Remove The SRI-Chisholm-PA-YYYYMMDD file**	**Removed because it was a onetime file sent to BYU in Jan. 2015. It is not a recurring file.**	**11/2015**
Yolanda Chanet	**Appendix F**	**Update: removed 001, 013, 138, 248. Change to E 011, 092, 182, 232. Change to D 022, 026, 028, 041, 042, 053, 055, 060, 068, 077, 084, 085, 087, 089, 093, 095, 097,098, 113, 114, 115,126,132, 136, 141,149,231, 234, 235, 236, 254, 255, 263, 268**	**Update the Encounter Edit code list**	**11/2015**
Yolanda Chanet	**Section 3**	**Encounter Data Certification Text addition**	Update	**11/2015**
Yolanda Chanet	**Appendix Z**	**Name Change**	Change file name to DHH_LEERS_EXPD	**11/2015**
Yolanda Chanet	**Appendix H**	**Name change on Outbound File Exchange Schedule**	Change file name to DHH_LEERS_EXPD	**11/2015**
Yolanda Chanet	**Appendix Y**	**Added Chisholm File Layout for CSOC**	Used Appendix for to Chisholm File Layout for CSOC	**11/2015**
Yolanda Chanet	**Section 2**	**Value Added Services: Added verbiage: ICD-10 diagnosis code Z01.20**	Added info	**11/2015**
Andrea Hollins	**Cover Page**	**Updated Version to 11.0 December 2015**		**12/2015**
Andrea Hollins	**Appendix F**	**Updated edit 556**	Disposition changed to D Effective 3/31/16	**12/2015**

Author of Change	Section Changed	Description	Reason	Date
Andrea Hollins	**Appendix D**	**Updated Prescriber Indicator**	Update	**12/2015**
Andrea Hollins	**Cover Page**	**Updated Version to 11.1 December 2015**	Changes made after the monthly release	**12/2015**
Andrea Hollins	**Appendix G**	**Updated Provider Supplemental File Layout**	Removed prior Provider Supplemental File Layout and Added the UPDATED Provider Supplemental File Layout Implementation Date determined to be 3/7/2016	**12/2015**
Andrea Hollins	**Appendix L**	**MCO Capitation Codes**	Updated MCO Capitation codes for NEMT and SBH Effective Date 12/1/2015	**12/2015**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule**	Incorporated the PIHP/CSoC Outbound/Inbound File Schedule into the MCO Schedule	**12/2015**
Andrea Hollins	**Appendix F**	**Encounter Edit Codes – Comprehensive List**	Edit 275 changed from 'D' to 'E'	**12/2015**
Andrea Hollins	**Appendix Q**	**Louisiana Health Information Exchange**	Changed LaHIE to Pharmacy Encounters Supplemental File	**12/2015**
Andrea Hollins	**Appendix Q**	**Added Pharmacy Encounters Supplemental File Layout**	Added the Pharmacy Encounters Supplemental File Layout…**Appendix Q** Implementation Date determined to be 2/15/2016	**12/2015**
Andrea Hollins	**Appendix Q**	**Louisiana Health Information Exchange**	Changed Appendix letter to "R"	**12/2015**
Andrea Hollins	**Appendix R**	**Prior Authorization Requests Data Elements**	Changed Appendix letter to "S"	**12/2015**
Andrea Hollins	**Appendix S**	**Supplement to Fee Schedule**	Changed Appendix letter to "T"	**12/2015**
Andrea Hollins	**Appendix T**	**Hospice Enrollment File Layout**	Changed Appendix letter to "U"	**12/2015**
Andrea Hollins	**Appendix U**	**Hospice Linkage Information File Layout**	Changed Appendix letter to "V"	**12/2015**
Andrea Hollins	**Appendix V**	**Receive Data for Historical Encounter Data File Layout**	Changed Appendix letter to "W"	**12/2015**
Andrea Hollins	**Appendix W**	**Retro Cancellation/Closure File Layout**	Changed Appendix letter to "X"	**12/2015**

Author of Change	Section Changed	Description	Reason	Date
Andrea Hollins	**Appendix X**	**Magellan Provider Registry**	Changed Appendix letter to "Y"	**12/2015**
Andrea Hollins	**Appendix Y**	**Chisholm Electronic File Layout for CSoC Information**	Changed Appendix letter to "Z"	**12/2015**
Andrea Hollins	**Appendix Z**	**LEERS File Layout**	Changed Appendix letter to "AA"	**12/2015**
Andrea Hollins	**Appendix AA**	**Psychiatric Residential Treatment Facility File Layout**	Changed Appendix letter to "AB"	**12/2015**
Andrea Hollins	**Appendix AB**	**Third Party Liability (TPL) Batch Full Reconciliation File Layout**	Changed Appendix letter to "AC"	**12/2015**
Andrea Hollins	**Appendix AC**	**Behavioral Health Provider Types, Specialties, and Taxonomy**	Changed Appendix letter to "AD"	**12/2015**
Andrea Hollins	**Appendix AD**	**Magellan Prior Authorization (PA) File Layout**	Changed Appendix letter to "AE"	**12/2015**
Andrea Hollins	**Appendix D**	**Provider File FI to MCO**	Added three (3) new Prescriber Indicators Column 490 6 = CCN Prescriber (see PT=56) 7 =EHR Incentive Program 8 = No Prescriptive Authority	**12/2015**
Andrea Hollins	**Appendix L**	**MCO Capitation Codes**	Removed Column 1 Combined Category of Aid Code	**12/2015**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule**	Added the RECIPIENT_WEEKY_RETRO_YYYYMMDD.ZIP FILE and supporting information to the Outbound File Exchange.	**01/2016**
Andrea Hollins	**Appendix K**	**Third Party Liability Batch File Submission and File Layout**	Add TPL Resource File – Medicare Coverage Additions/Updates	**01/2016**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule**	Added the CSoC Monthly 820 file information in the Outbound File Schedule. Name of file: CAP-2177141-YYYMMDD-CSOC.txt	**01/2016**
Andrea Hollins	**Cover Page**	**Updated Version to 13.0 February 2016**		**02/2016**
Andrea Hollins	**Appendix K**	**Third Party Liability Batch File Submission and File Layout**	Add Rules for Processing TPL Records	**02/2016**

Author of Change	Section Changed	Description	Reason	Date
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule – Outbound**	Added 3 return files: WEEKLY_RECIP_RECON_RESP_{DAILY 8}.TXT; WEEKLY_RECIP_RECON_REPT_{DAILY 8}.TXT; WEEKLY_RECIP_RECON_REPT_FILE_{DAILY8}.TXT .	**02/2016**
Andrea Hollins	**Appendix H**	**Master File Exchange Schedule – Inbound**	Stola_Molina_Recon_YYYYMMDD.TAB	**02/2016**
Andrea Hollins	**Appendix L**	**MCO Capitation Codes**	New Cap Codes for Foster Care Children, SBH, HCBS, LAP effective 02/01/2016	**02/2016**
Andrea Hollins	**Appendix G**	**Provider Supplemental File**	9-18 NPI 20-26 Managed Care Medicaid Assigned ID	**02/2016**
Andrea Hollins	**Appendix AF**	**17P Pre-Term Birth History File Layout**	Added new 17P Pre-term Birth History File Layout: 2 new fields added to the end of each record to designate the Measurement Year	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	042, 056, 070 - Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, DHH decided edit 042, 056, 070 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Note added: If you receive an empty response file, then that is an indication that all records on the submitted file are accepted with no errors.	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Added plan ICN to end of error file, field 24. See Part 2 information.	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Note Added: So, the 2nd compound segment may experience edits 090 through 094; the 3rd compound segment may experience edits 095 through 099, etc.	**02/2016**
Andrea Hollins	**Appendix F**	**Edit Disposition**	615, 622, 689, 705, 727, 740, 774, 802, 813, 815, 832, 842, 851, 852, 862, 864, 896, 897, 899, 906, and 926 (effective May 9, 2016	**02/2016**
Andrea Hollins	**Appendix F**	**Edit Dispositions**	Removed Change and Effective date columns (per Bryan Hardy, Krystal Berthelot, and Kerri Capello)	**02/2016**

Author of Change	Section Changed	Description	Reason	Date
Andrea Hollins	**Appendix G**	**Provider Registry File Layout**	Added R description; required when the Provider has a License, otherwise optional	**02/2016**
Andrea Hollins	**Appendix Q**	**Pharmacy Encounter Supplemental File**	Field 37 “flat tax field” PAID: Should be $0.10 since the provider fee should be paid on every claim to the pharmacy whether it is billed or not. If the MCO is a secondary payer however, only then would a zero would be acceptable in this field.	**03/2016**
Andrea Hollins	**Appendix F**	**Edit Disposition**	306, 316, 317, 328, 330, 332, 334, 336, 337, 338, 340, 351, 390, 400, 402, 405, 408, 429, 490, 492, 522, 523, 532, 539, (effective March 1, 2016)	**03/2016**
Andrea Hollins	**Appendix J**	**Provider Type**	Added AT, AZ	**03/2016**
Andrea Hollins	**Appendix J**	**Provider Specialty, Sub-Specialty**	Added Specialties 8U, 8R, 6B, 6C, 6G	**03/2016**
Andrea Hollins	**Appendix G**	**Provider Supplemental File Layout Error Codes**	Error Codes (A=Accepted, R=Rejected): 000=(A) No errors found 001=(R) Missing/Invalid NPI 003=(R) Provider record must include taxonomy 004=(R) Numeric field contains characters 005=(R) Invalid Ownership Code. Must be 01-19,88. 006=(R) Invalid Business Email Address format. Must contain "@" and ".". 007=(R) Invalid Physical Location Email Address format. Must contain "@" and ".". 009=(R) Invalid Plan ID 010=(R) Invalid License Type (must be 1,2,3,4,5.) 011=(R) Missing License or Accreditation Number 012=(R) Missing License Issuing ID 013=(R) Invalid License Effective Date 014=(R) Invalid License End Date or License End Date before License Effective Date 015=(R) Invalid MCO Enrollment Begin Date 016=(R) Invalid MCO Enrollment End Date or MCO Enrollment End Date before MCO Enrollment Begin Date	**03/2016**

Author of Change	Section Changed	Description	Reason	Date
			017=(R) Invalid MCO Enrollment Termination Code 018=(R) Invalid FIPS State or Parish 022=(R) Medicaid Assigned ID was not found on Provider Registry File 023=(R) Invalid Date of Birth Date 029=(R) Provider does not exist on Provider Registry 030=(R) Duplicate record was submitted	
Andrea Hollins	**Appendix H**	**File Exchange Schedule**	Add LEERS 17P Birth History File incoming and outgoing	**03/2016**
Andrea Hollins	**Appendix K**	**TPL**	Changed “weekly” to “daily “	**03/2016**
Andrea Hollins	**Section 2**	**Batch File Limitations**	A limit of 5,000 records is recommended; total of 120,000 encounters can be sent per day	**04/2016**
Andrea Hollins	**Appendix H**	**File Exchange Schedule**	Add LEERS Elective delivery file Layout (outbound)	**04/2016**
Andrea Hollins	**Appendix AG**	**LEER Elective Delivery File Layout**	Expanded LEER file layout	**04/2016**
Andrea Hollins	**Section 2**	**Dental**	Added Batch File Limitations	**04/2016**

Table of Contents

SECTION 1 1

Overview 1
- Introduction 1
- Encounter Data 1
- Purpose of Encounter Data Collection 1

DHH/Contractor Responsibilities 2
- DHH Responsibilities 2
- Fiscal Intermediary Responsibilities 2
  - Accepting and Storing Encounters 2
  - Technical Assistance 2
  - X12 Reporting 2
  - Proprietary Reports and Files 3
- Enrollment Broker Responsibilities 3
  - 834 X12 Transaction File 3
- Managed Care Organization (MCO) Responsibilities 3
  - Implementation 3
  - Encounter Submissions 3
  - File Exchanges 4

SECTION 2 5

Encounter Data Instructions 5
- Introduction 5
- EDI Validation 5
- *BHT06* *5*
- Submission of 837s with TPL 5
- Identifying Encounters for Non-covered EPSDT Services 6
- Batch File Limitations 6
- Provider Identifiers 6
- Atypical Providers 7
  - Non-Emergency Medical Transportation (NEMT) 7
- Billing Provider's Patient Control Number 9
- File Naming Conventions 10
- Encounters for Claims with Multiple Lines 11
- Molina ICN Format 11
- MCO ICN Format 12
- Encounter Reporting of Financial Fields 12
  - *Submitted Charge Amount* *12*
  - *MCO Paid Amount* *12*
  - Adjustment Amount 13
  - Interest Paid Amount 13

Claim Received Date 13
Historical Encounter Data 13
Adjustment Process 14
Line Adjustment Process 14
Additional Encounter Requirements 16
Newborn Birth Weight 16
Billing for Newborns 16
Category II CPT Codes 16
Transformed Medicaid Statistical Information System (T-MSIS) 16
Value Added Services 17
Dental 17

SECTION 3 18

Electronic Data Interchange (EDI) Certification and Testing 18
Introduction *18*
EDI Protocols *18*
MCO EDI Submitter Enrollment and Testing 18
Timing *19*
Encounter Processing Flow 19
Encounter Data Certification 20

SECTION 4 21

Data Management of File and Encounter Submissions 21

Introduction 21
File Rejection and Encounter Denial 21
EDI File Encryption Level (Entire File) 21
TA1 Level *21*
999 Level (Entire File) 22
Pre-processor Level (Entire File) 22
Correction of File and Encounter Errors 22
Entire File Rejection 22
Individual Record Denial 23
EDI Resolution *23*
EDI Dispute Resolution 23

SECTION 5 24

Denial Edit Codes and Descriptions 24
Introduction *24*
Encounter Edit Reports 24

SECTION 6 25

Continuous Quality Improvement 25
Introduction *25*
Minimum Standards 25
Repairable Denials 25
Data Volume Assessment 25

SECTION 7 26

Medicare Recovery Process 26

SECTION 8 27

Medicaid Administrative Retroactive Enrollment Correction Process 27

APPENDIX A 29

Definition of Terms 29

APPENDIX B 41

Frequently Asked Questions 41

APPENDIX C 43

Code Sets 43

APPENDIX D 45

System Generated Files and Reports 45
Encounter Claims Summary 46
Encounter Edit Disposition Summary 51
Edit Code Detail 55
Provider File *64*
Provider Rates File 73
820 File *77*

Prior Authorization File 89
Diagnosis File for Pre-Admission Certification 95

Procedure File for Prior Authorization 96
CLIA File 98
Quality Profiles Submission File 100
Denied Encounter Error Analysis – E-CP-O-90-D 110
Encounter EOB Analysis – E-CP-O-90-E 112

APPENDIX E 114

MCO Generated Reports 114
416 Reports *114*
Denied Claims Report 115

APPENDIX F 117

Encounter Edit Codes 117
Encounter Edits Listing, Comprehensive 118
Repairable Edits *134*
Non-Repairable Edits 138

APPENDIX G 141

Provider Directory/Network and Subcontractor Registry 141
Provider Types *142*
Provider Specialty Types 146
Provider Registry File Layout 158
Provider Registry Edit Report (sample) 177
Provider Registry Edit File Layout 181
Provider Registry Site File 183
Site File Format *184*
Error File Format *189*
Primary Care Physician (PCP) Linkage Directory 190
MCO Batch Electronic File Layout for PCP Linkage 191
Lookup Taxonomy Table (LTX) 196
Provider Supplemental Record Layout 215

APPENDIX H 233

EDI Test Plan and File Exchange Schedule 233
EDI Test Plan *233*
Tier I – Registration and Credentialing Phase 233
Tier II – Claims Testing Phase 234
Tier III – Production Phase 234
MCO EDI Test Plan - Tier I, II, & III 235

File Exchange Schedule **241**

APPENDIX I **256**

Helpful Websites **256**

APPENDIX J **260**

Common Data Element Values **260**
- **Types of Service (TOS)** 260
- **Category of Service (COS)** 262
- ***Provider Type*** *266*
- **Provider Specialty, Sub-Specialty** 271
- **Louisiana Medicaid Claim Type Codes** 283
- **Louisiana Medicaid Region Codes** 283
- **Louisiana Medicaid Parish Codes** 284
- **Louisiana Medicaid Pricing Action Code (PAC)** 287

APPENDIX K **288**

Third Party Liability (TPL) Batch File Submission and File Layout **288**
- TPL File Layout to Plan 297
- Scopes of Coverage *299*
- TPL Carrier Code File Layout 301

APPENDIX L **302**

Capitation Fee Payments **302**
- MCO Capitation Codes 302
- Member Category of Aid (COA) 303
- Member Region Code (RC) 304
  - *New 4-Region Codes* *304*
  - 9-Region to 4- Region Code Crosswalk 304
  - Member Parish to Region Code Crosswalk 305
  - Member Border Cities by Zip Code to Parish/Region Code Crosswalk 309
- Louisiana Medicaid Recipient Aid Category Codes 310
- Louisiana Medicaid Recipient Type Case Codes 312

APPENDIX M **319**

Claims Summary Report **319**

APPENDIX N **320**

Encounter Processing Flow **320**

APPENDIX O **321**

Encounter Data Certification Form **321**

APPENDIX P **324**

Batch Pharmacy Encounters Companion Guide **324**

APPENDIX Q **325**

Pharmacy Encounters Supplemental File Layout **325**

APPENDIX R **344**

Louisiana Health Information Exchange (LaHIE) **344**

LaHIE Interface *344*

APPENDIX S **345**

Prior Authorization Requests Data Elements **345**

APPENDIX T **349**

Supplement to Fee Schedule **349**

APPENDIX U **363**

Hospice Enrollment File Layout **363**

APPENDIX V **364**

Hospice Linkage Information File Layout 364

APPENDIX W **365**

Receive Date for Historical Encounter Data File Layout 365

APPENDIX X **366**

Retro Cancellation/Closure File Layout 366

APPENDIX Y **367**

Magellan Provider Registry 367

APPENDIX Z **373**

Chisholm Electronic File Layout for CSOC Information 373

APPENDIX AA **375**

LEERS File Layout 375

APPENDIX AB **380**

Psychiatric Residential Treatment Facility File Layout 380

APPENDIX AC **382**

Third Party Liability (TPL) Batch Full Reconciliation File Layout 382

APPENDIX AD **384**

Behavioral Health Provider Types, Specialties, and Taxonomy 384

APPENDIX AE **388**

Magellan Prior Authorization (PA) File Layout 388

APPENDIX AF 399

LEER 17P Preterm Birth History FILE LAYOUT 399

APPENDIX AG 405

LEER Elective Deliveries FILE LAYOUT 405

Section 1 Overview

Introduction

This document provides further guidance to Managed Care Organizations (MCO), in addition to the Request for Proposal (RFP), regarding DHH requirements for storing, submitting and reporting Encounter Data.

Encounters include paid and denied services for Medicaid members. The MCO is 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 Data

Encounters are defined as a distinct set of health care services provided to a Medicaid member enrolled with an MCO on the dates that services were delivered.

Health care encounter data includes:

- All data captured during the course of a single health care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter;
- The identification of the member receiving and the provider(s) delivering the health care services during the single encounter; and,
- A unique, i.e. unduplicated, identifier for the single encounter.

An encounter is comprised of the following components:

- Procedure(s) and/or services rendered during the contract
- Services paid as fee-for-service (FFS)
- Services paid under a capitated provider arrangement

The MCO must report all services (paid or denied), including services paid at $0, that are covered under the MCO Contract.

Purpose of Encounter Data Collection

Collecting complete and valid encounter data is vital to DHH, as it is utilized for the following purposes:

- Contract requirements compliance
- Rate Setting
- Quality Management and Improvement

DHH/Contractor Responsibilities

DHH Responsibilities

DHH is responsible for administering the State's Bayou Health MCO Program. Collection of encounter data is an instrumental tool in that administrative effort. Administration includes:

- Data analysis
- Productive feedback
- Comparative reports to MCOs
- Data confidentiality
- Maintaining the MCO System Companion Guide

Written questions or inquiries about the Guide must be directed to:

Bill Perkins	**Medicaid Deputy Director**
Telephone	225-342-8935
E-mail	Bill.Perkins@LA.GOV

DHH is responsible for the oversight of the Contract and MCO activities. DHH Encounter responsibilities include:

- Production and dissemination of the System Companion Guide
- Initiation and ongoing discussion of data quality improvement with each MCO
- MCO training

Fiscal Intermediary Responsibilities

The FI is under contract with DHH to provide Louisiana Medicaid Management Information System (MMIS) services to the MCOs. The FIs responsibilities include:

Accepting and Storing Encounters

Accepting, editing, and storing encounter data in the 837 and NCPDP formats received from the MCO.

Technical Assistance

The FI is required to provide technical assistance to the MCO during the EDI 837 and NCPDP testing process. The testing process can be found in **Section 3**. Additionally, **Appendix H** of this Guide provides the FI's complete step-by-step process for testing.

X12 Reporting

- 999 – Files containing syntactical errors in segments and elements are reported in the 999 Functional Acknowledgements.
- TA1 – The TA1 report is generated and utilized to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.

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

Proprietary Reports and Files

The FI is required to provide MCOs with proprietary MMIS Reports. The following reports and file formats are located in **Appendix D** of this Guide:

- Encounter Claims Summary
- Encounter Edit Disposition Summary
- Edit Code Detail
- Claims Processing Flowchart
- Provider File
- Provider Rates File
- 820 File
- Prior Authorization File
- Diagnosis File for Pre-Admission Certification
- Procedure File for Prior Authorization
- Quality Profiles Submission File

Enrollment Broker Responsibilities

834 X12 Transaction File

On a daily, weekly, and monthly basis the Enrollment Broker is required to make available to MCOs, via 834 X12 transactions, updates on members newly enrolled, disenrolled, or with demographic changes. In addition, at the end of each month, the Enrollment Broker is required to reconcile enrollments and disenrollments with a full 834 X12 Transaction File.

Managed Care Organization (MCO) Responsibilities

Implementation

Within sixty (60) days of operation, the MCO's System shall be ready to submit encounter data to DHH's Fiscal Intermediary.

Encounter Submissions

- The MCO is responsible for ensuring accurate and complete encounter reporting from their providers.
- The MCO must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction.
- The MCO must investigate the findings of encounter denials and be prepared to explain the underlying reasons for the identified encounter data quality issue(s).
- As encounter data issues are discussed, the MCO must incorporate corrective action steps into the Encounter Data 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 the following:

- Listing of each outstanding issue(s)
- Name of responsible party
- Projected resolution date

File Exchanges

The MCO must 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.

Section 2

Encounter Data Instructions

Introduction

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. Instructions are provided in detail in Implementation Guides (IGs), which define how each loop, segment and data element in a specified transaction set is used.

- The formats used for DHH are the 837I (Institutional) and 837P (Professional) Provider-to-Payer-to Payer Coordination of Benefits (COB) Model as defined in the HIPAA IGs, and NCPDP Batch Pharmacy 1.1 D.0.
- Detailed instructions on how to map encounters from the MCO's System to the 837 transaction can be found in the 837 Implementation Guide (IGs).
- MCOs shall create their 837 transactions for DHH using the HIPAA IG for Version 5010.
- The ANSI ASC X12N 837 Healthcare Claim Transactions- Institutional(I) and Professional(P) Companion Guide is intended for trading partner use in conjunction with the ANSI ASC X12 National Implementation Guide.

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

EDI Validation

DHH's FI provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 formats. The FI HIPAA Companion Guides can be found at www.lamedicaid.com or www.lmmis.com. The Guides may be accessed by selecting HIPAA Information Center from the left-hand menu of the site.

BHT06

The BHT06 is used to indicate the type of billed service being sent:

- Fee-for-Service (claim)
- Encounter

The ST-SE envelope must contain encounters only, and a value of "RP" must be used. If the "RP" value is not used when sending encounters, the entire batch of encounters will be rejected, or the batch will be processed as claims which will result in the denial of each claim.

Submission of 837s with TPL

- DHH requires the MCO to submit the Provider-to-Payer-to-Payer COB Model of the 837. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are the 2320 (Other Subscriber Information), 2330B (Other Payer information) and 2430 (Service Line Adjudication Information). In the first set of COB loops, the MCO will be required to include information about the SMO provider claim adjudication. In the first set of COB data, the MCO shall place their unique DHH carrier code in

loop 2330B, NM109. If there is Medicare TPL, the MCO shall place Medicare's unique DHH carrier code, 999999, in the second set of COB loops. The MCO shall provide DHH with any third-party payments, in subsequent COB loops, the MCO must include the DHH carrier code of the other payer in loop 2330B NM109. There can be only one single subsequent loop per unique payer.

BYU Plan and Medicare Unique DHH Carrier Code Assignment

- Plan Name:
- ACLA Assigned Carrier Code: 999991
- AMG Assigned Carrier Code: 999992
- LHC Assigned Carrier Code 999993
- UHC Assigned Carrier Code 999994
- AETNA Assigned Carrier Code 999995

- **Medicare Assigned Carrier Code: 999999**

Identifying Encounters for Non-covered EPSDT Services

MCO must identify EPSDT services that may be authorized by the MCO, but is a non-covered service by Medicaid. When billing these services, MCO must bill via 837P v5010, Loop 2400. Service line SV1-11 (EPSDT-Indicator) value must be 'Y".

Batch File Limitations

The MCO Plan may submit up to 99 batch encounter files per day. Each file can include up to 20,000 encounter records, but a limit of 5,000 records per file is recommended. Up to a total of 120,000 encounters can be sent per day. The daily cutoff is at 12:00 (noon) Central; so the EDI daily limits are calculated from 12:01 PM to 12:00 PM. The combined total for Saturday and Sunday should not exceed 150,000. If more than the 150,000 per day limit is needed, then the MCO Plan shall establish a submission schedule with the Molina EDI department.

MCOs may not submit Pharmacy batch encounters to the FI on Thursdays, but can submit on all other days.

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

Provider Identifiers

The MCO is required to submit the provider's NPI, Taxonomy Code and 9-digit zip code in each encounter. If the last four (4) digits of the zip code are unknown, then the MCO may substitute "9999".

Atypical Providers

Non-Emergency Medical Transportation (NEMT)

The MCO is required to follow the guidelines below for submitting encounters for NEMT claims:

1. For Text Based NEMT Claims, use the Billing Provider Internal Control Number (ICN) populated on the text based claim in Loop 2300 CLM01 segment of the 837.

2. NEMT text claims submitted without a Billing Provider Internal Control Number shall use "NOT SUPPLIED" in the CLM01 field of the 837.

3. Encounters for Electronic and Web-based claims submitted by an NEMT provider shall use the following guidelines:
   a. The Plan ICN length can be up to 30 characters.

   b. The first four Plan ICN characters shall use the following codes:
      Character 1: Claim Submission Media Type
      P = Paper Claim
      E = Electronic Claim
      W = Claim submitted over a web portal
      If other characters are submitted, the Plan shall provide a data dictionary.

      Character 2: Claim Status
      P = Paid Claim
      D = Denied Claim
      If any other characters are submitted, the Plan must provide a data dictionary.

      Characters 3-4: Vendor Information
      Each MCO must provide a data dictionary to indicate the vendor or organization that adjudicated the claim.

   c. A unique Plan ICN is to be populated for each service line in Loop 2400 REF*6R.

4. Modifiers Specific to NEMT Encounters
   For NEMT service claims, the MCOs should report an origin and destination modifier for each NEMT trip. Origin and destination modifiers used for NEMT services are created by combining two alpha characters. Each alpha character represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

   D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
   E = Residential, domiciliary, custodial facility (other than 1819 facility);
   G = Hospital based ESRD facility;
   H = Hospital;
   J = Freestanding ESRD facility;
   N = Skilled nursing facility;

P = Physician's office;
R = Residence;

While combinations of these items may duplicate other HCPCS modifiers, when billed with a NEMT code, the reported modifiers can only indicate origin/destination.

Billing Provider's Patient Control Number

The MCO is required to send the Patient Control Number value from the Billing Provider's Claim record as the Loop 2300 CLM01 value in the associated encounter record.

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

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

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

File Naming Conventions

Encounter files must be submitted using the following file extensions:

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

Encounters for Claims with Multiple Lines

The MCO is required to bill encounters with multiple claim lines at the document level. The following claim types billed for the same recipient, same billing provider, and same date of service must be billed as one (1) encounter in Loop 2300. The FI's system assigns an ICN (Internal Control Number) including a 2-digit line item number at the header level. Subsequent lines will be assigned the same ICN with sequential line item numbers.

CLAIM TYPE DESCRIPTION	CLAIM TYPE
Outpatient Hospital	03
Professional	04
Rehab	05
Home Health	06
Transportation	07
Non-Emergency Transportation	08
DME	09

Molina ICN Format

The format of the Molina ICN is as follows:

- Digit 1 =Last digit of year of receipt
- Digit 2-4 =Julian date of the year of receipt
- Digit 5 =Media code
  - 0=Paper
  - 1=EDI or Electronic Claim
  - 2=Paper Adjustment
  - 3=System Void
  - 4=Void
  - 5=Paper Claim with Attachment
- Digits 6-8 =3-digit Batch Number
- Digits 9-11 =3-digit Sequential Number in Batch
- Digits 12-13=Claim Line Number

MCO ICN Format

The MCO's ICN must be populated in Loop 2400 REF*6R (Line Item Control Number) segment. The maximum number of characters that the FI can store is 30, which includes the 4-digit prefix. The ICN that the MCO transmits in this segment is echoed back to the submitter in the 835. This permits the MCO to use the value in this field as a key in their system to match the encounter back to the information returned in the 835 transaction.

DHH requires MCOs to modify their ICN to contain a 4-digit prefix as follows:

Character 1 - Claim Submission Media Type

- **"P"** to indicate submission of claim via paper form
- **"Q"** to indicate submission of a value added service via paper form
- **"E"** to indicate submission of claim via electronic submission
- **"F"** to indicate submission of value added service via electronic submission
- **"W"** to indicate the submission of claim via web portal
- **"V"** to indicate the submission of value added service submitted via web portal

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

Character 2: Claim Status

The MCO, and/or sub-contractor, must indicate the status of the claim for this character position as follows:

- **"P"** for paid encounters
- **"D"** for denied encounters

Character 3-4: Vendor (Sub-contractor) Information

The MCO determines a two character code for each of its vendors. The MCO must provide DHH with a Data Dictionary to identify the two character code and the full name of the vendor it represents. As vendors are added or deleted, DHH must be furnished with an updated Data Dictionary.

Encounter Reporting of Financial Fields

DHH requires MCOs to report the following financial fields at the Header and Line Item:

Submitted Charge Amount

MCOs are required to report the provider's charge or billed amount; even when the amount is zero dollars.

MCO Paid Amount

If the MCO paid the provider for the service, the Paid Amount shall reflect the amount paid. If the service was not covered by the MCO or was covered under a capitation arrangement, zero ("$0") is the appropriate paid amount. The MCO paid amount is stored in the encounter in the same fields as a Third Party Liability (TPL) amount.

Adjustment Amount

If the paid amount reflects any adjustments to the submitted line item Charge Amount, then the adjustment amounts must be reported. If the Charge Amount does not equal the Paid Amount, the MCO 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.

Interest Paid Amount

Interest Paid by the MCO is required to be submitted in the Claim Interest Amount along with the Paid Date in 837P and 837I Encounter Data.

In the Claim Interest set of COB Loops, a value in INT99X format will be used (instead of using the MCO's unique DHH Carrier Code – 99999x) where the last digit is the same last digit from the Plan's unique DHH Carrier Code value.

- For Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2320 using CAS02 value 225. The interest Paid Amount will also be sent in AMT02 of the Loop 2320 AMT*D segment. The Interest Paid Date will be sent in Loop 2330B DTP*573 Segment.
- For non-Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in CAS03 of Loop 2430 using CAS02 value 225. The Interest Paid Amount will also be sent in Loop 2430 SVD02. The Interest Paid Date will be sent in the Loop 2430 DTP*573 Segment.

Claim Received Date

The MCO is required to submit the MCOs Claim Received Date in 837P and 837I encounter data. The Claim Received Date will be sent in Loop 2300 in the REF*D9 segment using date format **yyyymmdd**.

Historical Encounter Data

Below are the instructions for determining the receive date for historical encounter data:

1. Original Encounters
    - For original encounter records, the plan received date value should be the date that the MCO received the claim record from the billing provider.

2. Adjustment Encounters
    - For adjustment encounter records, if the adjustment was initiated by the billing provider, then the MCO receive date value should be the date that the MCO received the claim adjustment record from the billing provider.
    - If the adjustment was initiated by the MCO, then the plan receive date value should be the same as the MCO payment date of the adjustment.
    - If an adjustment is requested by DHH or Molina, then the original MCO receive date value should be the MCO receive date.

3. Void Encounters
    - For void encounter records, if the void was initiated by the billing provider, then the MCO received date value should be the date that the MCO received the claim void record from the billing provider.
    - If the void was initiated by the MCO, then the MCO received date value should be the date that the MCO processed the void record.
    - If a void is request by DHH or Molina, then the original MCO receive date value should be the date MCO receive date.

The FI provides to the MCO a file of encounter records that are missing the MCO receive date. The MCO is required to retrieve the file, populate the records with the missing data, and return the file to the FI. The MCO may retrieve the file from the MCO's non-EDI "from_molina" folder. The file name is: MCO_missing RecDate _DDMonYYYY.zip. The file layout can be found in Appendix V of this document.

Claim Paid Date

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

- For Inpatient records, the Claim Paid Date must be sent in Loop 2330B in the DTP*573 segment.
- For non-Inpatient records, the Claim Paid Date must be sent in Loop 2430 in the DTP*573 segment.

Adjustment Process

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

www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

To adjust an encounter with a line level denial, the MCO must make the correction(s) to the encounter and resubmit the corrected encounter 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, submit the 13-digit FI's ICN assigned by the adjudication system and printed on the remittance advice for the previously submitted claim that is being adjusted

Additional Encounter Requirements

Newborn Birth Weight

The birth weight of a newborn is required on encounters for delivery services; and it must be reported in Value Code segments of the 837I Loop 2300 HI value Code 54 (Newborn Birth Weight in Grams). It may be necessary for the MCO to crosswalk the diagnosis code from deliveries to populate the patient information for the birth weight.

Billing for Newborns

The MCO is required to submit the baby's facility bill, for the newborn only at the time of delivery, using the baby's Medicaid ID. The baby's Medicaid ID is to be used on the following newborn claims:

- Well babies
- Babies with extended stays (sick babies) past the mother's stay
- All aftercare and professional encounters

The MCO is required to hold the encounter until the newborn Medicaid ID can be obtained and submitted on the encounter.

Category II CPT Codes

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

On the ASC X12N 837 Professional Health Care Claim Transaction, Category II CPT and HCPCS Level II Codes are submitted in the SV1 "Professional Service" segment of the 2400 "Service Line" loop. The data element for the procedure code SV101-2 "Product/Service ID".

NOTE: It is also necessary for the MCO to identify that a Category II CPT/HCPCS Level II G – code is being provided. This is done by submitting "HC" code in data element SV101-1.

Transformed Medicaid Statistical Information System (T-MSIS)

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

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

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

Value Added Services

Dental

DHH requires the MCO to use ICD-9 diagnosis code V72.2 and ICD-10 diagnosis code Z01.20 when reporting value added dental services on the 837P encounter record. This code is ONLY required when the provider doesn't use a diagnosis on the value added dental claim.

In addition, tooth numbers, when used by the MCO, should be placed in the Procedure Code Modifier field of the 837P.

Procedure Code Modifier fields are 2 character fields; they must be 2 character values to pass 5010 validation. Therefore, for Tooth Numbers less than 10, use a zero (0) in front of the Tooth Number to make it 2 characters Tooth Number 8 would be reported as Modifier-1 value 08). The Tooth Number should be placed in SV101-3 (Procedure Modifier).

When Tooth Surface Codes are used by the MCO, the single character Tooth Surface Code values should be reported in Modifier-2 through Modifier-4 values, that's SV101-4, SV101-5 and SV101-6. Since the Procedure Code Modifier fields are 2 character fields, if only 1 or 3 or 5 Tooth Surface Codes are used, then place a dash (-) after the Tooth Surface Code value to complete the 2 character requirement. For example, if Tooth Surface Codes M, D and B are used, then the SV101-4 will be MD and the SV101-5 value will be B-.

Dental Batch Submissions

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

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

Section 3

Electronic Data Interchange (EDI) Certification and Testing

Introduction

The intake of encounter data from each MCO is treated as HIPAA compliant transactions by DHH and its FI. As such, the MCO is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the MCO is required to send real transmission data. DHH requires a minimum set of encounters for each transaction type based on testing needs.

EDI Protocols

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

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

MCO EDI Submitter Enrollment and Testing

Enrollment as an EDI submitter is achieved through the completion of the DHH/FI approval process and the successful testing of encounters by transaction type and claim type. Enrollment is processed through the following steps:

- Upon request from a DHH approved MCO, the FI will provide application and approval forms for completion by the MCO. Once complete, the forms must be mailed to the FI's Provider Enrollment Unit.
- During the authorization process, the MCO can call the EDI Department (225-216-6303) to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the submitter develops and tests application software to create EDI encounters.
- The FI requires the MCO to certify with a third-party vendor, EDIFECS, prior to submitting test encounters to the FI.
- When the submitter is ready to send a test file of encounters, the encounters are required to 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 format. 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, the MCO is required to submit additional test encounters until an acceptable test run is completed.

NOTE: The test submitter Number (4509999) shall be used for TEST submission 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 as successful, then the submitter will be notified that EDI encounters may be submitted to Production.

The encounter submitter process for approved MCO EDI submitters is as follows:

- Upon receipt of Production encounter submissions, the FI's EDI Department will log the submission and verify its completeness. Incomplete submissions are rejected and the submitter is notified of the reject reason(s) via electronic message or telephone call.
- The MCO is required to submit, annually, an EDI Certification Form. If the certification form has been completed, the EDI Department enters the submitted encounters into a pre-processor production run. The pre-processor generates the following items:
    - An encounter data file
    - The Claims Transmittal Summary Report
      The Claims Transmittal Summary Report lists the status (Accepted or Rejected) of a batch of encounters. Rejected encounters are identified and include the following information:
        - The provider number
        - The dollar ($) amount of the encounter
        - The number of encounters rejected

The MCO is required to submit to DHH and its FI a Test Plan with systematic plans for testing the ASC X12N837 COB. The three-tier (3) Test Plan is outlined and can be found in **Appendix H** of this Guide.

Timing

The MCO may initiate EDIFECS testing at any time. DHH's FI Business Support Analysts are available to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guides for specific instructions at:
http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

Encounter Processing Flow

The Process Flow Chart depicting incoming transactions through the FI's Electronic Data Interchange (EDI) can be found in **Appendix N**.

Encounter Data Certification

The Balanced Budget Act (BBA) requires certification of data submitted by the MCO when State Payments are to be made to an MCO based on the data submitted by the MCO. The certification applies to:

- Enrollment Data
- Encounter Data
- Any other information specified by the State

Based on CFR §438.606 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 MCO which are used to create payments and/or capitated rates, must be certified by a complete, and signed Encounter Data Certification Form; and is required to be submitted concurrently with each encounter file submission. The MCO may submit one (1) Encounter Data Certification Form for all encounter files submitted in one (1) day. The form's "**For The Period Ending**" field value should use the same date as the "**Date File Sent**" field values. The same date value should be used in "**Date File Sent**" for all files listed on the form; the form shall not contain span-dates. The form should be sent to DHH no later than one (1) business day after the encounter files were submitted. The data must be certified by one of the following individuals:

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

The Encounter Data Certification Form can be found in **Appendix O**.

Section 4
Data Management of File and Encounter Submissions

Introduction

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

File Rejection and Encounter Denial

Incoming 837 files may be rejected during EDI Front-end processing. Once the 837 transactions successfully make it to the MMIS encounter processing level, then individual encounter records are independently adjudicated as either denied or accepted. At the FI's Electronic Data Interchange, there are four (4) Front-end levels at which edits are present:

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

EDI File Encryption Level (Entire File)

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

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

TA1 Level

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

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

999 Level (Entire File)

EDI files that receive an accepted TA1 are processed through a set of 999 edits that validate the Functional Group (GS-GE) format and data content. If there is a problem at the 999 level, a rejected 999 will be returned to the submitter and the entire EDI file is not processed any further. EDI file problems reported at the 999 level are reported in ASC X12 999 transaction set format. EDI files that receive a rejected 999 will need to be resubmitted using a new Interchange Control Number (ISA13) value.

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

Pre-processor Level (Entire File)

EDI files that receive an accepted 999 are processed through Pre-processor level edits that validate LA Medicaid specific data content. LA Medicaid data content specifications are listed in Companion Guides located on the LAMedicaid website: (http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm). If there is a problem at the Pre-processor level, the submitter is notified by the FI's EDI Department and the entire EDI file is not processed any further. EDI files that hit Pre-processor level edits will need to be resubmitted using a new Interchange Control Number (ISA13) value.

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

A comprehensive list of encounter edits including the disposition; list of repairable edits and a list of non-repairable edits are located in **Appendix F**.

Correction of File and Encounter Errors

The MCO is required to correct all rejected files and repairable encounter edits applied to service line denials and resubmit corrected files and encounters to the FI as indicated below:

Entire File Rejection

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

- For EDI File Encryption rejections, the absence of a TA1 is the notification of a problem at this level.
- For TA1 rejections, the TA1 transaction reports the details of the problem.
- For 999 rejections, the 999 transaction reports the details of the problem.
- For Pre-processor rejections, the FI's EDI Department will notify the MCO submitter either by phone or email.

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

The MCO will receive an X12 835 (RA) for header level rejects. The MCO is required to adhere to the implementation guide, code sets, and looping structures to correct these transactions, as well as to the DHH-specific data rules as defined in the FI's Companion Guide and **Section 2** of this Guide.

Individual Record Denial

The MCO will receive an X12N 835 for transaction claims that have processed through the MMIS.

EDI Resolution

If after implementing correction processes, there remain unresolved edits; the MCO may present the outstanding issue(s) to DHH and/or its FI for clarification and/or resolution. DHH and/or the FI will review and triage the issue(s) to the appropriate entity for resolution; and will respond to the MCO with their findings. If the outcome is not agreeable to the MCO then the MCO may resubmit the outstanding issue(s) with supporting documentation to DHH for reconsideration. The outcome as determined by DHH will prevail.

EDI Dispute Resolution

The MCO has the right to file a dispute regarding denied encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. An MCO may believe that a denied encounter is the result of an FI error. An FI error is defined as a denied encounter that:

- The FI acknowledges to be the result of its own error
- Requires a change to the FI's systems programming (i.e., an update to the MMIS reference tables, or further research by the FI) and therefore requires FI resolution.

The MCO must notify DHH in writing within thirty (30) calendar days if it believes that the resolution of a denied encounter rests on the FI rather than the MCO. The MCO must submit a memorandum describing the issue. The edit report(s) provided by the FI may be attached to the memorandum as part of the written request. Denied encounter(s) that require research must be highlighted or otherwise identified.

The FI, on behalf of DHH, will respond in writing within thirty (30) calendar days of receipt of such notification. The FI will review the MCO's written request, and if needed, may request additional substantiating documentation from the MCO. The FI's response will identify the disposition of each denied encounter issue in question. If the FI disagrees with the MCO's claim of an FI error because the documentation does not support the claim, then the MCO will be required to correct the encounter, if repairable, and resubmit during the next billing cycle.

Section 5

Denial Edit Codes and Descriptions

Introduction

DHH has modified edits specifically for Managed Care Organizations encounter processing. In order to ensure that DHH has the most complete data for rate setting and data analysis, the MCO is required to repair as many denial edit codes as possible.

Encounter Edit Reports

On a weekly basis, the FI will post to the MCOs sFTP site, encounter reports identified in **Appendix D**. The reports are produced one (1) day after the MMIS adjudication cycle. The MCO is required to correct and resubmit repairable encounters.

The following items/issues are required to be corrected and resubmitted:

- Service lines to which a repairable edit has been applied
- Encounters that deny its entirety

Section 6
Continuous Quality Improvement

Introduction

Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the MCO will continue to undergo data quality checks beyond the minimum criteria used in the MMIS edit process. The result of edits and data quality improvement monitoring are combined to assist DHH and the MCOs in developing MCO-specific Encounter Quality Improvement Plans as they become necessary. 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 MCO with a comprehensive list of data quality issues present in the data for a given period of time. DHH will meet with MCO's as needed. The MCO meeting attendees are to include, but not be limited to the following staff:

- Claims
- EDI Experts
- Clinical Quality Assurance Staff

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

Minimum Standards

There are two (2) components to encounter data quality assessment:

- Repairable Denials
- Data Volume Assessment

Repairable Denials

Repairable denials must be for corrected and resubmitted in accordance with Section 17.8 of the RFP.

Data Volume Assessment

Data Volume Assessment is the evaluation to determine if key services meet expected rates of provision, as demonstrated in the data. The assessment is a core audit function; and allows DHH to determine the following:

- If the MCO is submitting data
- If all of the encounter data generated for a specified period has been received
- If the actual level of services are adequate to meet contractual requirements

The data is further used to justify capitation rates, and to provide appropriate access to care for the enrolled population.

Section 7

Medicare Recovery Process

On a monthly basis, the FI runs a query to identify Managed Care members who have retrospectively enrolled in Medicare (i.e., QMB, SLMB, & Part A/B). Once members have been identified, the FI generates and processes voids to recover the PMPM payments made on behalf of these members to an MCO. The FI will generate an 820 file with detailed information regarding the voids. The 820 file format is located in **Appendix D.** Only MCOs with impacted members will receive a CP-0-12D report which identifies the retrospectively enrolled members for which PMPM payments were made, and the 820 file which is placed on the MCO's FTP site for retrieval.

Upon receipt of the 820 file, the MCO is required to contact the Enrollment Broker to request disenrollment information for the impacted members if they have not received it in a previous 834 file. In addition, the MCO must notify the provider of the disenrollment prior to recovery of payments made to the provider.

Section 8
Medicaid Administrative Retroactive Enrollment Correction Process

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

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

- Based on this review, mid-month Molina will void identified Legacy claims paid by an incorrect entity, with denial reason code 999 – Administrative Correction, and providers will receive notice via 835s.

- Providers must check MEVS to obtain correct entity information based on the date of service. Please note that MEVs only returns information for one year from the date of service, but REVs may be used for anything older than one year from the date of service.

- A monthly report of affected members is given to all MCOs and Molina Provider Relations. This report includes detailed information to assist MCOs in anticipating claims which should be billed to them for their retro enrolled members including:

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

- The correct entity (MCO or Molina) must accept and honor authorizations (PA or Pre-cert) approved by the prior incorrect entity (unless the original authorization violates state or federal regulations), and payment shall be made whether provider is in-or out-of-network.

- Providers are required to submit **paper/hard copy** claims to the corrected entity (MCO or Molina) no later than 6 months from the date the claim is voided and:

    - Providers will not be required to obtain authorization (PA or Pre-cert) for these claims.
    - Providers must attach documentation supporting the void.
    - Claims cannot be denied for failure to meet timely filing, unless the claim is received more than 6 months after the date the claim is voided.

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

The fixed field, fixed length 78 character file layout can be found in Appendix W of this document.

Appendix A

Definition of Terms

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

837 Format	The file format used for electronic billing of professional services, institutional services or dental services. ANSI 837 is shorthand for the ASC X12N 837 (005010) file format.
999 Functional Acknowledgment	Transaction set-specific verification is accomplished using a 999 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents.
Administrative Region	Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa
Atypical providers	Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc.).
CAS Segment	Used to report claims or line level adjustments.
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 MCO 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.
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.
Corrective Action Plan (CAP)	A plan developed by the MCO that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe 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 or CHIP is entitled under the Louisiana Medicaid State Plan.
Data Certification	The Balanced Budget Act (BBA) requires that when State payments to an MCO are based on data that is submitted by the MCO, 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.
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.
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 educational 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.
Enrollee	Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.
Enrollment	The process conducted by the Enrollment

	Broker by which an eligible Medicaid recipient becomes a member of an MCO.
Enrollment Broker	The state's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO.
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.
Fraud	As relates to Medicaid Program Integrity, 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.
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.
Implementation Date	The date DHH notifies the MCO that Network Adequacy has been certified by DHH; the MCO has successfully completed the Readiness Review and is approved to begin enrolling members.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Interchange Envelope	Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Internal Control Number (ICN)	DHH's FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI's final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim.

Louisiana Department of Health and Hospitals (DHH)	The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.
Managed Care Organization (MCO)	The private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid MCO 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 22:1016 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.
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)	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 Enrollees.
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).
Member	As it relates to the Louisiana Medicaid Program and this RFP, refers to a Medicaid or CHIP eligible who enrolls in an MCO under the provisions of this RFP 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 RFP, "network" may be defined as a group of participating providers linked through subcontractual arrangements to an MCO to supply a range of primary and acute health care services. Also referred to as Provider Network.
Newborn	A live infant born to an MCO member.
Non-Contracting Provider	A person or entity that provides hospital or medical care, but does not have a contract or agreement with the MCO.
Non-Covered Services	Services not covered under the Title XIX

	Louisiana State Medicaid Plan.
Non-Emergency	An encounter by an MCO member who has presentation of medical signs and symptoms, to a health care provider.
Performance Measures	Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.
Policies	The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations.
Primary Care Provider	An individual physician, nurse practitioner , or physician assistant who accepts primary responsibility for the management of a member's health care 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.
Prior Authorization	The process of determining medical necessity for specific services before they are rendered.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.
Provider	Either (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the MCO 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 an MCO 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.
Readiness Review	Refers to DHH's assessment of the MCO's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of MCO 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 MCO'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 999 (Functional

	Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
Remittance Advice	An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the MCO, 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 edit code to indicate that the encounter is repairable.
SE Segment	The 837 transaction set trailer.
Security Rule (45 CFR Parts 160 & 164)	Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.
Service Line	A single claim line as opposed to the entire claim or the claim header.
Span of Control	Information systems and telecommunications capabilities that the MCO 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 MCO.
ST Transaction Set Header	Indicates the start of a transaction set and to assign a control number.
Surveillance and Utilization Review Subsystems	Surveillance and Utilization Review

(SURS) Reporting	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 999 (Functional Acknowledgement**)** will be returned to the submitter. The 999 contains **ACCEPT** or **REJECT** information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported.
System Unavailability	Measured within the MCO'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"orotherfunctionkey.
TA1	The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 999. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and

	Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B.
Taxonomy codes	These are national specialty codes used by providers to indicate their specialty at the claim level.
Trading Partners	Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Appendix B
Frequently Asked Questions

What is HIPAA and how does it pertain to MCOs?

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 MCO encounter data reporting.

Who is Molina and what is their role with the MCOs?

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

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

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

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

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

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

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

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

DHH's FI will provide MCOs with an electronic 835 Health Care Claim Payment/Advice (ERA), if requested and arranged for 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. 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 MCOs submit encounter data?

MCOs are required to submit encounter data based on requirements set forth in the RFP.

Appendix C

Code Sets

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

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

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

- International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following conditions:
  - Diseases;
  - Injuries;
  - Impairments;
  - Other health problems and their manifestations; and
  - Causes of injury, disease, impairment, or other health problems.
- ICD-9-CM, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by DHHS, for the following procedures or other actions taken for diseases, injuries, and impairments on inpatients reported by hospitals:
  - Prevention;
  - Diagnosis;
  - Treatment; and
  - Management.
- National Drug Codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:
  - Drugs; and
  - Biologics.
- 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 the MCOs submit CPT Category II codes. CPT Category II codes are supplemental tracking G-codes that can be used for performance measurement. The use of the tracking G-codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. Some codes in this category may relate to compliance by the health care professional with state or federal law.

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

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

- Effective October 2015, the MCOs will be required to submit ICD-10 Diagnosis, HCPCS and Procedure Codes.

Appendix D

System Generated Files and Reports

The overarching purpose of these reports is to enhance the quality of the encounter data. They provide DHH and the submitting MCO with basic accuracy and completeness assessment of claims after each encounter cycle, so that preliminary corrections and repairs can be conducted and the encounter resubmitted to the FI. These reports will take advantage of the existing MMIS reporting capacity for claims data. However, the reports are altered, as necessary, to enhance their usefulness in depicting encounter data errors.

Encounter data is submitted through the Fiscal Agent's Electronic Data Interchange (EDI) and undergoes a series of 837 COB edits, passing through to the MMIS, and then going through a set of edits that will result in Encounter Edit Disposition Summary Report. The report provides the repairable edit codes for the encounter data submitted; and can be found in this Section. The complete list of repairable edit codes are listed in **Appendix F**.

The following reports are generated by the FI's MMIS system and have been selected specifically to provide each MCO 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.** These quality reports will also depict accuracy and completeness at a volume and utilization level.

Encounter Claims Summary

CCN-W-001 (weekly)

This report will serve as the high-level error report for the MCO as a summarization of the errors incurred. The format is by claim type. This report will be distributed to MCOs as a delimited text file and it will include the overall claim count, the disposition of MMIS paid or denied status occurrence, and overall percentage. The number and percent to be denied represent all denials, repairable or non-repairable.

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	7	Numeric

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

Column(s)	Item	Notes	Length	Format
		08=Non-emergency Medical Transportation 09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services. 14=Medicare Crossover Instit. 15=Medicare Crossover Prof		
25	Delimiter		1	Uses the ^ character value
26-33	Number of claim records accepted		8	Numeric, no commas, decimal points.
34	Delimiter		1	Uses the ^ character value
35-42	Number of claim records denied		8	Numeric, no commas, decimal points.
43	Delimiter		1	Uses the ^ character value
44-51	Percentage of Denied Claims		8	Numeric, with decimal point. For example, 00015.99 represents 15.99%
52	Delimiter		1	Uses the ^ character value
53-81	End of Record		29	Value is spaces.

Column(s)	Item	Notes	Length	Format
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 of		8	Numeric, with decimal point.

Column(s)	Item	Notes	Length	Format
	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

CCN-W-005 (weekly)

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

Column(s)	Item	Notes	Length	Format
HEADER RECORD		There is only one header record per file.		
1	Record Type	0=Header	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “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 MCO.	7	Numeric
81	Delimiter		1	Uses the ^

Column(s)	Item	Notes	Length	Format
				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. The detail portion of the file is sorted by this number.	8	Numeric
22	Delimiter		1	Uses the ^ character value
23-24	Claim Type	Will have one of these values: 01=Inpatient 02=LTC/NH 03=Outpatient 04=Professional 05=Rehab 06=Home Health Outpatient 07=Emergency Medical Transportation 08=Non-emergency Medical Transportation	2	Numeric

Column(s)	Item	Notes	Length	Format
		09=DME 10=Dental 11=Dental 12=Pharmacy 13=EPSDT Services 14=Medicare Crossover Instit. 15=Medicare Crossover Prof.		
25	Delimiter		1	Uses the ^ character value
26-29	Error Code		4	Numeric
30	Delimiter		1	Uses the ^ character value
31-38	Number of claim records having this error code		8	Numeric
39	Delimiter		1	Uses the ^ character value
40-81	End of Record		42	Value is spaces.
TRAILER (TOTALS) RECORD		There is only one trailer record per file.		
1	Record Type	9=Trailer	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-005”	10	Character
13	Delimiter		1	Uses the ^ character value

14-21	Total Detail	This is a number	8	Numeric

Column(s)	Item	Notes	Length	Format
	Lines in the file	that represents the total detail lines submitted in the file.		
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

CCN-W-010 (weekly)

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

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 MCO.	7	Numeric
81	Delimiter		1	Uses the ^ character value
82	End of Record		1	Value is spaces.
DETAIL RECORD		There may be multiple detail records per file.		
1	Record Type	1=Detail	1	Numeric
2	Delimiter		1	Uses the ^ character value
3-12	Report ID	Value is “CCN-W-010”	10	Character
13	Delimiter		1	Uses the ^ character value
14-21	Detail Line Number	The line number of the detail record. The detail	8	Numeric

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

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

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

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

364-365	Billing Provider Type		2	See Provider Type values in Appendix H
366	Delimiter		1	Uses the ^ character value.
367-368	Servicing/ Attending Provider Type		2	See Provider Type values in Appendix H
369	Delimiter		1	Uses the ^ character value.
370	Claim Status		1	Numeric: 1=Paid Original 2=Adjustment/Void 3=Denied
371	Delimiter		1	Uses the ^ character value.
372	Claim Status Modifier		1	Numeric: 1=Paid Original 2=Adjustment 3=Void (for adjustment) 4=Void (from provider)
373	Delimiter		1	Uses the ^ character value.
374	Claim Type		2	01=Inpatient Hosp 02=LTC/ICF/NH 03=Outpatient Hosp 04=Professional 05=Rehab 06=Home Health 07=EMT 08=NEMT 09=DME 10=Dental EPSDT 11=Dental Adult 12=Pharmacy 13=EPSDT 14=Medicare Institutional Crossover 15=Medicare Professional Crossover 16=ADHC
376	Delimiter		1	Uses the ^ character value.
377	Claim or Encounter Indicator	1=claim 2=encounter	1	Identifies FFS claim vs. pre-paid encounter.
378	Delimiter		1	Uses the ^ character value.
379-380	Not populated		2	Spaces.
381	Delimiter		1	Uses the ^ character value.
382-383	Procedure Modifier 1		2	Character
384	Delimiter		1	Uses the ^ character value.

385-386	Procedure Modifier 2		2	Character
387	Delimiter		1	Uses the ^ character value.
388-389	Procedure Modifier 3		2	Character
390	Delimiter		1	Uses the ^ character value.
The following items represent revenue codes, HCPCS, units and charges associated with institutional claims. There are 23 occurrences.				
391-394	Revenue Code 1		4	Numeric
395	Delimiter		1	Uses the ^ character value.
396-400	Revenue HCPCS 1		5	Character
401	Delimiter		1	Uses the ^ character value.
402-406	Revenue Units 1		5	Numeric
407	Delimiter		1	Uses the ^ character value.
408-421	Revenue Charges 1		14	Numeric with decimal point, left zero-fill.
422	Delimiter		1	Uses the ^ character value.
There are 23 occurrences of the revenue items, with each occurrence being 32 bytes in length (consisting of code, HCPCS, Units and Charges, with delimiters).				
1127-1134	Claim Payment Date		8	Numeric data format in the format YYYYMMDD
1135	Delimiter		1	Uses the ^ character value.
1136-1140	Diagnosis Code 2	ICD-9-CM diag code, if available (this represents the secondary diagnosis)	5	Character, does not include the decimal.
1141	Delimiter		1	Uses the ^ character value.
1142-43	Place of Service	Uses the CMS 1500 standard Place of Service code values	1	2-digit numeric value. Only applicable to professional services claims.
1144	Delimiter		1	Uses the ^ character value.
1145-1152	Rx Prescription Date	Only populated on Pharmacy claims; otherwise, will have 0 value	8	Numeric, YYYYMMDD
1153	Delimiter		1	Uses the ^ character value.

1154-1157	Rx Days Supply	Only populated on Pharmacy claims; otherwise, will have 0 value	4	Numeric, left fill with zero.
1158	Delimiter		1	Uses the ^ character value.
1159-1169	Rx Quantity	Only populated on Pharmacy claims; otherwise, will have 0 value	11	Numeric with decimal point, left zero-fill.
1170	Delimiter		1	Uses the ^ character value.
1171-1180	Prescribing Provider NPI	Only populated on Pharmacy claims; otherwise, will have BLANK value	10	Numeric left zero fill.
1181	Delimiter		1	Uses the ^ character
1182	ICD Indicator	Used to identify whether ICFD-9 or ICD-10 CM codes were submitted on claim/encounter	1	0=ICD-10 9= ICD-9
1183	Delimiter		1	Uses the ^ character
1184-1190	ICD-10 CM primary diagnosis code		7	Will contain spaces if only ICD-9 code is submitted. If ICD-10 code was submitted, it will not contain the period.
1191	Delimiter		1	Uses the ^ character
1192-1198	ICD-10 CM		7	Will contain spaces if only ICD-9 code is submitted. If ICFD-10 code was submitted, it will not contain the period.
1199	Delimiter		1	Uses the ^ character
1200	End of Record		1	Character, value is space.

TRAILER (TOTALS)		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 ^ character value
26-33	Total Number of claim records denied.	This value represents the count of unique claim lines that appear in the detail portion of this file and have been denied.	8	Numeric
34	Delimiter		1	Uses the ^ character value
35	End of Record		1	Value is space.

Provider File

FI to MCO

This file is sent to MCOs on a weekly basis.

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number. This is the internal Louisiana Medicaid provider ID	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit. This is the external Louisiana Medicaid provider ID (the one known by providers)	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-46	Provider Name (Servicing)		30	Character
47	Delimiter		1	Uses the ^ character value
48-57	Provider NPI		10	Character
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character

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

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

Column(s)	Item	Notes	Length	Format
246	Delimiter		1	Uses the ^ character value
247-248	Provider State (Pay-To)	USPS abbreviation	2	
249	Delimiter		1	Uses the ^ character value
250-258	Provider Zip (Pay-To)	USPS ZIP code+4, if available	9	Numeric
259	Delimiter		1	Uses the ^ character value
260	Tax ID number (TIN) or SSN		9	Numeric, left fill with zeros
269	Delimiter		1	Uses the ^ character value
270	Medicare-registered or other LLC NPI number First occurrence		10	Numeric if present, otherwise spaces
280	Delimiter		1	
281	Medicare-registered or other LLC NPI number 2nd occurrence		10	Numeric if present, otherwise spaces
291	Delimiter		1	
292	Medicare- registered or other LLC NPI number 3rd occurrence		10	Numeric if present, otherwise spaces
302	Delimiter		1	

Column(s)	Item	Notes	Length	Format
303	Medicare-registered or other LLC NPI number 4th occurrence		10	Numeric if present, otherwise spaces
313	Delimiter		1	
314	Medicare-registered or other LLC NPI number 5th occurrence		10	Numeric if present, otherwise spaces
324	Delimiter		1	
325	Medicare-registered or other LLC NPI number 6th occurrence		10	Numeric if present, otherwise spaces
335	Delimiter		1	
336	Medicare-registered or other LLC NPI number 7th occurrence		10	Numeric if present, otherwise spaces
346	Delimiter		1	
347	Medicare-registered or other LLC NPI number 8th occurrence		10	Numeric if present, otherwise spaces
357	Delimiter		1	
358	Medicare-registered or other LLC NPI number 9th occurrence		10	Numeric if present, otherwise spaces
368	Delimiter		1	

Column(s)	Item	Notes	Length	Format
369	Medicare-registered or other LLC NPI number 10th occurrence		10	Numeric if present, otherwise spaces
379	Delimiter		1	
380	Medicare-registered or other LLC NPI number 11th occurrence		10	Numeric if present, otherwise spaces
390	Delimiter		1	
391	Medicare-registered or other LLC NPI number 12th occurrence		10	Numeric if present, otherwise spaces
401	Delimiter		1	
402	Medicare-registered or other LLC NPI number 13th occurrence		10	Numeric if present, otherwise spaces
412	Delimiter		1	
413	Medicare-registered or other LLC NPI number 14th occurrence		10	Numeric if present, otherwise spaces
423	Delimiter		1	
424	Medicare-registered or other LLC NPI number 15th occurrence		10	Numeric if present, otherwise spaces
434	Delimiter		1	

Column(s)	Item	Notes	Length	Format
435	Medicare-registered or other LLC NPI number 16th occurrence		10	Numeric if present, otherwise spaces
445	Delimiter		1	
446	Medicare-registered or other LLC NPI number 17th occurrence		10	Numeric if present, otherwise spaces
456	Delimiter		1	
457	Medicare-registered or other LLC NPI number 18th occurrence		10	Numeric if present, otherwise spaces
467	Delimiter		1	
468	Medicare-registered or other LLC NPI number 19th occurrence		10	Numeric if present, otherwise spaces
478	Delimiter		1	
479	Medicare-registered or other LLC NPI number 20th occurrence		10	Numeric if present, otherwise spaces
489	Delimiter		1	

490	Prescriber Indicator	1	Character with this value set: Blank = not applicable or no prescriptive authority. 0 = Full Rx Authority. 1 = Resident with Rx authority. 2 = Limited Rx authority (PA, NP, Medical Psychologist). 3 =Sanctioned. 4 = Full Rx authority plus ability to Rx Suboxone (opioid dependents). 5 = Pharmacist who can Rx Immunizations. 6 = CCN Prescriber (see PT=56) 7 =EHR Incentive Program 8 = No Prescriptive Authority
491	End of Record	1	Value is spaces.

Provider Rates File

FI to MCO

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-46	Provider Name (Servicing)		30	Character
47	Delimiter		1	Uses the ^ character value
48-57	Provider NPI		10	Character
58	Delimiter		1	Uses the ^ character value
59-68	Tie-Breaker	Taxonomy or Zip Code	10	Character
69	Delimiter		1	Uses the ^ character value
70-71	Provider Type		2	See Provider Type codes in Appendix H
72	Delimiter		1	Uses the ^ character value
73-74	Provider Specialty		2	See Provider Specialty codes in Appendix J

Column(s)	Item	Notes	Length	Format
75	Delimiter		1	Uses the ^ character value
76-83	Enrollment Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
84	Delimiter		1	Uses the ^ character value
85-92	Enrollment Effective End Date		8	Numeric, date value in the format YYYYMMDD
93	Delimiter		1	Uses the ^ character value
94-101	Rate 1	Inpatient General LOC Per-diem	8	Numeric with decimal and left-fill with zeros
102	Delimiter		1	Uses the ^ character value
103-110	Effective Date 1		8	Numeric, date value in the format YYYYMMDD
111	Delimiter		1	Uses the ^ character value
112-119	Rate 2	Other Inpatient (usually not applicable)	8	Numeric with decimal and left-fill with zeros
120	Delimiter		1	Uses the ^ character value

121-128	Effective Date 2	8	Numeric, date value in the format YYYYMMDD

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

157-164	Effective Begin Date	8	Numeric, date value in the format YYYYMMDD
165	Delimiter	1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
166-173	Rate		8	Numeric with decimal and left-fill with zeros
174	Delimiter		1	Uses the ^ character value
1228	End of Record		1	Value is spaces.

820 File
FI to CCN

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

- Per Member Per Month (PMPM)
- Maternity Kick Payments
- Date of Death Recoupments (DOD)
- Medicare Recoveries
- Department of Corrections Recoveries (DOC)
- Retro Baby Per Member Per Month
- Other
    - Special Adjustments
    - Payments
    - Recoupments

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

Loop	Segment	Field	Description	Valuation	Derived Value (D), Column Map (M), Static Value (S)
ST=Transaction Set Header					
Sample: ST*820*0001*005010X218~					
	ST	ST01	Transaction Set Identifier Code	'820'	S
Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges.					
		ST02	Transaction Set Control Number		D
Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.					
		ST03	Implementation Convention Reference	'005010X218'	S
Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time.					
BPR=Financial Information					
Sample: BPR*I*12345678.90*C*NON******1234567890******20150315~					

	BPR	BPR01	Transaction Handling Code	I=Remittance Information	S
				Only	
		BPR02	Monetary Amount	Total Premium Payment Amount	D
		BPR03	Credit/Debit Flag Code	C=Credit	S
		BPR04	Payment Method Code	NON=Non-payment 820	S
		BPR05	Payment Format Code	NOT USED	
		BPR06	(DFI) ID Number Qualifier	NOT USED	
		BPR07	(DFI) Identification Number	NOT USED	
		BPR08	Account Number Qualifier	NOT USED	
		BPR09	Account Number	NOT USED	
		BPR10	Originating Company Identifier	Federal tax ID number preceded by a 1.	S
		BPR11	Originating Company Supplemental Code	NOT USED	
		BRP12	(DFI) ID Number Qualifier	NOT USED	
		BPR13	(DFI) Identification Number	NOT USED	
		BRP14	Account Number Qualifier	NOT USED	
		BPR15	Account Number	NOT USED	
		BPR16	EFT Effective Date	Expressed CCYYMMDD	D

TRN=Re-association Trace Number					
Sample: TRN*3*1123456789*1234567890*~					
	TRN	TRN01	Trace Type Code	"3" – Financial Reassociation Trace Number. The payment and remittance information have been separated and need to be reassociated by the receiver.	S
		TRN02	Reference Identification	EFT Trace Number Used to reassociate payment with remittance information.	S
		TRN03	Originating Company Identifier	Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10	S
REF=Premium Receiver's Identification Key					
Sample: REF*18*123456789*CCN Fee Payment~					
		REF01	Reference Identification Qualifier	'18'=Plan Number	S
		REF02	Reference Identification	Premium Receiver Reference Identifier	D
		REF03	Description	'CCN Fee Payment' or	S

				'CCN Kick Payment'	
DTM=Process Date					
Sample: DTM*009*20120103~					
		DTM01	Date/Time Qualifier	"009" – Process	S
		DTM02	Date	Payer Process Date CCYYMMDD	D
DTM=Delivery Date					
Sample: DTM*035*20120103~					
		DTM01	Date/Time Qualifier	"035" – Delivered	S
		DTM02	Date	Payer Process Date CCYYMMDD	D
DTM=Report Period					
Sample: DTM*582****RD8*20120101-20120131~					
		DTM01	Date/Time Qualifier	"582" – Report Period	S
		DTM02	Not Used	Not Used	
		DTM03	Not Used	Not Used	
		DTM04	Not Used	Not Used	
		DTM05	Date Time Period Qualifier	'RD8'	S
		DTM06	Date Time Period	Range of Dates Expressed in Format CCYYMMDD-	D

				CCYYMMDD	
1000A PREMIUM RECEIVER'S NAME					
N1=Premium Receiver's Name					
Sample: N1*PE*CCN-S of Louisiana*FI*1123456789~					
	1000A	N101	Entity ID Code	"PE" – Payee	S
	1000A	N102	Name	Information Receiver Last or Organization Name	D
	1000A	N103	Identification Code Qualifier	"FI" – Federal	S
	1000A	N104	Identification Code	Receiver Identifier	D
1000B PREMIUM PAYER'S NAME					
N1=Premium Payer's Name					
Sample: N1*PR*LA-DHH-MEDICAID*FI*1123456789~					
	1000B	N101	Entity ID Code	"PR" – Payer	S
	1000B	N102	Name	Premium Payer Name	S
	1000B	N103	ID Code Qualifier	"FI" - Federal Taxpayer ID number	S

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

	2100B	NM104	Name First	Individual First Name	D
	2100B	NM105	Name Middle	Individual Middle Initial	D
	2100B	NM106	NOT USED	NOT USED	
	2100B	NM107	NOT USED	NOT USED	
	2100B	NM108	Identification Code Qualifier	"N" – Individual Identifier	S
	2100B	NM109	Identification Code	Individual Identifier – Recipient ID number	D
2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL					
RMR=Organization Summary Remittance Detail					
Sample: RMR*11*1234567890123**400.00~					
	2300B	RMR01	Reference Identification Qualifier	"11" - Account Number	S
	2300B	RMR02	Reference Identification	Claim ICN (Molina internal claims number).	D
	2300B	RMR04	Monetary Amount	Detail Premium Payment Amount	D
REF=Reference Information (1st occurrence)					

Sample: REF*ZZ*0101C~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Capitation Code	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (2nd occurrence)					
Sample: REF*ZZ*01~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Recipient Region code: Values 01 to 09.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		
REF=Reference Information (3rd occurrence)					
Sample: REF*ZZ*01~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Recipient Category of Assistance (aka Aid Category) – 2-digit number.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		

REF=Reference Information (4th occurrence)					
Sample: REF*ZZ*001~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	Recipient Type Case (aka Case Type) – 3-digit number	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		

REF=Reference Information (5th occurrence)					
Sample: REF*ZZ*001~					
	2300B	REF01	Reference Identification Qualifier	"ZZ" - Mutually Identified	S
	2300B	REF02	Reference Identification	FMP amount, numeric value in the format numeric (5.2), for a total length of eight bytes.	D
	2300B	REF03	Not Used		
	2300B	REF04	Not Used		

DTM=Individual Coverage Period

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

An adjustment of a previous original administrative fee payment will be shown as two (2) 2300B sets:

- A void of the previous payment; and
- A record showing the new adjusted amount

The void record will have RMR and ADX segments, where the RMR will have the original claim ICN in RMR02 and the original payment amount in RMR05. The ADX will have a negative amount (equal to the original payment) in ADX01 and the value '52' in ADX01. The record showing the new adjusted amount will behave in the same manner as an original payment (RMR). An example of an adjustment set is provided below:

Void sequence (reversal of prior payment):

ENT*107*2J*ZZ*7787998022222~

NM1*QE*1*DOE*JOHN*D***N*1234567890123~

RMR*AZ*1059610021800***500~

ADX*-500*52~

Adjusted Amount sequence:

ENT*107*2J*ZZ*7787998022222~

NM1*QE*1*DOE*JOHN*D***N*1234567890123~

RMR*AZ*1067610041100**600~

REF*ZZ*0101C~ (added to comply with HIPAA standard)

REF*ZZ*01~ (added to provide recipient region)

DTM*582****RD8*20120201-20120229~

Prior Authorization File

FI TO MCO

This file is a one-time file that contains a 2-year history of prior authorization and Pre-Admission Certification (Pre-cert) authorization transactions performed by the Louisiana Medicaid MMIS. Modifications for ICD-10 have been made to Columns 148-149.

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	LA-MMIS assigned ID number	7	Numeric, non-check-digit.
8	Delimiter		1	Uses the ^ character value
9-15	Provider Check-Digit ID	LA-MMIS assigned ID number, check-digit	7	Numeric
16	Delimiter		1	Uses the ^ character value
17-29	Recipient ID (Original)		13	Numeric
30	Delimiter		1	Uses the ^ character value
31-43	Recipient ID (Current)		13	Numeric
44	Delimiter		1	Uses the ^ character value
45-54	NPI		10	Character
55	Delimiter		1	Uses the ^ character value
56-65	Taxonomy		10	Character
66	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
67-71	Procedure Code		5	Character, CPT or HCPCS value
72	Delimiter		1	Uses the ^ character value
73	Authorized Units/Amount		10	Numeric, with decimal and left-zero fill
83	Delimiter		1	Uses the ^ character value
84-91	Effective Begin Date		8	Numeric, date value in the format YYYYMMDD
92	Delimiter		1	Uses the ^ character value
93-100	Effective End Date		8	Numeric, date value in the format YYYYMMDD
101	Delimiter		1	Uses the ^ character value
102-106	Admitting Diagnosis Code (for Inpatient Pre-Admission Certification) or Diagnosis code if required on the PA		5	ICD-9-CM
107	Delimiter		1	Uses the ^ character value
108-111	Length of Stay in Days (for Inpatient Pre-Admission Certification)		4	Numeric, left zero-fill

Column(s)	Item	Notes	Length	Format
112	Delimiter		1	Uses the ^ character value
113	PA or Pre-cert Type	1=PA 2=Pre-cert	1	Character
114	Delimiter		1	Uses the ^ character value
115-116	PA Type Or Pre-cert Type	**Pre-cert**: 03=Inpatient Acute **PA**: 04=Waiver 05=Rehab 06=HH 07=Air EMT 09=DME 10=Dental 11=Dental 14=EPSDT-PCS 16=PDHC 17=PDD or ASD 35=ROW 40=RUM 50=LT-PCS 60=Early Steps CM 66=RxPA 67=NEMT	2	

Column(s)	Item	Notes	Length	Format
		88=Hospice 99=Misc.		
117	Delimiter		1	Uses the ^ character value
118-119	PA or Precert Status	02=Approved 03=Denied	2	Character
120	Delimiter		1	Uses the ^ character value
121-125	Precert Level of Care (this field should be blank for Medical PA transactions, but it will contain the Therapeutic Class for RxPA transactions)	GEN ICU NICU REHA B PICU CCU TU=Telemetry LT=LTAC	5	Character
126	Delimiter		1	Uses the ^ character value

127-136	PA Line Amount Used	For an approved PA or Precert line item, this field contains any amount used as a result of claims processing. For an approved RxPA line item, this field contains the HICL in the first 6 characters.	10	Numeric, with decimal and left-zero fill.

Column(s)	Item	Notes	Length	Format
137	Delimiter		1	Uses the ^ character value
138-147	PA or Precert Number assigned by Molina		10	9- or 10-digit number
148	Delimiter		1	Uses the ^ character value
149	ICD indicator		1	Identifies if ICD-9 or ICD-10 code was submitted: 0=ICD-10 9=ICD-9
150	Delimiter		1	Uses the ^ character value
151-157	ICD-10 CM diagnosis. Admitting Diagnosis Code (for Inpatient Pre-Admission Certification) or Diagnosis code if required on the PA		7	Will contain spaces if ICD-9 code was submitted. If ICD-10 code was submitted, it will not contain the period.
158	Delimiter		1	Uses the ^ character value
159	End of Record		1	Value is spaces.

Diagnosis File for Pre-Admission Certification

FI to MCO

This file shows all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Pre-cert) operation with Louisiana Medicaid MMIS. Modifications for ICD-10 have been made to Columns 7; 27-35.

Column(s)	Item	Notes	Length	Format
1-5	Diagnosis Code		5	Character, does not include the period
6	Delimiter		1	Uses the ^ character value
7	Pre-Cert Status	1=Applicable 2=Not applicable/Not valid for Precert, 3=Not a valid diagnosis	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27-33	ICD-10 Diagnosis Code		7	Character, does not include the period.
34	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
35	End of Record		1	Value is spaces.

Procedure File for Prior Authorization

FI to MCO

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

Column(s)	Item	Notes	Length	Format
1-5	Procedure Code		5	Character
6	Delimiter		1	Uses the ^ character value
7	PA Status	1=Applicable 2=Not applicable	1	Numeric
8	Delimiter		1	Uses the ^ character value
9-16	Effective Begin Date		8	Numeric in date format YYYYMMDD
17	Delimiter		1	Uses the ^ character value
18-25	Effective End Date		8	Numeric in date format YYYYMMDD
26	Delimiter		1	Uses the ^ character value
27-28	Type of Service		2	Character. See Appendix H for code values
29	Delimiter		1	Uses the ^ character value

Column(s)	Item	Notes	Length	Format
30-39	Maximum Amount		10	Numeric, with decimal and left-fill with zeros, will be zero if not applicable
40	Delimiter		1	Uses the ^ character value
41-43	Minimum Age		3	Numeric, left-fill with zeros. Will be zero if not applicable.
44	Delimiter		1	Uses the ^ character value
45-47	Maximum Age		3	Numeric, left-fill with zeros. Will be zero if not applicable.
48	Delimiter		1	Uses the ^ character value
49	Sex Restriction Indicator	0=n/a 1=Male only 2=Female only	1	Character
50	Delimiter		1	Uses the ^ character value
51-53	Pricing Action Code		3	Character See Appendix J for Code values
54	Delimiter		1	Uses the ^ character value
55	End of Record		1	Value is spaces.

CLIA File

FI to MCO

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

Column(s)	Item	Notes	Length	Format
1-7	Provider ID	Non-check digit Medicaid Provider ID	7	Numeric
8	Delimiter		1	Uses the ^ character value
9-15	Provider ID (check-digit)	Check-digit Medicaid Provider ID	7	
16	Delimiter		1	Uses the ^ character value
17-26	Provider NPI	NPI	10	
27	Delimiter		1	Uses the ^ character value
CLIA numbers with effective dates, there are up to 15 occurrences of these items per CLIA number. Each occurrence is 31 bytes				
28-37	CLIA number		10	Character
38	Delimiter		1	Uses the ^ character value
39-46	CLIA Effective Begin Date		8	Numeric in date format YYYYMMDD
47	Delimiter		1	Uses the ^ character value
48-55	CLIA Effective End Date		8	Numeric in date format YYYYMMDD

Column(s)	Item	Notes	Length	Format
56	Delimiter		1	Uses the ^ character value
57	CLIA Type		1	Space=not avail. 1 = Registration 2 = Regular Certificate 3 = Accreditation 4 = Waiver 5 = Microscopy
58	Delimiter		1	Uses the ^ character value
493	End of Record		1	Value is spaces.

Quality Profiles Submission File

MCO to FI

There will be 1 single file, formatted as a text, CSV (comma-separated value) file.

There will be 4 record types on the file as shown in the grid below, so the file will have exactly 4 records.

Record Type 1: Performance Standards Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=1	1
Delimiter	2	Character, value='^'	1
QPS_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QPS_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QPS_PHONE_ACCESS_24X7_PERCENT	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QPS_SERVICE_AUTH_PERCENT	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QPS_PRE_PROCESS_CLAIMS_PERCENT	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QPS_REJECTED_CLAIMS_TO_PROV_PERCENT	38-43	Numeric in the format NNN.NN, with the decimal	6

		included.	
Delimiter	44	Character, value='^'	1
QPS_CALL_CENTER_CALLS_PERCENT	45-50	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	51	Character, value='^'	1
QPS_CALL_CENTER_AVERAGE_CALL_ANSWER_TIME	52-57	Numeric, 6 digits, no comma, no decimal, left fill with zeroes. Expressed in seconds.	6
Delimiter	58	Character, value='^'	1
QPS_CALL_CENTER_ABANDON_RATE	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QPS_GRIEVANCES_RESOLVED_RATE	66-71	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	72	Character, value='E'	1

Record Type 2: Incentive-Based Measures Record

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

QIB_WELL_CHILD_VISITS_FIFTH_YEAR	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QIB_WELL_CHILD_VISITS_SIXTH_YEAR	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QIB_ADOLESCENT_WELL_VISITS	66-71	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	72	Character, value='E'	1

Record Type 3: Level I Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=3	1
Delimiter	2	Character, value='^'	1
QLI_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QLI_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QLI_CHILD_AND_ADOL_ACCESS_TO_PCP	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QLI_TIMELINESS_OF_PRENATAL_AND_POSTPARTUM_CARE	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QLI_CHILDHOOD_IMMUN_STATUS	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QLI_IMMUNIZATIONS_FOR_ADOL	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1
QLI_LEAD_SCREENING_CHILDREN	45-50	Numeric in the format NNN.NN, with the decimal included.	6

Delimiter	51	Character, value='^'	1
QLI_CERVICAL_CANCER_SCREENING	52-57	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	58	Character, value='^'	1
QLI_PERCENT_LIVE_BIRTHS_WEIGHT_LT_2500G	59-64	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	65	Character, value='^'	1
QLI_WEIGHT_ASSESSMENT_CHILDREN_ADOL	66-71	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	72	Character, value='^'	1
QLI_MEDICATIONS_FOR_PERSONS_WITH_ASTHMA	73-78	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	79	Character, value='^'	1
QLI_COMPREHENSIVE_DIABETES_CARE	80-85	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	86	Character, value='^'	1
QLI_BREAST_CANCER_SCREENING	87-92	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	93	Character, value='^'	1
QLI_EPSDT_SCREENING_RATE	94-99	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	100	Character, value='^'	1
QLI_ADULT_ASTHMA_ADMISSION_RATE	101-106	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	107	Character, value='^'	1
QLI_CHF_ADMISSION_RATE	108-113	Numeric in the format NNN.NN, with the decimal included.	6

Delimiter	114	Character, value='^'	1
QLI_UNCONTROLLED_DIABETES_ADMISSION_RATE	115-120	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	121	Character, value='^'	1
QLI_INPATIENT_HOSP_READMISSION_RATE	122-127	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	128	Character, value='^'	1
QLI_WELL_CHILD_VISITS_IN_FIRST_15_MONTHS	129-134	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	135	Character, value='^'	1
QLI_AMBULATORY_CARE_ER_UTILIZATION	136-141	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	142	Character, value='E'	1

Record Type 4: Level II Measures Record

Data Field Number	Column positions	Format and Valuation	Length
Q_RECORD_TYPE	1	Character, value=4	1
Delimiter	2	Character, value='^'	1
QLII_CCN_PROV_ID	3-9	Numeric, this is your assigned CCN Provider ID. Left-fill with zeros.	7
Delimiter	10	Character, value='^'	1
QLII_TIMEKEY	11-15	Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4.	5
Delimiter	16	Character, value='^'	1
QLII_FOLLOWUP_CARE_CHILD_WITH_ADHD	17-22	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	23	Character, value='^'	1
QLII_OTITIS_MEDIA_EFFUSION	24-29	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	30	Character, value='^'	1
QLII_DEVEL_SCREENING_IN_FIRST_3_YEARS	31-36	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	37	Character, value='^'	1
QLII_PED_CENTRAL_LINE_ASSOC_BLOODSTREAM	38-43	Numeric in the format NNN.NN, with the decimal included.	6
Delimiter	44	Character, value='^'	1

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

QLII_PROVIDER_SATISFACTION	108-113	Numeric in the format NNN.NN, with the decimal included.	6
END-OF-RECORD-INDICATOR	114	Character, value='E'	1

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

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

An example of the E-CP-O-90-D can be found on the following page.

LAM2D070 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: E-CP-0-90-D
RUN: 12/12/14 15:30:48 DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF) PAGE: 1
CYCLE: 12/16/14
DENIED ENCOUNTER ERROR ANALYSIS
45XXXXX MCO

ERROR CODE	ERROR DESCRIPTION	HOSP 01	LTC 02	OPAT 03	PHY 04	RHAB 05	HH 06	AMBL 07	NAMB 08	DME 09	DNTLE 10	DNTL 11	RX 12	EPSDT 13	18-I 14	18-P 15	ADC 16	HAB 17	HMKR 18	TOTAL
022	INVALID BILLED CHRGS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
114	INV/MISSING HCPCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
123	RX > SERVICE DATE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
127	MISSING NDC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
130	DENY PROV. 9999999	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
134	ENC DENIED BY PLAN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
185	REQ NONCOVRD CHARGES	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
215	RECIPIENT NOT ON FIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
216	RECIPIENT NOT ELIG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
313	SUBMIT TO FI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
364	RECIP INELIG/DECEASE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
545	REV CODE INVALID NDC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
796	ORIG/ADJ PROV DIFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
797	DUP ADJ. RECORD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
798	HIST ALREADY ADJSTED	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
799	NO ADJ HISTORY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
805	EXACT DUPE 03 TO 03	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
843	EXACT DUPE 12 TO 12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
849	PD SAME ATTEN/DIF BL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	***** TOTAL *****	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Encounter EOB Analysis – E-CP-O-90-E

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

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

LAM2D070 LOUISIANA MEDICAID MANAGEMENT INFORMATION SYSTEMS REPORT NO: E-CP-0-90-E
RUN: 12/12/14 15:30:48 DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL (BHSF) PAGE: 1
CYCLE: 12/16/14 ENCOUNTER EOB ANALYSIS
45XXXXX MCO

ERROR CODE	ERROR DESCRIPTION	HOSP 01	LTC 02	OPAT 03	PHY 04	RHAB 05	HH 06	AMBL 07	NAMB 08	DME 09	DNTLE 10	DNTL 11	RX 12	EPSDT 13	18-I 14	18-P 15	ADC 16	HAB 17	HMKR 18	TOTAL
030	SERV THRU DT TOO OLD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
115	HCPC CD NOT ON FILE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
132	SECONDARY DX NOF____	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
201	PROVIDER NOT ELIG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
202	PROV CLAIM TYP CONFL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
210	PROV PROC CONFLICT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
212	PROV MUST BE INDIV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
231	NDC NOT ON P/F FILE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
232	PROCEDURE CODE NOF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
234	P/F AGE RESTRICTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
254	DIAG AGE RESTRICTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
272	CLAIM OVER 1 YEAR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
299	PROC/DRUG NOTCOVERED	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
416	ENC RCV DT ERROR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
813	EXACT DUPE 04 TO 04	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
855	SUSPCT DUPE 03 TO 03	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
863	SUSPCT DUPE 04 TO 04	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	***** TOTAL *****	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix E

MCO Generated Reports

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

416 Reports

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

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

Instructions for the 416 report may be found at:

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

Denied Claims Report

On a monthly basis, DHH will analyze claims that are denied for the following reasons:

- Denial Reason Code 1 – Lack of documentation to support Medical Necessity
- Denial Reason Code 2 – Prior Authorization was not on file
- Denial Reason Code 3 – Member has other insurance that must be billed first
- Denial Reason Code 4 – Claim was submitted after the filing deadline
- Denial Reason Code 5 – Service was not covered by the MCO
- Denial Reason Code 6 – Other (when denial codes in this category, MCO must cross walk their 3-digit denial reason code to “6”)

In addition, the MCO is required to submit a Denied Claims Summary as part of the Denied Claims Report.

The MCO is required to submit to DHH an electronic report monthly on the number and type of denied claims referenced above. The report shall include:

- Billing Provider NPI
- 13-digit recipient ID number
- Servicing Provider NPI
- Plan Internal Control Number for the claim
- DHH 2-digit Claim Type
- Provider Billed Amount
- Date of Service
- Date of receipt by MCO
- Date Claim Denied by MCO
- Denial Reason Code – as shown above 1-6; (6 must include MCO 3-digit denial reason code)
- Primary Diagnosis Code
- Secondary Diagnosis Code (if applicable)
- CPTP Procedure/HCPCS Code(s)
- Surgical Procedure Code(s) (if applicable)
- Revenue Code(s) (if applicable)
- Primary Insurance Carrier Code (if applicable)

NOTE: The MCO is required to report the following claim types as follows:

- Document Item/level
  Inpatient Hospital Claims

- Detail/Line item/level
  Outpatient Hospital Claims
  Home Health Claims
  Rehabilitation Claims
  Professional Claims

In the future, DHH reserves the right to obtain additional denied claims information.

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 FI's MMIS are subject to edits. Edits may post at the line or at the header level. If an encounter denies at the header level, the encounter must be corrected and resubmitted. Instructions for correcting line level denials are found in **Section 4**.

Encounter data edits can have one of the following dispositions:

- Encounter passes all edits and is accepted into the MMIS
- Encounter contains a fatal error that results in its denial

The MCO is required to correct repairable edits and resubmit the encounter to the FI for processing.

Encounter Edits Listing, Comprehensive

Disposition values: D=Deny, E=Education ONLY

Edit Code	Disposition	Short Description	Long Description
002	D	INVALID PROVIDER NO	PROVIDER NUMBER MISSING OR NOT NUMERIC
003	D	RECIPIENT # INVALID	RECIPIENT NUMBER INVALID OR LESS THAN 13 DIGITS
005	D	INVAL SERV FROM DATE	SERVICE FROM DATE MISSING/INVALID
006	D	INVAL SERV THRU DATE	INVALID OR MISSING THRU DATE
007	D	SERV THRU LT SERV FM	SERVICE THRU DATE LESS THAN SERVICE FROM DATE
008	D	SERV FRM GT ENTR DTE	SERVICE FROM DATE LATER THAN DATE PROCESSED
009	D	SERV THR GT ENTR DTE	SERVICE THRU DATE GREATER THAN DATE OF ENTRY
011	E	TPL INDICATOR NOT Y N OR SPACE	TPL INDICATOR NOT Y N OR SPACE
015	D	INVALID ACCIDENT IND	ACCIDENT INDICATOR MUST BE Y,N,SPACE
016	D	INVALID ACCID IND	ACCIDENT INDICATOR NOT Y, N OR SPACE
017	D	INVALID EPSDT IND	EPSDT INDICATOR NOT Y, N, OR SPACE
020	D	INVAL/MISS DIAG CODE	INVALID OR MISSING DIAGNOSIS CODE
021	D	INVALID FORMER REFNO	FORMER REFERENCE NUMBER MISSING OR INVALID

Edit Code	Disposition	Short Description	Long Description
022	D	INVALID BILLED CHRGS	BILLED CHARGES MISSING OR NOT NUMERIC
023	D	INV PARTIAL RECIP	RECIPIENT NAME IS MISSING
024	D	INV BILLING PROV NO	BILLING PROVIDER NUMBER NOT NUMERIC
026	D	TOT DOC CHG MISS OR NOT NUM	TOTAL DOC CHARGE MISSING OR NOT NUMBERIC
028	D	INV OR MISS PROC CODE	INVALID OR MISSING PROCEDURE CODE
030	E	SERV THRU DT TOO OLD	SERV THRU DATE MORE THAN TWO YEARS OLD
035	D	REBILL CORRECT HCPC	ASC,OP FAC/PHYS.BILLED DIFF CODE;REBILL CORRECT HC
040	D	INV ADMISSION DATE	ADMISSION DATE MISSING OR INVALID
041	D	ADM DATE > FR DATE	ADMISSION DATE GREATER THAN SERVICE FROM DATE
042	D	INV UB92 TYPE BILL CODE	INVALID UB92 TYPE BILL CODE (LOGIC CHANGE NEEDED: bump bill type in encounter against list of valid BILL TYPES)
044	E	INV NATURE OF ADMIT	NATURE OF ADMISSION MISSING OR INVALID
045	D	INV PATIENT STATUS	PATIENT STATUS CODE INVALID OR MISSING
046	D	INV PATIENT STAT DTE	PATIENT STATUS DATE MISSING OR INVALID

Edit Code	Disposition	Short Description	Long Description
047	D	PAT STAT DTE GT THRU	PATIENT STATUS DATE GREATER THAN THRU DATE
048	D	INVALID/MISS PROC	INVALID OR MISSING PROCEDURE CODE
049	D	INV/CONFLIC SURG DTE	INVALID/CONFLICT SURGICAL DATE
053	D	INV ACCOMODATION DAY	ACCOMODATION DAYS MISSING OR INVALID
055	D	INV ACCOM/ANCILL CHG	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID
060	D	INVALID COVERED DAYS	COVERED HOSPITAL DAYS NOT NUMERIC OR MISSING
063	E	INVALID TOTAL CHARGE	THE TOTAL HOSPITAL CHARGE IS NOT NUMERIC
064	E	INVALID NET AMOUNT	THE NET BILLED AMOUNT IS NOT NUMERIC
067	E	INVALID NON-COVERED	NON COVERED HOSP DAYS NOT NUMERIC OR MISSING
068	D	INV POINT ORIGIN	INVALID POINT OF ORIGIN
069	D	INV OCCUR DATE	INVALID OCCURRENCE DATE
071	D	INV STMT COVERS FROM	STATEMENT COVERS FROM DATE INVALID

Edit Code	Disposition	Short Description	Long Description
072	D	INV STMT COVER THRU	STATEMENT COVERS THRU DATE INVALID
073	D	STMT FRM LT SERV FRM	STATEMENT COVERS FROM DATE LESS THAN SERVICE FROM
074	D	STMT THRU GT SRV THR	STATEMENT COVERS THRU DATE IS GREATER THAN SERVICE
077	D	ATT PROV = BILLING	ATTENDING PROV MUST EQUAL BILLING
081	D	INVALID STATUS DATE	INVALID OR MISSING PATIENT STATUS DATE
082	D	INVALID STATUS CODE	INVALID PATIENT STATUS CODE
084	D	INVALID TREAT PLACE	INVALID OR MISSING PLACE OF TREATMENT
085	D	INV/MISS UNITS	INVALID OR MISSING UNITS VISITS AND STUDIES
087	D	MISS/INV COIN DAYS	MISSING OR INVALID COINSURANCE DAYS
089	D	MISS/INV INCENT AMT	MISSING OR INVALID INCENTIVE AMOUNT
092	E	INV/MISS MOD	INVALID OR MISSING MODIFIER
093	D	REVENUE CODE MISSING	REVENUE CODE MISSING/INVALID
094	D	MISSING PINTS BLOOD	MISSING PINTS BLOOD
095	D	COND CODE 40 FROM	CONDITION CODE 40 FROM THRU NOT EQUAL

Edit Code	Disposition	Short Description	Long Description
097	D	NON-COVCHG > BILLCHG	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	D	BILL CLASS 2 REQ M'CARE ALLOW AMT IN LOC 54	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
113	D	ONLY 1 ER REV CODE PER VISIT	ONLY ONE ER REVENUE (450/
114	D	INV/MISS HCPCS	INVALID OR MISSING HCPCS
115	D	HCPC CD NOT ON FILE	HCPC CODE NOT ON FILE
120	D	QTY INVALID/MISSING	QUANTITY INVALID/MISSING
126	D	REFILL CODE MISS/> 11	REFILL CODE MISSING NOT NUMERIC OR GREATER THAN 11
127	D	MISSING NDC	NDC CODE MISSING OR INCORRECT
130	D	DENY PROV. 9999999	ALL PROVIDERS 9999999 TO BE DENY
131	D	PRIMARY DX NOF	PRIMARY DIAGNOSIS NOT ON FILE
132	D	SECONDARY DX NOF	SECONDARY DIAGNOSIS NOT ON FILE

Edit Code	Disposition	Short Description	Long Description
133	O	BH XOVER SENT TO SMO(MAG)	BEHAVIORAL HEALTH CROSSOVER SENT TO SMO (MAGELLAN)
134	D	ENC DENIED BY PLAN	DENIED ENCOUNTER SUBMITTED BY PLAN
136	D	NO ELIG SERVICE PAID	NO ELIGIBLE SERVICE PAID – ENCOUNTER DENIED
141	D	NOT FILLED W/IN 12 MTH	REFILL NOT FILLED WITHIN 12 MONTHS
149	D	DESI INEFFECT-NOT PAY	DESI INEFFECTIVE-NOT PAYABLE
180	D	INVALID ADMIT DATE	THE ADMISSION DATE WAS NOT A VALID DATE
182	E	PROC CLAIM TYPE CONFLICT	PROCEDURE CLAIM TYPE CONFLICT
183	D	SURGERY PROC NOF	SURGICAL PROCEDURE NOT ON FILE
186	D	USE CORRECT MODIFIER	CRNA'S MUST BILL CORRECT MODIFIER
200	D	PROV/ATTEND NOF	PROVIDER/ATTENDING PROVIDER NOT ON FILE
201	E	PROVIDER NOT ELIG	PROVIDER NOT ELIGIBLE ON DATES OF SERVICE
202	E	PROV CLAIM TYP CONFL	PROVIDER CANNOT SUBMIT THIS TYPE CLAIM
203	E	PROVIDER ON REVIEW	PROVIDER ON REVIEW
206	D	BILL PROV NOT ON FIL	BILLING PROVIDER NOT ON FILE
210	E	PROV PROC CONFLICT	PROVIDER NOT CERTIFIED FOR THIS PROCEDURE

Edit Code	Disposition	Short Description	Long Description
211	D	DOS LESS THAN DOB	DATE OF SERVICE LESS THAN DATE OF BIRTH
212	D	PROV MUST BE INDIV	ATTENDING PROVIDER MUST BE INDIVIDUAL
215	D	RECIPIENT NOT ON FIL	RECIPIENT NOT ON FILE
216	D	RECIPIENT NOT ELIG	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
217	D	RECIP NAME MISMATCH	NAME AND/OR NUMBER ON CLAIM DOES NOT MATCH FILE RE
222	D	SVC OVERLAPS REC ELI	RECIPIENT INELIGIBLE ON ONE OR MORE SERVICE DATES
231	D	NDC NOT ON P/F FILE	NDC CODE NOT ON FILE
232	E	PROCEDURE CODE NOF	PROCEDURE/TYPE OF SERVICE NOT COVERED BY PROGRAM
234	D	P/F AGE RESTRICTION	P/F AGE RESTRICTION
235	D	P/F SEX RESTRICTION	P/F SEX RESTRICTION
236	D	P/F PLACE RESTRICTION	P/F PLACE RESTRICTION

Edit Code	Disposition	Short Description	Long Description
237	E	P/F PROV SPEC RESTRT	P/F PROVIDER SPECIALTY RESTRICTION
252	D	DIAGNOSIS NOT ON FIL	DIAGNOSIS NOT ON FILE
254	D	DIAG AGE RESTRICTION	DIAGNOSIS AGE RESTRICTION
255	D	DIAG SEX RESTRICTION	DIAG SEX RESTRICTION
258	D	SPAN DATES/QUANT DIF	DIFFERENCE BETWEEN SERVICE DATES AND QUANT
263	D	PROCEDURE-AGE-RESTRT	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
266	D	INVALID AMB SURG REV	REV CODE INVALID FOR AMBULATORY SURG PROC.
267	D	REQ-ICD-SURGICAL-CD	REVENUE CODE 490 REQUIRES VALID ICD SURGICAL PROC
268	D	TREAT PL INCORRECT	TREATMENT PLACE IS INCORRECT
272	E	CLAIM OVER 1 YEAR	CLAIM EXCEEDS 1 YEAR FILING LIMIT
275	E	RECIP MEDICARE ELIG	RECIPIENT IS MEDICARE ELIGIBLE
279	E	PROF COMP INVLD POT	INVALID PLACE OF TREATMENT FOR PROF COMP

Edit Code	Disposition	Short Description	Long Description
289	D	INV DENY FOR PROV NO	INVALID PROVIDER NUMBER WHEN DENY APPLIED
299	E	PROC/DRUG NOTCOVERED	PROC/DRUG NOT COVERED BY MEDICAID
306	E	INV BABY ADMISSION	BABY ONLY / PENDING FOR REVIEW.
307	D	SURG PROC MISSING	SURGICAL PROCEDURE MISSING
309	D	SURG DATE MISSING	DATE OF SURGERY MISSING
310	D	SURG DTE LT SRV FROM	DATE OF SURGERY LESS THAN SERVICE FROM DATE
316	E	COV DAYS NE ACCOM	COVERED DAYS DO NOT EQUAL ACCOMODATION DAYS
317	E	STMT DTE/ACCOM CONFL	STATEMENT DATES CONFLICT WITH ACCOMODATION DAYS
318	D	SUSP CON MIS/REQ-RF2	SUSPECTED CONDITION MISSING AND REQUIRED FOR REFER
319	D	SUSP CON MIS/REQ-RF3	SUSPECTED CONDITION MISSING REQUIRED FOR REFERRAL
328	D	NH/ICF NOT COVERED	NOT COVERED FOR RECIPIENT IN NH/ICF
329	E	CLIA NOT CERT DOS	CLIA # DOES NOT COVER DATE OF SERVICE
330	E	QMB NOT MED. ELIG.__	QMB NOT MEDICAID ELIGIBLE_____
332	D	STERILIZATION < 21	STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 2
334	D	CONSENT 30/180 DAYS	CONSENT MUST BE AT LEAST 30 BUT NO MORE THAN 180 D
336	E	AB REQUIRES REVIEW	ABORTION REQUIRES REVIEW

Edit Code	Disposition	Short Description	Long Description
337	E	CONSENT FORM REVIEW	STERILIZATION OFS FORM 96 REQUIRES REVIEW
338	E	HYSTER REQ REVIEW	ACKNOWLEDGEMENT REQUIRES REVIEW
330	E	QMB NOT MED. ELIG.__	QMB NOT MEDICAID ELIGIBLE_____
339	D	OCCUR DATES CONFLICT	OCCUR CODES/DATES CONFLICT
340	E	SPAN DAYS CONFLICT	SPAN DAYS/NON COVERED DAYS CONFLICT
351	D	SPAN DATE INVALID __	SPAN DATE NOT ALLOWED MUST BILL PER DAY_____
364	D	RECIP INELIG/DECEASE	RECIPIENT INELIGIBLE/DECEASED
386	E	NOT PAY W/CLIA CERT	NOT PAYABLE WITH CLIA CERT TYPE
387	E	CLIA # NOT ON FILE	NO CLIA # ON OUR FILE
390	E	SERV, MAX 1 PER MO	SERVICE EXCEEDS MAXIMUM ALLOWABLE OF 1 PER MONTH
400	E	REFER PHYSICIAN REQD	REFERRING/ATTENDING PHYSICIAN REQUIRED
401	E	CONCURRENT CARE	CONCURRENT CARE IS NOT COVERED BY THE PROGRAM
402	E	NO SERV EXCEEDS MAX	NUMBER OF SERVICES EXCEEDS STATE MAX/ CUTBACK APPL
405	E	OUTSIDE LAB NOT COVD	OUTSIDE LABORATORY SERVICES NOT COVERED
408	E	NON-EMER MLS GR 400	NON-EMER MILES EXCEED 400-STATE AUTHO REQUIRED
410	D	ENC PREFIX ERROR	LICN PREFIX ON ENCOUNTER IS MISSING OR INVALID

Edit Code	Disposition	Short Description	Long Description
414	D	ENC PLAN PMT DT ERR	PLAN PAYMENT DATE ON ENCOUNTER IS MISSING OR INVALID
416	D	ENC RCV DT ERROR	PLAN RECEIVE DATE ON ENCOUNTER IS MISSING OR INVALID
417	D	ENC INT PMT ERROR	INTEREST PAYMENT ON PLAN ENCOUNTER IS INVALID
429	E	NOT PAY FOR MED NEED	NOT PAYABLE FOR MED NEEDY PROGRAM_____
433	D	MISSING/INVALID DIAG	MISSING/INVALID DIAGNOSIS CODE
444	D	M/I SERVICE PROVIDER	MISSING/INVALID SERVICE PROVIDER
475	E	QW MODIFIER NEEDED	QW MODIFIER NEEDED FOR TYPE OF CLIA CERTIFICATE
490	E	UTILIZE HMO_____	MUST UTILIZE HMO SERVICES_____
492	E	HMO REVIEW_____	HMO EOB REQUIRES REVIEW_____
506	D	SUB PROV NON PAR BYU	SUBMIT TO RECIPIENTS SHARED PLAN
507	D	SUB CLM TO BYU PLN	SUBMIT CLAIM TO BAYOU HEALTH PLAN
513	D	HCPCS REQ	HCPCS REQUIRED
522	D	MOTH/NEWBRN BILL SEP	MOTHER/NEWBORN MUST BE BILLED SEPARATE_____
523	D	CANNOT BE ADJUSTED__	ADJUSTMENT IS INVALID, VOID AND REBILL_____
532	E	OOS SRVC REQ APPRVL_	OUT OF STATE SERVICES REQUIRE DHH APPROVAL LETTER
539	D	CLAIM REQ DETAIL____	CLAIM REQUIRES DETAILED BILLING_____
545	D	REV CODE INVALID NDC	REVENUE CODE INVALID FOR REPORTING NDC INFO

Edit Code	Disposition	Short Description	Long Description
550	E	NO MULTI – PROVIDERS	MULTIPLE PROVIDERS WILL NOT BE PAID FOR THIS PROCE
555	O	SUB CLM TO LBHP SMO	SUBMIT CLAIM TO LOUISIANA BEHAVIORAL HEALTH PLAN STATEWIDE MANAGEMENT ORGANIZATION
556	E	ATND PRV NOT LNK BYU	ATTENDING/SERVICING PROVIDER NOT LINKED TO BYU PLA ***** EFFECTIVE 03-31-2016 DISPOSITION WILL BE CHANGED TO "D"
563	D	ADJ-ADD-ON-WITH-51	ADJ ADD-ON CODE WITH 51 MOD THEN REBILL PRIMARY PR
578	E	INV POS/MOD COMBO	INVALID PLACE OF SERVICE/PROCEDURE MODIFIER COMBIN
615	E	REBIL W/APP PRIM CDE	MUST BE BILLED WITH APPROPRIATE PRIMARY CODE
618	E	URINALYSIS NOT BILLE	URINEALYSIS BILLED INCORRECTLY
620	E	PAN & IND CODE/ PANE	ONE URINALYSIS PER PREGNANCY AVAILABLE
622	D	EXACT DUPE 01 TO 03	OUTPATIENT AND INPATIENT HOSPITAL SERVICES ON SAME DAY
631	D	EPSDT AGE ERROR	EPSDT AGE OVER 21
644	D	VISIT CODE PD/DOS	VISIT CODE ALREADY PAID FOR THIS DATE OF SERVICE
663	E	NO ABORTION DONE	ABORTION NOT DONE-FETUS NOT ALIVE AT TIME OF PROCE
673	D	EVAL & MGT PD DOS	EVAL AND MGT CODE PAID FOR THIS DOS
675	D	VACCINE/ADM CONFLICT	VACC & ADM MUST PAY/AGREE;IF ONLY ONE PAYS TOTAL D
676	D	PRIMARY CODE DENIED	PAYABLE ONLY IF PRIMARY CODE IS PAID
678	E	GLOBAL CODE PD	GLOBAL CODE PD THIS DOS THIS RECIP

Edit Code	Disposition	Short Description	Long Description
679	E	COMPONENT CODE PD	COMPONENT CODE PD THIS DOS RECIP
680	E	ABORT PD MOTHER LIFE	ABORTION PAID MOTHERS LIFE ENDANGERED
689	D	MHR SERV PD THIS DOS	MHR SERVICES ALREADY PAID FOR THIS DATE OF SERVICE
695	D	HOSP DISCHARGE PAID	ONE HOSPITAL DISCHARGE SERVICE PAID PER ADMISSION
702	D	NEW PT/EST PT CD CON	NEW PATIENT/ESTABLISHED PATIENT CODE CONFLICT
704	D	ER VISIT/INP HOS SER	ER VISIT ON DATE OF INP HOS SERVICES
705	D	AID/RN/PT NO SAME DY	AIDE/RN/PT VISIT SAME DAY NOT ALLOWED/H. HEALTH
706	D	SEPARATE NB CARE CHG	FOLLOWUP NB CARE BILLED SEPARATELY
711	E	SAME SPEC/SUBSP PAID	SAME SPECIALTY/SUBSPECIALTY PAID ON SAME DATE OF S
712	D	INITIAL HOSP INPT PD	ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER AD
715	E	2ND. VISIT SAME DAY	FOUND DUPLICATE VISIT SAME DAY
716	D	PROC INCLUDED IN OV	PROCEDURE INCLUDED IN THE PHYSICIAN VISIT
720	D	TO BE BILLED BY PROV	MUST BE BILLED BY PROVIDER OF SERVICE
721	E	SUR ASST NOT NEEDED	PROCEDURE DOES NOT WARRANT SURGICAL ASSIST
727	E	EXCEEDS DAILY MAX	EXCEEDS DAILY SERVICE MAXIMUM
735	O	PREV PD ANES-SAME RE	PREVIOUSLY PAID ANES.OR SUPERVISING ANES,SAME RECI

Edit Code	Disposition	Short Description	Long Description
740	E	1-INTRAOCULAR-LEN-AL	ONLY ONE PROCEDURE V2630 V2631 V2632 ALLOWED PER RECIP
746	D	SAME ATTD PD IP CONS	SAME ATTENDING PROV PAID INPT CONSULTATION SAME ST
748	D	1 DEL.ALLOW. 6MTH.SP	ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN
749	D	DEL HYST/STER CONFLI	DELIVERY BILLED AFTER HYSTERECTOMY/STERLIZ WAS DON
750	E	STERILIZATION INDIC	FOUND PROC. 2 X INDICATES STERILIZATION
753	D	REBILL-DELIVERY	REBILL DELIVERY (DELIVERY-SURGERY) CODE & OFFICE V
755	D	BILL AS ADJ/CNT STAY	THIS SHOULD BE BILLED AS ADJUST.FOR CNT STAY
757	D	ADJ PD LINE 51 MOD	ADJUST PAID LINE WITH 51 MODIFIER THEN RESUBMIT M
758	D	FND DUP SERV SM DAY	FOUND DUPLICATE SERVICE SAME DAY
774	E	INC IN RELATED SERV	INCLUDED IN RELATED SERVICE
777	E	ABORTION RAPE-PAID	ABORTION DUE TO RAPE PAID
781	E	MODIFIER NOT CORRECT	INAPPROPRIATE PROCEDURE CODE MODIFIER-REBILL
789	E	ABORTION INCEST-PAID	ABORTION DUE TO INCEST PAID
794	D	INPT SER PD SAME ATT	INPT HOSP SERV PAID FOR SAME DOS TO SAME ATTENDING
796	D	ORIG/ADJ PROV DIFF	ORIG/ADJ BILLING PROVIDER NUMBER DIFFERENT
797	D	DUP ADJ. RECORD	DUPLICATE ADJUSTMENT RECORDS ENTERED

Edit Code	Disposition	Short Description	Long Description
798	D	HIST ALREADY ADJSTED	HISTORY RECORD ALREADY ADJUSTED
799	D	NO ADJ HISTORY	NO HISTORY RECORD ON FILE FOR THIS ADJUSTMENT
800	D	ON-LINE DUPE DENY	DUPLICATE OF PREVIOUSLY PAID CLAIM
801	D	EXACT DUPE 01 TO 01	EXACT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
802	D	EXACT DUPE 01 TO 14	EXACT DUPLICATE ERROR: HOSPITAL AND TITLE18-INSTITUTION
805	D	EXACT DUPE 03 TO 03	EXACT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIMS
806	D	EXACT DUPE 03 TO 05	EXACT DUPLICATE ERROR: OUTPATIENT AND REHAB SERVIC
807	D	EXACT DUPE 03 TO 06	EXACT DUPLICATE ERROR: OUTPATIENT AND HOME HEALTH
808	D	EXACT DUPE 03 TO 07	EXACT DUPLICATE ERROR: OUTPATIENT AND AMBULANCE
810	D	EXACT DUPE 03 TO 09	EXACT DUPLICATE ERROR: OUTPATIENT AND DURABLE-EQUI
813	D	EXACT DUPE 04 TO 04	EXACT DUPLICATE ERROR: IDENTICAL PHYSICIAN CLAIMS
815	D	EXACT DUPE 05 TO 05	EXACT DUPLICATE ERROR: IDENTICAL REHAB-SERVICES CL
816	D	EXACT DUPE 05 TO 06	EXACT DUPLICATE ERROR: REHAB-SERVICES AND HOME HEA
817	D	EXACT DUPE 05 TO 07	EXACT DUPLICATE ERROR: REHAB-SERVICES AND AMBULANC
818	D	EXACT DUPE 05 TO 08	EXACT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMBU
819	D	EXACT DUPE 05 TO 09	EXACT DUPLICATE ERROR: REHAB-SERVICES AND DURABLE

Edit Code	Disposition	Short Description	Long Description
822	D	EXACT DUPE 06 TO 06	EXACT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAIM
823	D	EXACT DUPE 06 TO 07	EXACT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
828	D	EXACT DUPE 07 TO 07	EXACT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
830	D	EXACT DUPE 07 TO 09	EXACT DUPLICATE ERROR: AMBULANCE AND DURABLE-EQUIP
832	D	EXACT DUPE 07 TO 15	EXACT DUPLICATE ERROR: AMBULANCE AND TITLE18
833	D	EXACT DUPE 08 TO 08	EXACT DUPLICATE ERROR: IDENTICAL NON-AMBULANCE CLA
837	D	EXACT DUPE 09 TO 09	EXACT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP CLA
842	D	EXACT DUPE 11 TO 11	EXACT DUPLICATE ERROR: IDENTICAL DENTAL-ADULT CLAIMS
843	D	EXACT DUPE 12 TO 12	EXACT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS
849	D	PD SAME ATTEN/DIF BL	ALREADY PAID SAME ATTENDING DIFFERENT BILLING PROV
851	D	SUSPCT DUPE 01 TO 01	SUSPCT DUPLICATE ERROR: IDENTICAL HOSPITAL CLAIMS
852	D	SUSPCT DUPE 01 TO 14	SUSPT DUPLICATE ERROR: HOSPITAL AND TITLE18
855	E	SUSPCT DUPE 03 TO 03	SUSPCT DUPLICATE ERROR: IDENTICAL OUTPATIENT CLAIM
857	E	SUSPCT DUPE 01 TO 06	SUSPCT DUPLICATE ERROR: OUTPATIENT AND HOME-HEALTH
859	E	SUSPCT DUPE 03 TO 08	SUSPCT DUPLICATE ERROR: OUTPATIENT AND NON-AMBULAN
860	D	ENCOUNTER DATA ERROR	INVALID DATA IN FIRST COB LOOP

Edit Code	Disposition	Short Description	Long Description
862	E	SUSPCT DUPE 03 TO 15	SUSPCT DUPLICATE ERROR: OUTPATIENT AND TITLE18-PROF
863	E	SUSPCT DUPE 04 TO 04	SUSPCT DUPLICATE ERROR:IDENTICAL PHYSICIAN CLAIMS
864	E	SUSPCT DUPE 04 TO 15	SUSPCT DUPLICATE ERROR: PHYSICIAN AND TITLE18-PROF
865	E	SUSPCT DUPE 05 TO 05	SUSPEC DUPLICATE ERROR: IDENTICAL REHAB-SERVICES C
866	E	SUSPCT DUPE 05 TO 06	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND HOME HE
867	E	SUSPCT DUPE 05 TO 07	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND AMBULAN
868	E	SUSPCT DUPE 05 TO 08	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND NON-AMB
869	E	SUSPCT DUPE 05 TO 09	SUSPCT DUPLICATE ERROR: REHAB-SERVICES AND DME
872	E	SUSPCT DUPE 06 TO 06	SUSPCT DUPLICATE ERROR: IDENTICAL HOME HEALTH CLAI
873	E	SUSPCT DUPE 06 TO 07	SUSPCT DUPLICATE ERROR: HOME HEALTH AND AMBULANCE
874	E	SUSPCT DUPE 06 TO 08	SUSPCT DUPLICATE ERROR: HOME HEALTH AND NON-AMBULA
878	E	SUSPCT DUPE 07 TO 07	SUSPCT DUPLICATE ERROR: IDENTICAL AMBULANCE CLAIMS
879	E	SUSPCT DUPE 07 TO 08	SUSPCT DUPLICATE ERROR: AMBULANCE AND NON-AMBULANC
884	E	SUSPCT DUPE 08 TO 09	SUSPECT DUPLICATE ERROR: NON-AMBULANCE AND DME CLA
887	E	SUSPCT DUPE 09 TO 09	SUSPECT DUPLICATE ERROR: IDENTICAL DURABLE-EQUIP C
893	E	SUSPCT DUPE 12 TO 12	SUSPECT DUPLICATE ERROR: IDENTICAL PHARMACY CLAIMS

Edit Code	Disposition	Short Description	Long Description
896	E	SUSPCT DUPE 14 TO 14	SUSPECT DUPLICATE ERROR: IDENTICAL TITLE18-INST CLAIMS
897	E	SUSPCT DUPE 15 TO 15	SUSPECT DUPLICATE ERROR: IDENTICAL TITLE18-PROF CLAIMS
898	D	EXACT DUPE SAME ICN	EXACT DUPE SAME ICN – DROPPED
899	E	SUSPCT DUPE 12 TO 15	SUSPECT DUPLICATE ERROR:DRUG & PARTB MC CLAIMS
900	D	LIFETIME LIMITS-ONE	ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED
906	E	EXCEEDS MAX ALLOWED	EXCEEDS MAMIMUM ALLOWED
917	D	OVER LIFETIME LIMIT	LIFETIME LIMITS FOR THIS SERVICE HAVE BEEN EXCEEDE
924	E	EFF 11/5/10 NDC REQU	EFF 11/5/10 PAS FOR THIS HCPC REQUIRES CORRECT NDC
926	D	EXACT DUPLICATE	EXACT DUPLICATE OF ANOTHER ADJUSTMENT
946	E	SPLIT BILL FOR PART.	SPLIT BILL FOR PARTIAL ELIGIBILITY
948	E	INC IN MAJ SUR PROC	INCLUDED IN MAJOR SURGICAL PROCEDURE
951	E	DISCH DATE NOT COV	DATE OF DISCHARGE NOT COVERED
952	E	INC IN OV/RELAT PROC	INCLUDED IN OFFICE VISIT/RELATED PROCEDURE
957	E	PROC/DIAG NO MED NEC	PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY
970	D	INAPPROPRIATE CODE,	INAPPROPRIATE CODE, BILL LAB OR SPECIFIC HANDLING
973	E	NO SURGERY MODIFIER	CLAIM DESCRIPT INDICATES PROC CODE SHOULD HAVE MOD

Edit Code	Disposition	Short Description	Long Description
980	E	INVALID ADJ REASON	INVALID ADJUSTMENT REASON
983	D	SYS CALC NET TOTAL	SYSTEM CALCULATED TOTAL – NET BILLED NOT IN BALANC
991	E	PROCEDURE IN PANEL	PROCEDURE INCLUDED IN PANEL

Repairable Edits

EDIT CODE	EDIT DISPOSITION – DENY (REPAIRABLE UNDER LIMITED CIRCUMSTANCES)[1] EDIT DESCRIPTION
049	INVALID-CONFLICT-SURG-DATE
200	PROVIDER-NOT-ON-FILE
216	RECIPIENT-NOT-ELIGIBLE
258	SPANNING-DATES-QUANT-DIFF
339	CODES-DATE-CONFLICT
364	RECIPIENT-INELIGIBLE-DECEASED
545	REV-NDC-INVALID
556	ATTENDING/SERVICING PROVIDER NOT LINKED TO BAYOU HEALTH PLAN

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
015	INVALID ACCIDENT IND
016	INVALID ACCID IND

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

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
017	INVALID EPSDT IND
020	DIAG-MISSING
021	INVALID FORMER REFNO
022	BILLING CHARGES MISSING OR NOT NUMERIC
023	INV PARTIAL RECIP
024	INV BILLING PROV NO
026	TOTAL DOCUMENT CHARGE MISSING OR NOT NUMBERIC
028	INVALID OR MISSING PROCEDURE CODE
040	INVALID-ADMISSION-DTE-ERR
041	ADMISSION DATE GREATER THAN SERVICE FROM DATE
042	INVALID UB92 TYPE BILL CODE (LOGIC CHANGE NEEDED: bump bill type in encounter against list of valid BILL TYPES)
045	INV PATIENT STATUS
046	INV PATIENT STAT DTE
047	PAT STAT DTE GT THRU
053	ACCOMODATION DAYS MISSING OR INVALID
055	ACCOMODATION/ANCILLARY CHARGE MISSING OR INVALID
060	COVERED HOSPITAL DAYS NOT NUMBERIC OR MISSING
068	INVALID POINT OF ORIGIN
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
077	ATTENDIN PROV MUST EQUAL BILLING
081	INVALID STATUS DATE

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
082	INVALID STATUS CODE
084	INVALID OR MISSING PLACE OF TREATMENT
085	INVALID OR MISSING UNITS VISITS AND STUDIES
087	MISSING OR INVALID COINSURANCE DAYS
093	REVENUE CODE MISSING/INVALID
094	MISSING-PTS-BLOOD
095	CONDITION CODE 40 FROM THRU NOT EQUAL
097	NON-COVERED CHARGES EXCEED BILLED CHARGES
098	BILL CLASS 2 REQUIRES MEDICARE ALLOWED AMOUNT IN LOC#54
114	INVALID OR MISSING HCPCS
115	HCPC CODE NOT ON FILE
120	QTY-INVALID-MISSING
126	REFILL CODE MISSING NOT NUMERIC OR GREATER THAN 11
130	DENY-PROV-9999999
132	SECONDARY DIAGNOSIS NOT ON FILE
149	DESI INEFFECTIVE-NOT PAYABLE
180	INVALID ADMIT DATE
186	CRNA-MUST-BILL-CORRECT-MOD
206	BILL PROV NOT ON FIL
211	DOS-LESS-THAN-DOB
212	ATTENDING PROVIDER MUST BE INDIVIDUAL
215	RECIPIENT-NOT-ON-FILE
217	NAME AND/ORNUMBER O CLAIM DOES NOT MATCH FILE RECORD
266	INVALID-AMB-SURG-REV
267	REQ-ICD9-SURGICAL-CD

EDIT CODE	EDIT DISPOSITION – DENY REPAIRABLE EDIT DESCRIPTION
268	TREATMENT PLACE IS INCORRECT
289	REJ-DENY-INV-PROV
307	SURG PROC MISSING
309	SURG DATE MISSING
310	SURG DTE LT SRV FROM
318	SUSP-COND-MISS-REF2
319	SUSP-COND-MISS-REF3
400	REFER-PHYS-REQD
444	M/I SERVICE PROVIDER
513	HCPCS-REQUIRED
563	ADJ-ADD-ON-WITH-51
676	PRIMARY CODE DENIED
702	NEW PT/EST PT CD CON
706	FOLLOW-UP-NB-CARE-BILLED
720	TO BE BILLED BY PROV
753	REBILL-DELIVERY
755	BILL AS ADJ/CNT STAY
757	ADJ PD LINE 51 MOD
796	ORIG/ADJ PROV DIFF
799	NO ADJ HISTORY
970	INAPPROPRIATE CODE
983	TOTAL-CHRG-CHANGED
TBD	PROV-NOT-CCN

Non-Repairable Edits

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

EDIT CODE	EDIT DISPOSITION - NON REPAIRABLE DENIALS EDIT DESCRIPTION
035	REBILL CORRECT HCPC
113	ONLY ONE ER REVENUE (450/459) CODE PER VISIT
115	HCPC CODE NOT ON FILE
133	BEHAVIORAL HEALTH CROSSOVER SENT TO SMO (MAGELLAN)
141	REFILL NOT FILLED WITHIN 12 MONTHS
149	DESI INEFFECTIVE-NOT PAYABLE
222	RECIP-ELIG-DATE-OVERLAP
231	NDC CODE NOT ON FILE
234	P/F AGE RESTRICTION
235	P/F SEX RESTRICTION
236	P/F PLACE RESTRICTION
254	DIAGNOSIS AGE RESTRICTION
255	DIAG SEX RESTRICTION
263	PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD
425	BEHAVIORAL HEALTH CROSSOVER SENT TO BYU PLAN
426	SUBMIT CLAIM TO BYU
456	SUBMIT CLAIM TO CSoC PLAN – MAGELLA
507	SUBMIT CLAIM TO BYU PLAN
555	SUBMIT CLAIM TO LBHP SMO
631	EPSDT-AGE-ERROR

644	VISIT CODE PD/DOS
673	EVAL & MGT PD DOS
695	HOSP DISCHARGE PAID
704	ER VISIT/INP HOS SER
712	INITIAL HOSP INPT PD
716	PROC-INCLUDED-IN-OV
735	PREV PD ANES-SAME RE
746	SAME ATTD PD IP CONS
748	1 DEL.ALLOW. 6MTH.SP
749	DEL HYST/STER CONFLI
758	FND DUP SERV SM DAY
794	INPT SER PD SAME ATT
797	DUP ADJ. RECORD
798	HIST ALREADY ADJSTED
800	ON-LINE DUPE DENY
801	EXACT DUPE 01 TO 01
805	EXACT DUPE 03 TO 03
806	EXACT DUPE 03 TO 05
807	EXACT DUPE 03 TO 06
808	EXACT DUPE 03 TO 07
810	EXACT DUPE 03 TO 09
816	EXACT DUPE 05 TO 06
817	EXACT DUPE 05 TO 07
818	EXACT DUPE 05 TO 08
819	EXACT DUPE 05 TO 09
822	EXACT DUPE 06 TO 06
823	EXACT DUPE 06 TO 07

828	EXACT DUPE 07 TO 07
830	EXACT DUPE 07 TO 09
833	EXACT DUPE 08 TO 08
837	EXACT DUPE 09 TO 09
843	EXACT DUPE 12 TO 12
849	PD SAME ATTEN/DIF BL
898	EXACT DUPE SAME ICN
900	LIFETIME LIMITS-ONE
917	OVER LIFETIME LIMIT

Appendix G

Provider Directory/Network and Subcontractor Registry

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

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

The MCO listing of contracted providers is to be submitted electronically through the state's Fiscal Intermediary (FI). Only one unique record per combined NPI and Taxonomy should be submitted in the master Provider Registry. If a provider practices at multiple sites the MCO should submit only the primary site in the Provider Registry. Secondary sites for PCPs and specialist can be submitted through the "Provider Registry Site" file, described in this Appendix. Providers that are no longer accepting patients must be clearly identified.

Many of the data elements are publicly available from NPPES through the Freedom of Information Act (FOIA). The complete listing of data elements and file specifications are also detailed in this Appendix.

In addition, the file layout for the Magellan Provider Registry can be found in Appendix X of this guide.

The MCO is responsible for:

- Ensuring the completeness and accuracy of the data submitted
- Timely submission of all updates to the registry to the FI on a weekly basis (each Friday by close of business 5 PM CST).

Provider Types

The MCO is required to populate the Provider Type field to a DHH valid provider type code as shown in the list below:

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

25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy
27	Dentist
28	Optometrist and Optometrist Group
29	Title V Part C Agency Services(EarlySteps)
30	Chiropractor and Chiropractor Group
31	Psychologist
32	Podiatrist and Podiatrist Group
33	Prescribing Only Provider
34	Audiologist
35	Physical Therapist
36	Not Assigned
37	Occupational Therapist
38	School Based Health Center
39	Speech Therapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother
44	Home Health Agency
45	Case Management
46	Case Mgmt – HIV
47	Case Management – CMI
48	Case Management – Pregnant Women
49	Case Management – Develop Disabled
50	PACE (All-Inclusive Care – Elderly)
51	Ambulance Transportation
52	Co-ordin Care Network – Shared
53	Self Direct/Direct Support
54	Ambulatory Surgery Center
55	Emergency Access Hospital
56	Prescriber Only for MCO

57	OPH Public Health Registered
	Nurse
58	Not Assigned
59	Neurological Rehabilitation Unit (Hospital)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
64	Mental Health Hospital Freestanding
65	Rehabilitation Center
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital – Distinct Part Psychiatric
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
73	Social Worker
74	Mental Health Clinic
75	Optical Supplier
76	Hemodialysis Center
77	Mental Health Rehabilitation
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
80	Nursing Facility
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant – Waiver
83	Center-Based Respite Care
84	Substitute Family Care – Waiver
85	Adult Day Health Care – Waiver
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home

89	Supervise Independent Living – Waiver
90	Nurse-Midwife
91	CRNA or CRNA Group
92	Private Duty Nurse
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities
96	Psychiatric Residential Treatment Facility
97	Residential Care
98	Supported Employment
99	Greater New Orleans Community Health Connection
AA	Assertive Community Treatment Team
AB	Prepaid Inpatient Health Plan
AC	Family Support Organization
AD	Transition Coordination
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehab Agency
AH	Licensed Marriage & Family Therapy
AJ	Licensed Addiction Counselor
AK	Licensed Professional Counselor
AL	Community Choice Waiver – Nurs
AM	Home Delivered Meals
AN	Caregiver Temporary Support
AQ	Non-Medical Group Home
AR	Therapeutic Foster Care
AS	Office of Public Health Clinic
AT	Therapeutic Group Home
AU	Office of Public Health Registered Dietitian
AV	Extended Duty Dental Assistant
AW	Permanent Support Housing Agent

AX	Certified Behavior Analyst
AY	Dental Benefit Plan Manager
AZ	Substance Use Residential Treatment Facility
BC	Birth Center – Free Standing
BI	Behavior Intervention
IP	HER Incentive Program
MI	Monitored In-Home Caregiving
MW	Licensed Mid-Wife
SP	Super Provider/OHCDS
XX	Error Provider

Provider Specialty Types

For providers registered as individual practitioners, DHH requires the MCO 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
11	Not In Use	n/a
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

Provider Specialty	Description	Associated Provider Types
20	Orthopedic Surgery	19,20
21	Pathologic Anatomy; Clinical Pathology (DO only)	19
22	Pathology	20
23	Peripheral Vascular Disease or Surgery (DO only)	19
24	Plastic Surgery	19,20
25	Physical Medicine Rehabilitation	19,20
26	Psychiatry	19,20,93
27	Psychiatry; Neurology (DO only)	19
28	Proctology	19,20
29	Pulmonary Diseases	19,20
30	Radiology	19,20
31	Roentgenology, Radiology (DO only)	19
32	Radiation Therapy (DO only)	19
33	Thoracic Surgery	19,20
34	Urology	19,20
35	Chiropractor	30,35
36	Pre-Vocational Habilitation	13
37	Pediatrics	19,20,93
38	Geriatrics	19,20
39	Nephrology	19,20
40	Hand Surgery	19,20
41	Internal Medicine	19,20
42	Federally Qualified Health Centers	72
43	Not in Use	n/a
44	Public Health	66,70
45	NEMT - Non-profit	42
46	NEMT - Profit	42
47	NEMT - F+F	42
48	Podiatry - Surgical Chiropody	20,32
49	Miscellaneous (Admin. Medicine)	20
50	Day Habilitation	1

Provider Specialty	Description	Associated Provider Types
51	Med Supply / Certified Orthotist	40
52	Med Supply / Certified Prosthetist	40
53	Med Supply / Certified Prosthetist Orthotist	40
54	Med Supply / Not Included in 51, 52, 53	40
55	Indiv Certified Orthotist	40
56	Indiv Certified Protherist	40
57	Indiv Certified Protherist - Orthotist	40
58	Indiv Not Included in 55, 56, 57	40
59	Ambulance Service Supplier, Private	51
60	Public Health or Welfare Agencies & Clinics	57,61,62,66,67, AU
62	Psychologist Crossovers only	29,31
63	Portable X-Ray Supplier (Billing Independently)	25
64	Audiologist (Billing Independently)	29,34
65	Indiv Physical Therapist	29,35
66	Dentist, DDS, DMS	27
67	Oral Surgeon - Dental	27
68	Pedodontist	27
69	Independent Laboratory (Billing Independently)	23
70	Clinic or Other Group Practice	19,20,68,74,76, AS
71	Speech Therapy	29
72	Diagnostic Laboratory	23
73	Social Worker Enrollment	73
74	Occupational Therapy	29,37
75	Other Medical Care	65
76	Adult Day Care	85
77	Habilitation	85
78	Mental Health Rehab	77
79	Nurse Practitioner	78
80	Environmental Accessibility Adaptations	1

Provider Specialty	Description	Associated Provider Types
81	Case Management	07,08,43,46,81
82	Personal Care Attendant	1
83	Respite Care	83
84	Substitute Family Care	1
85	Extended Care Hospital	60
86	Hospitals and Nursing Homes	55,59,60,64,69, 80,88
87	All Other	26,40,44
88	Optician / Optometrist	28,75
89	Supervised Independent Living	1
90	Personal Emergency Response System – Waiver	1
91	Assistive Device	1
92	Prescribing Only Providers/Providers Not Authorized to Bill Medicaid	1
93	Hospice Service for Dual Elig.	09
94	Rural Health Clinic	79,87
95	Psychologist (PBS Program Only)	31
96	Psychologist (PBS Program and X-Overs)	31
97	Family Planning Clinic	71
98	Supported Employment	1
99	Provider Pending Environment	1
1A	Adolescent Medicine	2
1B	Diagnostic Lab Immunology	2
1C	Neonatal Perinatal Medicine	2
1D	Pediatric Cardiology	2
1E	Pediatric Critical Care Medicine	2
1F	Pediatric Emergency Medicine	2
1G	Pediatric Endocrinology	2
1H	Pediatric Gastroenterology	2

Provider Specialty	Description	Associated Provider Types
1I	Pediatric Hematology – Oncology	2
1J	Pediatric Infectious Disease	2
1K	Pediatric Nephrology	2
1L	Pediatric Pulmonology	2
1M	Pediatric Rheumatology	2
1N	Pediatric Sports Medicine	2
1P	Pediatric Surgery	2
1Q	Pediatric Neurology	2
1R	Pediatric Genetics	2
1S	BRG – Med School	2
1T	Emergency Medicine	19,20
1U	Pediatric Developmental Behavior	2
1Z	Pediatric Day Health Care	2
2A	Cardiac Electrophysiology	2
2B	Cardiovascular Disease	2
2C	Critical Care Medicine	2
2D	Diagnostic Laboratory Immunology	2
2E	Endocrinology & Metabolism	2
2F	Gastroenrology	2
2G	Geriatric Medicine	2
2H	Hematology	2
2I	Infectious Disease	2
2J	Medical Oncology	2
2K	Nephrology	2
2L	Pulmonary Disease	2
2M	Rheumatology	2
2N	Surgery – Critical Care	2
2P	Surgery – General Vascular	2
2Q	Nuclear Medicine	1
2R	Physician Assistant	94
2S	LSU Medical Center New Orleans	2

2T	American Indian/Native Alaskan	95
2Y	OPH Genetic Disease Program	1
3A	Critical Care Medicine	2
3B	Gynecologic Oncology	2
3C	Maternal & Fetal Medicine	2
3D	Community Choices Waiver – Respiratory Therapy	2
3E	Community Choices Waiver – PT and OT	2
3F	Community Choices Waiver – PT and S/L T	2
3G	Community Choices Waiver – PT and RT	2
3H	Community Choices Waiver – OT and S/L T	2
3J	Community Choices Waiver – OT and RT	2
3K	Community Choices Waiver - /L T and RT	2
3L	Community Choices Waiver – PT, OT & S/L T	2
3M	Community Choices Waiver – PT, OT &RT	2
3N	Community Choices Waiver – PT, S/L T & RT	2
3P	Organized Health Care Delivery System (OHCDS)	2
3Q	Community Choices Waiver – OT, S/L T & RT	2
3R	Community Choices Waiver – All Skilled Maintenance Therapies (PT, OT, S/L, T, RT)	2
3S	LSU Medical Center Shreveport	2
3T	DBPP – Dental Benefit Plan Prescriber	1
3U	Community Choices Waiver – Assistive Devices – Home Health	2
3W	Supportive Housing Agency	1
3X	Extended Duty Dental Assistant	1

Provider Specialty	Description	Associated Provider Types
3Y	DBPM – Dental Benefit Plan Management	1
4A	Developmentally Disabled (DD)	1
4B	NOW RN	1
4C	NOW LPN	1
4D	NOW Psychologist	1
4E	NOW Social Worker	1
4G	New, Provider Domain	1
4H	Conversion, Participant Domain	1
4J	Conversion, Provider Domain	1
4K	Home and Community-Based Services	1
4L	New, Participant Domain	1
4M	EHR Managed Care (Behavior Health)	2
4P	OAAS	1
4R	Registered Dietician	1
4S	Ochsner Med School	2
4U	OPH Registered Dietician	1
4W	Waiver Services	1
4X	Waiver – Only Transportation	1
4Y	EHR Managed Care (Medical)	2
5A	PCS-LTC	1
5B	PCS-EPSDT	24
5C	PAS	24
5D	PCS-LTC, PCS-EPSDT	1
5E	PCS-LTC, PAS	1
5F	PCS-EPSDT, PAS	24
5H	Community Mental Health Center	18
5I	Statewide Management Organization (SMO)	1
5J	Youth Support	1
5K	Family Support	1
5L	Both Youth and Family Support	1

Provider Specialty	Description	Associated Provider Types
5M	Multi-Systemic Therapy	1
5N	Substance Abuse and Alcohol Abuse Center	1
5Q	CCN-P (Coordinated Care Network, Pre-paid)	1
5R	CCN-S (Coordinated Care Network, Shared Savings	1
5S	Tulane Med School	2
5T	Community Choices Waiver (CCW)	1
5U	Individual	1
5V	Agency/Business	1
5W	Community Choices Waiver – Personal Assistance Service	2
5X	Therapeutic Group Home	1
5Y	PRCS Addiction Disorder	1
5Z	Therapeutic Group Home Disorder	1
6A	Psychologist -Clinical	31
6B	Psychologist-Counseling	31
6C	Psychologist - School	31
6D	Psychologist - Developmental	31
6E	Psychologist - Non-Declared	31
6F	Psychologist - All Other	31
6G	Psychologist – Medical	31
6H	LaPOP	1
6N	Endodontist	27
6P	Periodontist	27
6S	E Jefferson Family Practice Center – Residency Program	2
6T	Community Choices Waiver – Physical Therapy	2
6U	Applied Behavioral Analyst	1
6W	Licensed Mid-Wife	1
7A	SBHC – NP – Part Time – less than 20 hrs week	38
7B	SBHC – NP – Full Time – 20 or more hrs week	38

Provider Specialty	Description	Associated Provider Types
7C	SBHC – MD – Part Time – less than 20 hrs week	38
7D	SBHC – MD – Full Time – 20 or more hrs week	38
7E	SBHC – NP + MD – Part Time – combined less than 20 hrs week	38
7F	SBHC – NP + MD – Full Time – combined less than 20 hrs week	38
7G	Community Choices Waiver – Speech/Language Therapy	2
7H	Community Choices Waiver – Occupational Therapy	2
7M	Retail Convenience Clinics	2
7N	Urgent Care Clinics	2
7P	ABA Therapy Psychologist	1
7R	Aquatic Therapy	1
7T	Art Therapy	1
7U	Art and Music	2
7V	Music Therapy	1
7X	Sensory Integration	1
7Y	Therapeutic Horseback Riding	1
7Z	Hippotherapy	1
7S	Leonard J Chabert Medical Center – Houma	2
8A	Elderly, Community Choices Waiver, DD	2
8B	Elderly, Community Choices Waiver	2
8C	DD Services	2
8D	Community Choices Waiver – Caregiver Temporary Support	1
8E	CSoC/Behavioral Health	1, 2
8F	Community Choices Waiver – Caregiver Temporary Support – Home Health	2

Provider Specialty	Description	Associated Provider Types
8G	Community Choices Waiver – Caregiver Temporary Support – Assisted Living	2
8H	Community Choices Waiver – Caregiver Temporary Support – ADHC	2
8J	Community Choices Waiver – Temporary Support – Nursing Facility	2
8K	ADHC HCBS	1
8L	Hospital-Based PRTF	1
8M	Community Choices Waiver – Home-Delivered Meals	1
8N	Community Choices Waiver – Nursing	2
8O	IP – Doctor of Osteopathic Medicine	1
8P	IP – Physician – MD	1
8Q	EAA Assesor, Inspector, Approver	2
8R	Psychiatric Residential Treatment Facility	96
8S	OLOL Med School	2
8U	Residential Treatment Facility – Psychiatric and Substance Abuse	96, AZ
9A	Community Choices Waiver – Nursing and Personal Assistance Services	2
9B	Psychiatric Residential Treatment Facility	96
9D	Residential Care	97
9E	Children's Choice Waiver	1
9F	Therapeutic Foster Care (TFC)	1
9G	Non-Medical Group Home (NMGH)	1
9L	RHC/FQHC OPH Certified SBHC	1
9M	Monitored in-Home Caregiving (MIHC)	1

Provider Specialty	Description	Associated Provider Types
9P	GNOCHC – Greater New Orleans Community Health Connection	1
9Q	PT 21 – Third-Party Biller/Submitter	2

Provider Specialty	Description	Associated Provider Types
9R	Electronic Visit Verification Submitter	2
9S	IP – Optical Supplier	1
9T	Exempted from State EW	2
9U	Medicare Advantage Plans	1
9V	OCDD – Point of Entry	1
9W	OAAS – Point of Entry	1
9X	OAD – Point of Entry	1
9Y	Juvenile Court/Drug Treatment Center	1
9Z	Other Contract with a State Agency	1
XX	Error Provider	1

Provider Registry File Layout

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

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the MCO 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 O characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them.	
44	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
45-74	Provider Name OR the Legal Business Name for Organizations.		30	Character If the entity type=1 (individual), please format the name in this manner: First 13 positions= provider first name, 14th position=middle initial (or space), 15-30th characters=last name, If names do not fit in these positions, please truncate the end of the item so that it fits in the positions. **DO NOT include suffixes or titles in the last name see columns 761-765 Provider Suffix and 767-776 Provider Title**	R
75	Delimiter		1	Character, use the ^ character value	
76-105	Provider Business Mailing Address (First line address)		30	Character	R
106	Delimiter		1	Character, use the ^ character value	
107-136	Provider Business Mailing Address (Second line address)		30	Character	O

137	Delimiter	1	Character, use the ^ character value

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
138-167	Provider Business Mailing Address (City,)		30	Character	R
168	Delimiter		1	Character, use the ^ character value	
169-170	Provider Business Mailing Address (State)	USPS state code abbreviation	2	Character	R
171	Delimiter		1	Character, use the ^ character value	
172-181	Provider Business Mailing Address (9-Digit Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
182	Delimiter		1	Character, use the ^ character value	
183-192	Provider Business Mailing Address (Country Code if outside U.S.)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
193	Delimiter		1	Character, use the ^ character value	
194-203	Provider Business Mailing Address (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
204	Delimiter		1	Character, use the ^ character value	
205-214	Provider Business 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	No P.O. Box here, please use a physical address.	30	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	Address (First line address)				
246	Delimiter		1	Character, use the ^ character value	
247-276	Provider Business Location Address (Second line address)		30	Character	O
277	Delimiter		1	Character, use the ^ character value	
278-307	Provider Business Location Address (City,)		30	Character	R
308	Delimiter		1	Character, use the ^ character value	
309-310	Provider Business Location Address (State)		2	USPS state code abbreviation	R
311	Delimiter		1	Character, use the ^ character value	
312-321	Provider Business Location Address (Postal Code)		10	Character, left-justify, right-fill with spaces if necessary	R
322	Delimiter		1	Character, use the ^ character value	
323-332	Provider Business Location Address (Country Code if outside U.S)	Leave blank if business mailing address is not outside the U.S.	10	Character, left-justify, right-fill with spaces if necessary	O
333	Delimiter		1	Character, use the ^ character value	

334-343	Provider Business Location	Do not enter dashes or parentheses.	10	Numeric	R

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

378-387	Healthcare Provider Taxonomy Code 3	Use if necessary; otherwise leave blank.	10	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
388	Delimiter		1	Character, use the ^ character value	
389-395	Other Provider Identifier	If available, enter the provider's Louisiana Medicaid Provider ID	7	Numeric, left-fill with zeroes.	R, if provider is already enrolled with Medicaid; otherwise, optional.
396	Delimiter		1	Character, use the ^ character value	
397-400	Other Provider Identifier Type Code	Provider Type and Provider Specialty	4	1st 2 characters are provider type; last 2 characters (3-4) are provider specialty. See 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	O
410	Delimiter		1	Character, use the ^ character value	
411-418	Last Update Date	NPPES last update date; leave all zeros if not available.	8	Numeric, format YYYYMMDD	O
419	Delimiter		1	Character, use the ^ character value	

420-439	NPI Deactivation Reason Code	NPPES deactivation reason; leave blank if appropriate.	20	Left justify, right-fill with spaces.	O
440	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
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, required when the Provider has a License, otherwise optional
481	Delimiter		1	Character, use the ^ character value	
482-483	Provider License Number State Code	2-character USPS state code value	2	Character	R
484	Delimiter		1	Character, use the ^ character value	

485-534	Authorized Official Contact Information (First Name, Middle Name, Last Name)		50	Character, left-justified, right-fill with spaces.	R
535	Delimiter		1	Character, use the ^ character value	
536-565	Authorized Official Contact Information		30	Character, left-justified, right-fill with spaces.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
	(Title or Position)				
566	Delimiter		1	Character, use the ^ character value	
567-576	Authorized Official Contact Information (Telephone Number)	Do not enter dashes or parentheses.	10	Numeric	R
577	Delimiter		1	Character, use the ^ character value	
578	Panel Open Indicator	**Y**=Yes, panel is open. **N**=No, panel is not open.	1	Character	R for PCPs; otherwise optional.
579	Delimiter		1	Character, use the ^ character value	
580	Language Indicator 1 (this is the primary language indicator)	1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
581	Delimiter		1	Character, use the ^ character value	

582	Language Indicator 2 (this is a secondary language indicator)	0=no other language supported 1= Accepts English-speaking patients 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-	1	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		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 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O

587	Delimiter		1	Character, use the ^ character value	
588	Language Indicator 5 (this is a secondary language indicator)	0=no other language supported 1=English-speaking patients only 2=Accepts Spanish-speaking patients 3=Accepts Vietnamese-speaking patients 4=Accepts French-speaking patients 5=Accepts Cambodian-speaking patients	1	Character	O
589	Delimiter		1	Character, use the ^ character value	
590	Age Restriction Indicator	**0**=no age restrictions **1**=adult only **2**=pediatric only	1	Character	R for PCPs, specialists and other professionals; otherwise optional.
591	Delimiter		1	Character, use the ^ character value	
592-596	PCP Linkage Maximum	Numeric	5	Numeric, left fill with zeroes. This number represents the **maximum number** of patients that can be linked to the PCP within **this plan.** It should be left all zeroes if the provider is not a PCP/specialist.	R for PCPs; otherwise optional.
597	Delimiter		1	Character, use the ^ character value	

598-602	PCP Actual Linkages with Plan	Numeric	5	Numeric, left fill with zeroes. This number represents the actual number of plan enrollees that are currently linked to the PCP. It should be left all zeroes if the provider is not a PCP	R for PCPs; otherwise optional.
603	Delimiter		1	Character, use	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
				the ^ character value	
604-608	PCP Linkages with **all** MCOs	Numeric	5	Numeric, left fill with zeroes. **Leave this field all zeroes.**	R
609	Delimiter		1	Character, use the ^ character value	
610	MCO Enrollment Indicator	**N**=New enrollment **C**=Change to existing enrollment **D**=Disenrollment **X**=Remove	1	Use this field to identify new providers, changes to existing providers, disenrolled providers and remove records from the registry	R
611	Delimiter		1	Character, use the ^ character value	
612-619	MCO 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 the Companion Guide	2		R for PCPs; otherwise optional.
625	Delimiter		1	Character, use the ^ character value	
626-627	Provider Sub-Specialty 2	If necessary, Value set is determined by DHH and is available in the Companion	2		O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		Guide			
628	Delimiter		1	Character, use the ^ character value	
629-630	Provider Sub-Specialty 3	If necessary, Value set is determined by DHH and is available in the Companion Guide	2		O
631	Delimiter		1	Character, use the ^ character value	
632-661	MCO Contract Name or Number	This should represent the contract name/number that is established between the MCO and the Provider	30	Character	R, but you may enter 0s or spaces to indicator a non-contracted network provider.
662	Delimiter		1	Character, use the ^ character value	
663-670	MCO Contract Begin Date	Date that the contract between the MCO and the provider started	8	Numeric date value in the form YYYYMMDD	R, but you may enter 0s.
671	Delimiter		1	Character, use the ^ character value	

672-679	MCO Contract Term Date	Date that the contract between the MCO and the provider was terminated.	8	Numeric date value in the form YYYYMMDD	O, you may enter 0s. If Contract Begin Date is not 0, then Contract End date must be greater than or equal to Contract Begin Date. Open End Date=20991231
680	Delimiter		1	Character, use the ^ character value	
681-682	Provider Parish served – 1st or primary	Parish code value that represents the primary parish that the provider serves	2	2-digit parish code value. See the Companion Guide.	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
683	Delimiter		1	Character, use the ^ character value	
684-685	Provider Parish served – 2nd	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the 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 Companion Guide.	O
689	Delimiter		1	Character, use the ^ character value	

690-691	Provider Parish served – 4th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
692	Delimiter		1	Character, use the ^ character value	
693-694	Provider Parish served – 5th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
695	Delimiter		1	Character, use the ^ character value	
696-697	Provider Parish served – 6th	Parish code value that represents a	2	2-digit parish code value.	O

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

702-703	Provider Parish served – 8th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
704	Delimiter		1	Character, use the ^ character value	
705-706	Provider Parish served – 9th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
707	Delimiter		1	Character, use the ^ character value	
708-709	Provider Parish served – 10th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise	2	2-digit parish code value. See the Companion Guide.	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		enter 00.			
710	Delimiter		1	Character, use the ^ character value	
711-712	Provider Parish served – 11th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
713	Delimiter		1	Character, use the ^ character value	
714-715	Provider Parish served – 12th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
716	Delimiter		1	Character, use the ^ character value	
717-718	Provider Parish served – 13th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
719	Delimiter		1	Character, use the ^ character value	
720-721	Provider Parish served – 14th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
722	Delimiter		1	Character, use the ^ character value	

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
723-724	Provider Parish served – 15th	Parish code value that represents a secondary or other parish that the provider serves. Use only if necessary; otherwise enter 00.	2	2-digit parish code value. See the Companion Guide.	O
725	Delimiter		1	Character, use the ^ character value	
726	PCP Indicator	0=Not a PCP. 1=Regularly serves as a PCP for a general population group (i.e. can have age or gender limits, but not other specialized limitations on populations served) This would include appropriate provider types and have agreed to fulfill PCP responsibilities for general populations. 2=PCP Extenders – must be linked to a supervising PCP 3=PCP Specialized – for designated individuals only (would not show up as a PCP in any registry or directory.	1	Numeric, value 0, 1, 2 or 3.	R
727	Delimiter		1	Character, use the ^ character	
728	Display Online indicator	0=don't display on EB website 1=display on EB website.		Numeric, value 0 or 1	R
729	Delimiter		1	Character, use the ^ character	
730-759	Expanded Age Restriction	To allow free-form entry for provider to expand for their	30	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
		practice			
760	Delimiter		1	Character, use the ^ character	
761-765	Provider Suffix	Example: JR, SR, etc.	5	Character	O
766	Delimiter		1	Character, use the ^ character	
767-776	Provider Title	Example: MD, RN, etc.	10	Character	O
777	Delimiter		1	Character, use the ^ character	
778	Prescribe r Indicator	Used for Prescriber types: Medical Psychologists, Physicians, Psychiatrists, etc. Valid values are: Blank = not applicable or no prescriptive authority 0 = Full Rx authority 1 = Resident with Rx authority 2 = Limited Rx authority (PA, NP, Medical Psychologist) 3 = Sanctioned 4 = Full Rx authority plus ability to Rx Suboxone (opioid dependents) 5 = Pharmacist who can Rx Immunizations			R for Prescriber types; otherwise, leave blank
779	Space	End of record filler	1	Character, enter a space value	
780	End of record	End of record delimiter	1	Character, use the ^ character value	

Provider Registry Edit Report (sample)

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

CCN ID: NNNNNNN – PROVIDER NAME FROM LMMIS PROVIDER FILE

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

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

Error Codes (A=Accepted, R=Rejected):

000= (A) No errors found

001=(R) Missing/Invalid NPI (not 10 digits)

002=(R) Missing/Invalid Entity Type (must be 1 or 2)

003=(R) Provider record must include taxonomy

004=(R) Missing required information (name, address, contact name, etc.)

005=(R) Missing/Invalid provider type or specialty

006=(R) Invalid provider sub-specialty (if one is submitted and it is not a valid value)
```

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007=(R) Missing/Invalid enrollment indicator (must be N, C, D or X)

008=(R) Missing/Invalid enrollment effective date

009=(R) Invalid panel open indicator value (must be Y, N)

010=(R) Invalid Language indicator value (must be 0, 1, 2, 3, 4, or 5)

011=(R) Invalid Age Restriction indicator value (must be 0, 1, 2)

012=(R) Invalid PCP Linkage Maximum value (must be numeric or zeros)

013=(R) Invalid PCP Linkage BAYOU HEALTH value (must be numeric or zeros)

014=(R) Invalid PCP Linkage Other value (must be numeric or zeros)

015=(R) Invalid Family-Only indicator value (must be 0, 1)

016=(R) Missing BAYOU HEALTH Contract Name or Number (found only spaces)

017=(R) Missing/Invalid BAYOU HEALTH Contract begin date

018=(R) Missing/Invalid BAYOU HEALTH Contract termination date

019=(R) Missing provider parish (at least 1 must be submitted)

020=(R) Invalid provider parish value (for a submitted value)

021=(R) Duplicate NPI records found. Only first one in the file is accepted

022=(R) Medicaid Provider ID (Other Provider Identifier) is not found on MMIS Provider File

023=(R) Missing/Invalid NPPES Enum Date

024=(R) Missing/Invalid Provider License Data

025= (A) NPI not found on LMMIS Provider Enrollment File

026=(R) BAYOU HEALTH provider not found on LMMIS Provider Enrollment File

027=(R) Unable to assign a Medicaid provider... too many collisions
```

```
028=(R) Enrollment Ind=N (new), but provider already exists on registry
```

```
029=(R) Enrollment Ind=C or D, but provider does not exist on registry

030=(R) Invalid taxonomy format (Special characters not allowed)

031=(R) Missing Replacement NPI for an atypical provider

032=(R) Shared Plan providers must be actively enrolled in LA Medicaid

033=(R) Shared Plan Fiscal Agent-Waiver, EDI Billing Agent and Prescribing Only providers not allowed

034=(R) Shared Plan Other Provider Type does not match MMIS enrollment file

035= (A) Non-Par Contractor

036= (A) Shared Plan Other Provider Specialty does not match MMIS enrollment file
037=(R) Invalid PCP Indicator Field (must be 0, 1, 2 or 3)
038=(R) Invalid display online field (must be 0 or 1)
END OF REPORT
```

Provider Registry Edit File Layout

Columns	Field Name	Format	Size	Comments
1-7	MCO Plan ID number	Numeric	7 digits	This is the plan ID.
8	Delimiter	Character	1	Value is ^ character.
9	Enroll Code	Character	1	Submitted by plan: N=New C=Change D=Disenroll X=Remove.
10	Delimiter	Character	1	Value is ^ character.
11-17	Provider ID	Numeric	7 digits	This is the provider's LA Medicaid ID number
18	Delimiter	Character	1	Value is ^ character.
19-28	Provider NPI	Character	10	
29	Delimiter	Character	1	Value is ^ character.
30-59	Provider Name	Character	30	
60	Delimiter	Character	1	Value is ^ character.
61-70	Provider Taxonomy	Character	10	
71	Delimiter	Character	1	Value is ^ character.
72-78	Provider ID	Numeric	7 digits	
79	Delimiter	Character	1	Value is ^ character.
80	Molina Accept/Reject Indicator	Character	1	A=Accepted R=Rejected
81	Delimiter	Character	1	Value is ^ character.
82-84	Edit Code 1	Character	3	
85	Delimiter	Character	1	Value is ^ character.
86-88	Edit Code 2	Character	3	
89	Delimiter	Character	1	Value is ^ character.
90-92	Edit Code 3	Character	3	
93	Delimiter	Character	1	Value is ^ character.
94-96	Edit Code 4	Character	3	
97	Delimiter	Character	1	Value is ^ character.
98-100	Edit Code 5	Character	3	

101	Delimiter	Character	1	Value is ^ character.
102-104	Edit Code 6	Character	3	
105	Delimiter	Character	1	Value is ^ character.
106-108	Edit Code 7	Character	3	
109	Delimiter	Character	1	Value is ^ character.
110-112	Edit Code 8	Character	3	
113	Delimiter	Character	1	Value is ^ character.
114-116	Edit Code 9	Character	3	
117	Delimiter	Character	1	Value is ^ character.
118-120	Edit Code 10	Character	3	
121	Delimiter	Character	1	Value is ^ character.

Provider Registry Site File

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

www.lamedicaid.com

The MCO must log in to this website before being allowed to get to the menu page. The process for using the site is similar to the Provider Registry where the plan will upload their site file updates to Molina using the naming schema "YYYYMMDD_NNNNNNN_Site_PR.txt", where YYYYMMDD is the date of the submission (YMD) and NNNNNNN is their assigned Medicaid check digit provider ID.

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

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

Site File Format

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

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

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

33	289-318	Age Restriction Information	Character	30	Optional	If not known, then place all spaces in this field.	This is a text field that may be used by the plan to represent age restrictions at the practice site/location. If	
							there are no age restrictions, you may enter the value NONE.	
34	319	Delimiter	Character	1	Required	^		023
35	320-369	Group Affiliation Information	Character	50	Optional	If not used, then place all spaces in this field.	This is a text field that the plan may use to identify a group or clinic for which the provider site is affiliated. Examples are: LSU Healthcare Network Ochsner Clinics We request that the plan maintain consistency in this field.	
36	370	Delimiter	Character	1	Required	^		023
37	371	Submission Type / Enrollment Indicator	Character	1	Required	**N**=New Site Record **C**=Change to Existing Site Record **D**=Disenrollment of Site Record **X**=Remove	For changes and dis-enrollments, this record (identified by **Plan ID, NPI, Taxonomy and Site Number**) must already exist on the site registry. For new records, the record must not already exist on the site registry.	005, 018, 019
38	372	Delimiter	Character	1	Required	^		023
39	373-380	Submission Date	Numeric	8	Required	Must be a numeric date value in the format YYYYMMDD.	This is the date that you are submitting the record.	006
40	381	Delimiter	Character	1	Required	^		023
41	382-389	Site Enrollment Effective Begin Date	Numeric	8	Required	Must be a numeric date value in the format YYYYMMDD.	This is the effective begin date of the practice/site enrollment. You may not use zeros, and it must represent a valid date.	009
42	390	Delimiter	Character	1	Required	^		023

43	391-398	Site Enrollment Effective End Date	Numeric	8	Required	Must be a numeric date value in the format YYYYMMDD.	This is the effective end date of the practice/site enrollment. You may not use zeros, and it must represent a valid date.	010
							Do not use zeros to indicate open-end; instead, use 20991231 to indicate open-end. The enrollment end date must be greater than or equal to the enrollment begin date.	
44	399	END OF RECORD INDICATOR	Character	1	Required	^	If not present, the record will be rejected.	023

Error Messages

'000'='No errors found'

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

digits)'

'002'='Provider record must include taxonomy'

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

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

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

'006'='Missing/Invalid submission date'

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

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

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

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

'011'='Missing provider site parish'

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

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

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

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

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

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

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

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

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

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

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

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

Error File Format

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

Primary Care Physician (PCP) Linkage Directory

MCOs are required to send to the FI, along with the Weekly Provider Registry File, a full replacement recipient Primary Care Physician Linkage Directory. The format for the PCP Linkage File Layout, along with instructions, can be found on the following pages.

MCO Batch Electronic File Layout for PCP Linkage

Subject to Change

PART 1: PLAN FILE SUBMISSIONS

File submissions should occur once per week on or before Friday COB (5:00 p.m. CT) unless it is a holiday and then the MCO may submit the file on the previous applicable work day. If the MCO chooses to do so because it is applicable to its processing environment, a file may be submitted on Friday if it is a holiday.

The MCO may submit only one file per week, and this file should contain all records that you expect to submit during that week.

The weekly file should be a full file representing all PCP-to-recipient linkages (current and historical) that the MCO has in its system. There is no incremental update process; instead, the FI will perform a full replacement from the MCOs weekly file submission.

File submissions should utilize Molina's non-EDI FTP service.

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

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

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*R=Required O=Optional*	*Notes*
001	1-7	PCP_LINKAGE_PLAN_ID	number(7)	R	Use your assigned plan ID
002	8-17	PCP_LINKAGE_PCP_NPI	number(10)	R	10-digit NPI of the PCP.
003	18-27	PCP_LINKAGE_PCP_TAXONOMY	char(10)	R	10-character taxonomy of the PCP.
004	28-40	PCP_LINKAGE_RECIPIENT_MEDICAID_ID	char(13)	R	13-digit Medicaid ID number of the Recipient. Left-fill with zero(s).
005	41-49	PCP_LINKAGE_RECIPIENT_SSN	char(9)	R	9-digit Social Security Number of the Recipient. Left-fill with zero(s).
006	50-57	PCP_LINKAGE_RECIPIENT_DOB	number(8)	R	Recipient Date of Birth. Format=YYYYMMDD.
007	58-65	PCP_LINKAGE_BEGIN_DATE_YYMMDD	number(8)	R	Beginning date of Recipient's Linkage to PCP. Format=YYYYMMDD. Value should not precede 20120201.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
008	66-73	PCP_LINKAGE_END_DATE_YYMMDD	number(8)	R	Ending date of Recipient's Linkage to PCP. Format=YYYYMMDD. Value for an open-ended linkage should be 99991231.
009	74-100	FILLER	char(27)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture the MCOs file, archive it, edit it, and use it to update Molina's Data Warehouse. Molina's update process performs edits and produces an error text file that they will send back to the MCO via your FTP server (showing only your submitted records, if they hit an edit). If none of the MCO's records hit an edit, Molina will send back an empty error text file.

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

The error text file will have this layout:

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

ERROR CODES

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

001 Invalid value for Field 001 (PCP_LINKAGE_PLAN_ID).
21 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The NPI value submitted does not have 10 digits.
22 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The NPI value submitted is zero or the value is not numeric.
23 Invalid value for Field 002 (PCP_LINKAGE_PCP_NPI). The NPI value submitted is not found on your plan's provider registry for the given Taxonomy value.
31 Invalid value for Field 003 (PCP_LINKAGE_PCP_TAXONOMY). Taxonomy value submitted does not have 10 characters.
32 Invalid value for Field 003 (PCP_LINKAGE_PCP_TAXONOMY). Taxonomy value submitted is not found on your plan's provider registry for the given NPI value.
41 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is not 13 digits.
42 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is zero or the value is not numeric.
43 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is not found in the LMMIS Medicaid Recipient File.
043 Invalid value for Field 004 (PCP_LINKAGE_RECIPIENT_MEDICAID_ID). Recipient ID submitted is not linked to the plan.
51 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is not 9 digits.
52 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is zero or the value is not numeric.
53 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is not found in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
54 Invalid value for Field 005 (PCP_LINKAGE_RECIPIENT_SSN). Recipient SSN submitted is not equal to the one in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
61 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is zero or the value is not numeric.
62 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is too far in the past or is in the future.
63 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is not a valid date value.
64 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is not found in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
65 Invalid value for Field 006 (PCP_LINKAGE_RECIPIENT_DOB). DOB value submitted is not equal to the one in the LMMIS Medicaid Recipient File for the submitted Recipient ID.
71 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is zero or the value is not numeric.
72 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is before 20120201 or is after 99991231.
73 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is after the End Date value submitted.
74 Invalid value for Field 007 (PCP_LINKAGE_BEGIN_DATE_YYMMDD). The Begin Date value submitted is not a valid date value.
81 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is zero or the value is not numeric.
82 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is before 20120201 or is after 99991231.

83 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is before the Begin Date value submitted.
84 Invalid value for Field 008 (PCP_LINKAGE_END_DATE_YYMMDD). The End Date value submitted is not a valid date value.

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

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

END OF SECTION

Lookup Taxonomy Table (LTX)

(Effective 7-13-2015)

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

09	HOSPICE SERVICES (IN-ST)	93	Hospice Service for Dual Elig.	315D00000X	Nursing & Custodial Care Facilities Hospice, Inpatient
10	COMPREHENSIVE COMM SUPPORT SRV	70	Clinic or Other Group Practice	253Z00000X	Agencies In Home Supportive Care
11	SHARED LIVING (WVR) (IN-ST)	4A	Developmentally Disabled (DD)	372600000X	Nursing Service Related Providers Adult Companion
12	MULTI-SYSTEMIC THER (IN-ST)	5M	Multi-Systemic Therapy	261QP2000X	Ambulatory Health Care Facilities Clinic/Center Physical Therapy
13	PREVOC REHAB (WVR) (IN-ST)	36	Pre-Vocational Habilitation	251C00000X	Agencies Day Training, Developmentally Disabled Services
14	DAY HABILITAT (WVR) (IN-ST)	50	Day Habilitation	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
15	ENVIR ACC ADAP (WVR) (IN-ST)	80	Environmental Accessibility Adaptations	171W00000X	Other Service Providers Contractor
16	PERS EMERG RESP SYS (WVR)	90	Personal Emergency Response Sys (Waiver)	333300000X	Suppliers Emergency Response System Companies
17	ASSISTIVE DEVICES (WVR)	91	Assistive Devices	225CA2400X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers Rehabilitation Counselor Assistive Technology Practitioner
18	COMM MENTAL HLTH CTR/PART HOSP	5H	Community Mental Health Center	261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health
19	DR OF OSTEOPATH MED (IND & GP)	01	General Practice	208D00000X	Allopathic & Osteopathic Physicians/General Practice
19	DR OF OSTEOPATH MED (IND & GP)	02	General Surgery	208600000X	Allopathic & Osteopathic Physicians/Surgery
19	DR OF OSTEOPATH MED (IND & GP)	03	Allergy	207K00000X	Allopathic & Osteopathic Physicians/Allergy and Immunology

19	DR OF OSTEOPATH MED (IND & GP)	04	Otology, Laryngology, Rhinology	207YX0901X	Allopathic & Osteopathic Physicians/Otolaryngology/Otology & Neurotology
19	DR OF OSTEOPATH MED (IND & GP)	05	Anesthesiology	207L00000X	Allopathic & Osteopathic Physicians/Anesthesiology
19	DR OF OSTEOPATH MED (IND & GP)	06	Cardiovascular Disease	207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Cardiovascular Disease
19	DR OF OSTEOPATH MED (IND & GP)	07	Dermatology	207N00000X	Allopathic & Osteopathic Physicians/Dermatology
19	DR OF OSTEOPATH MED (IND & GP)	08	Family Practice	207Q00000X	Allopathic & Osteopathic Physicians/Family Medicine
19	DR OF OSTEOPATH MED (IND & GP)	09	Gynecology (DO only)	207V00000X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology
19	DR OF OSTEOPATH MED (IND & GP)	10	Gastroenterology	207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine, Gastroenterology
19	DR OF OSTEOPATH MED (IND & GP)	12	Manipulative Therapy (DO only)	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
19	DR OF OSTEOPATH MED (IND & GP)	13	Neurology	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
19	DR OF OSTEOPATH MED (IND & GP)	14	Neurological Surgery	207T00000X	Allopathic & Osteopathic Physicians/Neurological Surgery
19	DR OF OSTEOPATH MED (IND & GP)	15	Obstetrics (DO only)	207V00000X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology
19	DR OF OSTEOPATH MED (IND & GP)	16	OB/GYN	207VG0400X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Gynecology
19	DR OF OSTEOPATH MED (IND & GP)	17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	207W00000X	Allopathic & Osteopathic Physicians/Ophthalmology
19	DR OF OSTEOPATH MED (IND & GP)	19	Orthodontist	1223X0400X	Orthodontics and Dentofacial Orthopedics

19	DR OF OSTEOPATH MED (IND & GP)	1T	Emergency Medicine	207P00000X	Allopathic & Osteopathic Physicians/Emergency Medicine
19	DR OF OSTEOPATH MED (IND & GP)	20	Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery
19	DR OF OSTEOPATH MED (IND & GP)	21	Pathologic Anatomy; Clinical Pathology (DO only)	207ZP0102X	Allopathic & Osteopathic Physicians/Pathology, Anatomic Pathology & Clinical Pathology
19	DR OF OSTEOPATH MED (IND & GP)	23	Peripheral Vascular Disease or Surgery (DO only)	246XC2903X	Vascular Specialist
19	DR OF OSTEOPATH MED (IND & GP)	24	Plastic Surgery	208200000X	Allopathic & Osteopathic Physicians/Plastic Surgery
19	DR OF OSTEOPATH MED (IND & GP)	25	Physical Medicine Rehabilitation	208100000X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation
19	DR OF OSTEOPATH MED (IND & GP)	26	Psychiatry	2084P0800X	Allopathic & Osteopathic Physicians/Psychiatry
19	DR OF OSTEOPATH MED (IND & GP)	27	Psychiatry; Neurology (DO only)	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
19	DR OF OSTEOPATH MED (IND & GP)	28	Proctology	208C00000X	Allopathic & Osteopathic Physicians/Colon & Rectal Surgery
19	DR OF OSTEOPATH MED (IND & GP)	29	Pulmonary Diseases	207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
19	DR OF OSTEOPATH MED (IND & GP)	2Q	Nuclear Medicine	207U00000X	Allopathic & Osteopathic Physicians/Nuclear Medicine
19	DR OF OSTEOPATH MED (IND & GP)	30	Radiology	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
19	DR OF OSTEOPATH MED (IND & GP)	31	Roentgenology, Radiology (DO only)	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology

19	DR OF OSTEOPATH MED (IND & GP)	32	Radiation Therapy (DO only)	2085R0001X	Allopathic & Osteopathic Physicians/Radiology, Radiation Oncology
19	DR OF OSTEOPATH MED (IND & GP)	33	Thoracic Surgery	208G00000X	Allopathic & Osteopathic Physicians/Thoracic Surgery (Cardiothoracic Vascular Surgery)
19	DR OF OSTEOPATH MED (IND & GP)	34	Urology	208800000X	Allopathic & Osteopathic Physicians/Urology
19	DR OF OSTEOPATH MED (IND & GP)	37	Pediatrics	208000000X	Allopathic & Osteopathic Physicians/Pediatrics
19	DR OF OSTEOPATH MED (IND & GP)	38	Geriatrics	207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
19	DR OF OSTEOPATH MED (IND & GP)	39	Nephrology	207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
19	DR OF OSTEOPATH MED (IND & GP)	40	Hand Surgery	207XS0106X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery/Hand Surgery
19	DR OF OSTEOPATH MED (IND & GP)	41	Internal Medicine	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
19	DR OF OSTEOPATH MED (IND & GP)	70	Clinic or Other Group Practice	193200000X	Multi-Specialty Group
20	PHYSICIAN (IND & GP)	01	General Practice	208D00000X	Allopathic & Osteopathic Physicians/General Practice
20	PHYSICIAN (IND & GP)	02	General Surgery	208600000X	Allopathic & Osteopathic Physicians/Surgery
20	PHYSICIAN (IND & GP)	03	Allergy	207K00000X	Allopathic & Osteopathic Physicians/Allergy and Immunology
20	PHYSICIAN (IND & GP)	04	Otology, Laryngology, Rhinology	207YX0901X	Allopathic & Osteopathic Physicians/Otolaryngology/Otology & Neurotology
20	PHYSICIAN (IND & GP)	05	Anesthesiology	207L00000X	Allopathic & Osteopathic Physicians/Anesthesiology

20	PHYSICIAN (IND & GP)	06	Cardiovascular Disease	207RC0000X	Allopathic & Osteopathic Physicians/Internal Medicine, Cardiovascular Disease
20	PHYSICIAN (IND & GP)	07	Dermatology	207N00000X	Allopathic & Osteopathic Physicians/Dermatology
20	PHYSICIAN (IND & GP)	08	Family Practice	207Q00000X	Allopathic & Osteopathic Physicians/Family Medicine
20	PHYSICIAN (IND & GP)	10	Gastroenterology	207RG0100X	Allopathic & Osteopathic Physicians/Internal Medicine, Gastroenterology
20	PHYSICIAN (IND & GP)	13	Neurology	2084N0400X	Allopathic & Osteopathic Physicians/Psychiatry and Neurology, Neurology
20	PHYSICIAN (IND & GP)	14	Neurological Surgery	207T00000X	Allopathic & Osteopathic Physicians/Neurological Surgery
20	PHYSICIAN (IND & GP)	16	OB/GYN	207VG0400X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Gynecology
20	PHYSICIAN (IND & GP)	18	Ophthalmology	207W00000X	Allopathic & Osteopathic Physicians/Ophthalmology
20	PHYSICIAN (IND & GP)	19	Orthodontist	1223X0400X	Orthodontics and Dentofacial Orthopedics
20	PHYSICIAN (IND & GP)	1T	Emergency Medicine	207P00000X	Allopathic & Osteopathic Physicians/Emergency Medicine
20	PHYSICIAN (IND & GP)	20	Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery
20	PHYSICIAN (IND & GP)	22	Pathology	207ZP0102X	Allopathic and Osteopathic Physicians - Pathology - Anatomic Pathology and Clinical Pathology
20	PHYSICIAN (IND & GP)	24	Plastic Surgery	208200000X	Allopathic & Osteopathic Physicians/Plastic Surgery

20	PHYSICIAN (IND & GP)	25	Physical Medicine Rehabilitation	208100000X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation
20	PHYSICIAN (IND & GP)	26	Psychiatry	2084P0800X	Allopathic & Osteopathic Physicians/Psychiatry
20	PHYSICIAN (IND & GP)	28	Proctology	208C00000X	Allopathic & Osteopathic Physicians/Colon & Rectal Surgery
20	PHYSICIAN (IND & GP)	29	Pulmonary Diseases	207RP1001X	Allopathic & Osteopathic Physicians/Internal Medicine, Pulmonary Disease
20	PHYSICIAN (IND & GP)	2Q	Nuclear Medicine	207U00000X	Allopathic & Osteopathic Physicians/Nuclear Medicine
20	PHYSICIAN (IND & GP)	30	Radiology	2085R0202X	Allopathic & Osteopathic Physicians/Radiology, Diagnostic Radiology
20	PHYSICIAN (IND & GP)	33	Thoracic Surgery	208G00000X	Allopathic & Osteopathic Physicians/Thoracic Surgery (Cardiothoracic Vascular Surgery)
20	PHYSICIAN (IND & GP)	34	Urology	208800000X	Allopathic & Osteopathic Physicians/Urology
20	PHYSICIAN (IND & GP)	37	Pediatrics	208000000X	Allopathic & Osteopathic Physicians/Pediatrics
20	PHYSICIAN (IND & GP)	38	Geriatrics	207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine
20	PHYSICIAN (IND & GP)	39	Nephrology	207RN0300X	Allopathic & Osteopathic Physicians/Internal Medicine, Nephrology
20	PHYSICIAN (IND & GP)	40	Hand Surgery	207XS0106X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery/Hand Surgery
20	PHYSICIAN (IND & GP)	41	Internal Medicine	207R00000X	Allopathic & Osteopathic Physicians/Internal Medicine
20	PHYSICIAN (IND & GP)	48	Podiatry - Surgical Chiropody	213E00000X	Podiatric Medicine and Surgery Providers - Podiatrists

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

24	PERSONAL CARE SERVICES (IN-ST)	5E	Personal Assistant Service (PAS)	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5F	PCS-EPSDT, PAS	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
24	PERSONAL CARE SERVICES (IN-ST)	5G	PCS-LTC, PCS-EPSDT, PAS	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
25	MOBILE XRAY/RADIATION THRPY CT	63	Portable X-Ray Supplier (Billing Independently)	261QR0208X	Ambulatory Health Care Facilities/Clinic-Center, Radiology, Mammography
26	PHARMACY (OOS-CROSSOVERS ONLY)	87	All Other	333600000X	Suppliers/Pharmacy
27	DENTIST (IND & GP)	66	General Dentistry (DDS/DMS)	122300000X	Dental Providers Dentist
27	DENTIST (IND & GP)	67	Oral and Maxillofacial Surgery	1223S0112X	Dental Providers - Dentists - Oral and Maxillofacial Surgery
27	DENTIST (IND & GP)	68	Pediatric Dentistry	1223P0221X	Dental Providers - Dentists - Pediatric Dentistry
27	DENTIST (IND & GP)	6N	Endodontist	1223E0200X	Dental Providers - Dentists - Endodontics
27	DENTIST (IND & GP)	6P	Periodontist	1223P0300X	Dental Providers - Dentists - Periodontics
28	OPTOMETRIST (IND & GP)	88	Optician / Optometrist	152W00000X	Eye and Vision Service Providers/Optometrist
29	EARLYSTEPS (IND & GP) (IN-ST)	62	Psychologist Crossovers only	103T00000X	Behavioral Health & Social Service Providers/Psychologist
29	EARLYSTEPS (IND & GP) (IN-ST)	64	Audiologist (Billing Independently)	231H00000X	Speech, Language and Hearing Service Providers/Audiologist
29	EARLYSTEPS (IND & GP) (IN-ST)	65	Indiv Physical Therapist	225100000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Physical Therapist
29	EARLYSTEPS (IND & GP) (IN-ST)	71	Speech Therapy	235500000X	Speech, Language and Hearing Service Providers Specialist/Technologist

29	EARLYSTEPS (IND & GP) (IN-ST)	74	Occupational Therapy	225X00000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Occupational Therapist
30	CHIROPRACTOR (IND & GP)	35	Chiropractor	111N00000X	Chiropractic Providers/Chiropractor
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	62	Psychologist Crossovers only	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6A	Psychologist -Clinical	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6B	Psychologist-Counseling	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6C	Psychologist - School	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6D	Psychologist - Developmental	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6E	Psychologist - Non-Declared	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	6F	Psychologist - All Other	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	95	Psychologist (PBS Program Only)	103T00000X	Behavioral Health & Social Service Providers/Psychologist
31	PSYCHOLOGIST (LIC/MED) (IN-ST)	96	Psychologist (PBS Program and X-Overs)	103T00000X	Behavioral Health & Social Service Providers/Psychologist
32	PODIATRIST (IND & GP)	48	Podiatry - Surgical Chiropody	213E00000X	Podiatric Medicine & Surgery Service Providers/Podiatrist
33	PRESCRIBING ONLY PROVIDER	92	PRESCRIBING ONLY PROVIDER	NA	
34	AUDIOLOGIST (IN-ST)	64	Audiologist (Billing Independently)	231H00000X	Speech, Language and Hearing Service Providers/Audiologist
35	PHYSICAL THERAPIST (IN-ST)	35	Chiropractor	111N00000X	Chiropractic Providers/Chiropractor
35	PHYSICAL THERAPIST (IN-ST)	65	Indiv Physical Therapist	225100000X	Respiratory, Developmental, Rehabilitative & Restorative Service Providers/Physical Therapist

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

40	DME (OOS-CROSSOVERS ONLY)	56	Indiv Certified Prosthetist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	57	Indiv Certified Prosthetist - Orthotist	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	58	Indiv Not Included in 55, 56, 57	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
40	DME (OOS-CROSSOVERS ONLY)	87	All Other	332B00000X	Suppliers/Durable Medical Equipment & Medical Supplies
41	REGISTERED DIETICIAN (IN-ST)	4R	Registered Dietician	133V00000X	Dietary & Nutritional Service Providers/Dietician, Registered
42	NON-EMER MED TRANSPORT (IN-ST)	45	NEMT - Non-profit	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	46	NEMT - Profit	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	47	NEMT - F+F	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	4W	Waiver Services	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
42	NON-EMER MED TRANSPORT (IN-ST)	4X	Waiver-Only Transportation	343900000X	Transportation Services Non-emergency Medical Transport (VAN)
43	CASE MGT - NHV/FTM (IN-ST)	81	Case Management	163WC0400X	Nursing Service Providers Registered Nurse Case Management
44	HOME HEALTH AGENCY (IN-ST)	87	All Other	251E00000X	Agencies/Home Health
45	CASE MGMT - CONTRACTOR (IN-ST)	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
46	CASE MGMT - HIV	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
47	CASE MGMT - CMI	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
48	CASE MGMT - PREGNANT WOMEN	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator

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

64	MENTAL HLTH HOSP (FREE-STAND)	86	Hospitals and Nursing Homes	283Q00000X	Hospitals/Psychiatric Hospital
65	REHABILITATION CENTER (IN-ST)	75	Other Medical Care	261QR0400X	Ambulatory Health Care Facilities/Clinic/Center, Rehabilitation
66	KIDMED SCREENING CLINIC	44	Public Health/EPSDT	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
66	KIDMED SCREENING CLINIC	60	Public Health or Welfare Agencies & Clinics	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
67	PRENATAL HLTH CARE CL (IN-ST)	60	Public Health or Welfare Agencies & Clinics	261QP2300X	Ambulatory Health Care Facilities Clinic/Center Primary Care
68	SUBS/ALCOH ABSE CTR (X-OVERS)	5N	Substance Abuse and Alcohol Abuse Center	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility
68	SUBS/ALCOH ABSE CTR (X-OVERS)	70	Clinic or Other Group Practice	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility
69	DIST PART PSYCH HOSP (IN-ST)	86	Hospitals and Nursing Homes	283Q00000X	Hospitals/Psychiatric Hospital
70	EPSDT HEALTH SERVICES (IN-ST)	44	Public Health/EPSDT	251300000X	Agencies Local Education Agency (LEA)
71	FMLY PLANNING CLINIC (IN-ST)	97	Family Planning Clinic	261QF0050X	Ambulatory Health Care Facilities Clinic/Center Family Planning, Non-Surgical
72	FED QUALIFIED HLTH CTR (IN-ST)	42	Federally Qualified Health Centers	261QF0400X	Ambulatory Health Care Facilities/Federally Qualified Health Center (FQHC)
72	FED QUALIFIED HLTH CTR (IN-ST)	9L	RHC/FQHC OPH Certified SBHC	261QF0400X	Ambulatory Health Care Facilities/Federally Qualified Health Center (FQHC)
73	LIC CL SOCIAL WORKER (IN-ST)	73	Social Worker Enrollment	104100000X	Behavioral Health & Social Service Providers Social Worker

74	MENTAL HEALTH CLINIC (IN-ST)	70	Clinic or Other Group Practice	261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health
75	OPTICAL SUPPLIER	88	Optician / Optometrist	332H00000X	Suppliers Eyewear Supplier (Equipment, not the service)
76	HEMODIALYSIS CENTER (IN-ST)	70	Clinic or Other Group Practice	261QE0700X	Ambulatory Health Care Facilities/End-Stage Renal Disease (ESRD) Treatment
77	MENTAL REHAB AGENCY (IN-ST)	78	Mental Health Rehab	103TR0400X	Behavioral Health & Social Service Providers/Psychologist, Rehabilitation
78	NURSE PRACTITIONER (IND & GP)	08	Family Practice	363LF0000X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Family
78	NURSE PRACTITIONER (IND & GP)	16	OB/GYN	363LX0001X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Obstetrics & Gynecology
78	NURSE PRACTITIONER (IND & GP)	26	Psychiatry	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health
78	NURSE PRACTITIONER (IND & GP)	37	Pediatrics	363LP0200X	Physician Assistants and Advanced Practice Nursing Providers - Nurse Practitioner - Pediatrics
78	NURSE PRACTITIONER (IND & GP)	79	Nurse Practitioner	363L00000X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner
79	RURAL HLTH CL(PROV-BSE)(IN-ST)	94	Rural Health Clinic	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center, Rural Health
80	NURSING FACILITY (IN-ST)	86	Hospitals and Nursing Homes	314000000X	Nursing and Custodial Care Facilities/Skilled Nursing Facility

81	CASE MGMT - VENT ASSTD CARE	81	Case Management	171M00000X	Other Service Providers Case Manager/Care Coordinator
82	PERS CARE ATTEND (WVR) (IN-ST)	82	Personal Care Attendant	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
82	PERS CARE ATTEND (WVR) (IN-ST)	8D	Community Choices Waiver - Caregiver Temporary Support	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
83	CTR BASED RESPITE CARE (IN-ST)	83	Respite Care	385H00000X	Respite Care Facility Respite Care
83	CTR BASED RESPITE CARE (IN-ST)	8D	Community Choices Waiver - Caregiver Temporary Support	385H00000X	Respite Care Facility Respite Care
84	SUBSTIT FMLY CARE (WVR)(IN-ST)	84	Substitute Family Care	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
85	ADLT DAY HLTH CA (WVR) (IN-ST)	76	Adult Day Care	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
85	ADLT DAY HLTH CA (WVR) (IN-ST)	77	Habilitation	261QA0600X	Ambulatory Health Care Facilities Clinic/Center Adult Day Care
86	ICF/DD REHABILITATION			261QR0400X	Ambulatory Health Care Facilities/Clinic/Center, Rehabilitation
87	RURAL HLTH CL(INDEPEND)(IN-ST)	94	Rural Health Clinic	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center, Rural Health
88	ICF/DD - GROUP HOME (IN-ST)	86	Hospitals and Nursing Homes	261QD1600X	Ambulatory Health Care Facilities Clinic/Center Developmental Disabilities
89	SPRVISE INDEP LIV (WVR)(IN-ST)	89	Supervised Independent Living	372600000X	Nursing Service Related Providers Adult Companion
90	CERTIFIED NURSE MIDWIFE	16	OB/GYN	367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse
91	CERT REG NURS ANEST (IND & GP)	05	Anesthesiology	163W00000X	Nursing Service Providers Registered Nurse

91	CERT REG NURS ANEST (IND & GP)	70	Clinic or Other Group Practice	163W00000X	Nursing Service Providers Registered Nurse
92	PRIVATE DUTY NURSE			NA	
93	CLINICAL NURSE SPECIALIST	02	General Surgery	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist
93	CLINICAL NURSE SPECIALIST	26	Psychiatry	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist
94	PHYSICIAN ASSISTANT	26	Psychiatry	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health
94	PHYSICIAN ASSISTANT	2R	Physician Assistant	363A00000X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant
95	AMERICAN INDIAN/638 FACILITY	2T	American Indian / Native Alaskan	332800000X	Suppliers Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy
96	PSYCH RESID TREAT FACILITY	8L	Hospital-based PRTF	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
96	PSYCH RESID TREAT FACILITY	8P	IP - Physician - MD	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
96	PSYCH RESID TREAT FACILITY	9B	Psychiatric Residential Treatment Facility	323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
97	ADULT RESIDENTIAL CARE FAC	9D	Residential Care	3747P1801X	Nursing Service Related Providers Technician Personal Care Attendant
98	SUPPORTED EMPLYMENT (IN-ST)	98	Supported Employment	251C00000X	Agencies Day Training, Developmentally Disabled Services
99	GREAT NO COMM HLTH CONN(IN-ST)	9P	GNOCHC - Greater New Orleans Community Health Connection	251K00000X	Agencies/Public Health or Welfare

AA	ASSERTIVE COMM TREAT TEAM			261QC1500X	Ambulatory Health Care Facilities Clinic/Center Community Health
AB	PREPAID INPATIENT HLTH PLAN	5I	Statewide Management Organization (SMO)	305R00000X	Managed Care Organizations Preferred Provider Organization
AC	FAMILY SUPPORT ORGANIZATION	5J	Youth Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AC	FAMILY SUPPORT ORGANIZATION	5K	Family Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AC	FAMILY SUPPORT ORGANIZATION	5L	Both Youth and Family Support	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health
AD	TRANSITION COORDINATION	5U	Individual	251C00000X	Agencies Day Training, Developmentally Disabled Services
AD	TRANSITION COORDINATION	5V	Agency/Business	251C00000X	Agencies Day Training, Developmentally Disabled Services
AE	RESPITE CARE SERVICE AGENCY	83	Respite Care	385H00000X	Respite Care Facility Respite Care
AF	CRISIS RECEIVING CENTER	8E	CSoC/Behavioral Health	261Q00000X	Ambulatory Health Care Facilities Clinic/Center
AG	BEHAVIORAL HLTH REHAB AGENCY	8E	CSoC/Behavioral Health	251S00000X	Agencies Community/Behavioral Health
AH	LIC MARRIAGE & FAMILY THERAPY	8E	CSoC/Behavioral Health	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
AJ	LICENSED ADDICTION COUNSELOR	8E	CSoC/Behavioral Health	101YA0400X	Behavioral Health & Social Service Providers Counselor Addiction (Substance Use Disorder)
AK	LICENSED PROFESSION COUNSELOR	8E	CSoC/Behavioral Health	101YP2500X	Behavioral Health & Social Service Providers Counselor Professional
AL	COMMUNITY CHOICE WAIVER-NURS	8K	ADHC HCBS	251K00000X	Agencies/Public Health or Welfare

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

Provider Supplemental Record Layout

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
NOTE: This record format describes a fixed-format layout. The record size is fixed at 683 bytes. If a field is listed as Optional (O), and the MCO elects not to populate the field, then it should be filled with blanks as appropriate to the Length. *Note: Numeric values will be filled with blanks, if missing.					
1-7	MCO-Plan ID	Managed Care Provider ID	7	Numeric	R
8-8	Delimiter	Use the ^ character value	1	Character	R
9-18	NPI	National Provider Identification number. If the NPI does not exist, use the Replacement NPI submitted on the Provider Registry. It will never contain the Medicaid-Assigned-ID	10	Numeric	R
19-19	Delimiter	Use the ^ character value	1	Character	R
20-26	Medicaid Assigned ID	Managed Care Medicaid Assigned ID Not the Medicaid Legacy ID, but the ID assigned to the provider for the MCO. Note that the provider will have a different ID for each MCO.	7	Numeric	R
27-27	Delimiter	Use the ^ character value	1	Character	R
28-36	SSN	Provider Social Security Number	9	Numeric	O R if Tax ID is blank
37-37	Delimiter	Use the ^ character value	1	Character	R
38-46	Tax ID	Provider Tax ID	9	Numeric	O R if SSN is blank
47-47	Delimiter	Use the ^ character value	1	Character	R
48-55	Date of Birth	Provider Date of Birth	8	Date	O
56-56	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
57-58	Ownership-Code	A code denoting the ownership interest and/or managing control information. The valid values list is a Medicare standard list. 01 Voluntary – Non-Profit – Religious Organizations 02 Voluntary – Non-Profit – Other 03 Voluntary – multiple owners 04 Proprietary – Individual 05 Proprietary – Corporation 06 Proprietary – Partnership 07 Proprietary – Other 08 Proprietary – multiple owners 09 Government – Federal 10 Government – State 11 Government – City 12 Government – County 13 Government – City-County 14 Government – Hospital District 15 Government – State and City/County 16 Government – other multiple owners 17 Voluntary /Proprietary 18 Proprietary/Government 19 Voluntary/Government 88 N/A – The individual only practices as part of a group, e.g., as an employee	2	Numeric	R
59-59	Delimiter	Use the ^ character value	1	Character	R
60-61	FIPS State	The FIPS State code is a 2-digit code developed by the US Census Bureau for state designation. To obtain the correct state designation, please click the name of the field.	2	Numeric	O
62-62	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
63-65	FIPS Parish/County	The FIPS County code is a 3-digit code developed by the US Census Bureau for county designation within a state. To obtain the correct county designation, please click the name of the field.	3	Numeric	O
66-66	Delimiter	Use the ^ character value	1	Character	R
67-126	Provider Business Mailing Email Address	The email address associated with the provider's billing address. Blank (Space filled) if no email address exists.	60	Character	O
127-127	Delimiter	Use the ^ character value	1	Character	R
128-187	Provider Business Location Email Address	The email address associated with the provider's physical address. Blank (Space filled) if no email address exists.	60	Character	O
188-188	Delimiter	Use the ^ character value	1	Character	R
189-189	License Type 1	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other	1	Numeric	R
190-190	Delimiter	Use the ^ character value	1	Character	R
191-210	License Or Accreditation-Number 1	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	R
211-211	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
212-271	License issuing ID 1	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	R
272-272	Delimiter	Use the ^ character value	1	Character	R
273-280	License effective date 1	The beginning effective date of the license	8	Date	R
281-281	Delimiter	Use the ^ character value	1	Character	R
282-289	License End date 1	The last date the license was active. (20991231 for open and unknown)	8	Date	R
290-290	Delimiter	Use the ^ character value	1	Character	R
291-291	License Type 2	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
292-292	Delimiter	Use the ^ character value	1	Character	R
293-312	License Or Accreditation-Number 2	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
313-313	Delimiter	Use the ^ character value	1	Character	R
314-373	License issuing ID 2	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
374-374	Delimiter	Use the ^ character value	1	Character	R
375-382	License effective date 2	The beginning effective date of the license	8	Date	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
383-383	Delimiter	Use the ^ character value	1	Character	R
384-391	License End date 2	The last date the license was active. (20991231 for open and unknown)	8	Date	R
392-392	Delimiter	Use the ^ character value	1	Character	R
393-393	License Type 3	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
394-394	Delimiter	Use the ^ character value	1	Character	R
395-414	License Or Accreditation-Number 3	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
415-415	Delimiter	Use the ^ character value	1	Character	R
416-475	License issuing ID 3	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
476-476	Delimiter	Use the ^ character value	1	Character	R
477-484	License effective date 3	The beginning effective date of the license	8	Date	O
485-485	Delimiter	Use the ^ character value	1	Character	R
486-493	License End date 3	The last date the license was active. (20991231 for open and unknown)	8	Date	R
494-494	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
495-495	License Type 4	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
496-496	Delimiter	Use the ^ character value	1	Character	R
497-516	License Or Accreditation-Number 4	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
517-517	Delimiter	Use the ^ character value	1	Character	R
518-577	License issuing ID 4	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
578-578	Delimiter	Use the ^ character value	1	Character	R
579-586	License effective date 4	The beginning effective date of the license	8	Date	O
587-587	Delimiter	Use the ^ character value	1	Character	R
588-595	License End date 4	The last date the license was active. (20991231 for open and unknown)	8	Date	R
596-596	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
597-597	License Type 5	1 State, county, or municipality professional or business license 2 DEA license 3 Professional society accreditation 4 CLIA accreditation 5 Other Blank (Space filled) if no additional license or accreditation	1	Numeric	O
598-598	Delimiter	Use the ^ character value	1	Character	R
599-618	License Or Accreditation-Number 5	A data element to capture the license or accreditation number issued to the provider by the licensing entity or accreditation body.	20	Character	O
619-619	Delimiter	Use the ^ character value	1	Character	R
620-679	License issuing ID 5	A free text field to capture the identity of the entity issuing the license or accreditation.	60	Character	O
680-680	Delimiter	Use the ^ character value	1	Character	R
681-688	License effective date 5	The beginning effective date of the license	8	Date	O
689-689	Delimiter	Use the ^ character value	1	Character	R
690-697	License End date 5	The last date the license was active. (20991231 for open and unknown)	8	Date	R
698-698	Delimiter	Use the ^ character value	1	Character	R
699-706	MCO Enrollment Begin Date 1	Effective beginning date of services which can be paid by MCO	8	Date	R
707-707	Delimiter	Use the ^ character value	1	Character	R
708-715	MCO Enrollment End Date 1	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
716-716	Delimiter	Use the ^ character value	1	Character	R
717-718	MCO Enrollment Termination Code 1	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	R
719-719	Delimiter	Use the ^ character value	1	Character	R
720-727	MCO Enrollment Begin Date 2	Effective beginning date of services which can be paid by MCO	8	Date	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
728-728	Delimiter	Use the ^ character value	1	Character	R
729-736	MCO Enrollment End Date 2	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
737-737	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
738-739	MCO Enrollment Termination Code 2	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
740-740	Delimiter	Use the ^ character value	1	Character	R
741-748	MCO Enrollment Begin Date 3	Effective beginning date of services which can be paid by MCO	8	Date	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
749-749	Delimiter	Use the ^ character value	1	Character	R
750-757	MCO Enrollment End Date 3	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
758-758	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
759-760	MCO Enrollment Termination Code 3	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
761-761	Delimiter	Use the ^ character value	1	Character	R
762-769	MCO Enrollment Begin Date 4	Effective beginning date of services which can be paid by MCO	8	Date	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
770-770	Delimiter	Use the ^ character value	1	Character	R
771-778	MCO Enrollment End Date 4	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
779-779	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
780-781	MCO Enrollment Termination Code 4	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
782-782	Delimiter	Use the ^ character value	1	Character	R
783-790	MCO Enrollment Begin Date 5	Effective beginning date of services which can be paid by MCO	8	Date	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
791-791	Delimiter	Use the ^ character value	1	Character	R
792-799	MCO Enrollment End Date 5	Effective ending date of services of which can be paid by MCO 20991231 if no ending date is available.	8	Date	O
800-800	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
801-802	MCO Enrollment Termination Code 5	60 Term - Abuse of billing privileges 61 Term - Action Taken by Medicaid/CHIP 62 Term - Action Taken by Medicare 63 Term - Change of Ownership 64 Term - Failure to report a change of address/ownership 65 Term - False or misleading information 66 Term - Federal exclusion/ debarment, etc. 67 Term - Felony conviction 68 Term - Involuntary Termination 69 Term - License Expired 70 Term - License Revoked 71 Term - Loss of license or other State action 72 Term - Medicare/Medicaid Exclusion 73 Term - Medicaid Authority 74 Term - Medicare Termination 75 Term - Misuse of billing number 76 Term - No Claims Activity 77 Term - Non-Compliance 78 Term - Onsite review/ Provider is no longer operational 79 Term - Other 80 Term - Provider Deceased 81 Term - State exclusion/ debarment, etc. 82 Term - Unknown 83 Term - Voluntary Termination Blank if contract is still enforce	2	Numeric	O
803-803	Delimiter	Use the ^ character value	1	Character	R
804-813	Taxonomy 01	Primary (Current) Taxonomy	10	Character	O
814-814	Delimiter	Use the ^ character value	1	Character	R

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
815-824	Taxonomy 02	Secondary taxonomy	10	Character	O
825-825	Delimiter	Use the ^ character value	1	Character	R
826-835	Taxonomy 03	Tertiary taxonomy	10	Character	O
836-836	Delimiter	Use the ^ character value	1	Character	R
837-846	Taxonomy 04	Additional taxonomy	10	Character	O
847-847	Delimiter	Use the ^ character value	1	Character	R
848-857	Taxonomy 05	Additional taxonomy	10	Character	O
858-858	Delimiter	Use the ^ character value	1	Character	R
859-868	Taxonomy 06	Additional taxonomy	10	Character	O
869-869	Delimiter	Use the ^ character value	1	Character	R
870-879	Taxonomy 07	Additional taxonomy	10	Character	O
880-880	Delimiter	Use the ^ character value	1	Character	R
881-890	Taxonomy 08	Additional taxonomy	10	Character	O
891-891	Delimiter	Use the ^ character value	1	Character	R
892-901	Taxonomy 09	Additional taxonomy	10	Character	O
902-902	Delimiter	Use the ^ character value	1	Character	R
903-912	Taxonomy 10	Additional taxonomy	10	Character	O
913-913	Delimiter	Use the ^ character value	1	Character	R
914-923	Taxonomy 11	Additional taxonomy	10	Character	O
924-924	Delimiter	Use the ^ character value	1	Character	R
925-934	Taxonomy 12	Additional taxonomy	10	Character	O
935-935	Delimiter	Use the ^ character value	1	Character	R
936-945	Taxonomy 13	Additional taxonomy	10	Character	O
946-946	Delimiter	Use the ^ character value	1	Character	R
947-956	Taxonomy 14	Additional taxonomy	10	Character	O
957-957	Delimiter	Use the ^ character value	1	Character	R
958-967	Taxonomy 15	Additional taxonomy	10	Character	O

Column(s)	Item	Notes	Length	Format	R=Required O=Optional
968-968	Delimiter	Use the ^ character value	1	Character	R
969-978	Taxonomy 16	Additional taxonomy	10	Character	O
979-979	Delimiter	Use the ^ character value	1	Character	R
980-989	Taxonomy 17	Additional taxonomy	10	Character	O
990-990	Delimiter	Use the ^ character value	1	Character	R
991-1000	Taxonomy 18	Additional taxonomy	10	Character	O
1001-1001	Delimiter	Use the ^ character value	1	Character	R
1002-1011	Taxonomy 19	Additional taxonomy	10	Character	O
1012-1012	Delimiter	Use the ^ character value	1	Character	R
1013-1022	Taxonomy 20	Additional taxonomy	10	Character	O
1023-1023	Delimiter	Use the ^ character value	1	Character	R
1024-1048	Filler	spaces	25	Character	O
1049-1049	Delimiter	Use the ^ character value	1	Character	R

Provider Supplemental Record Layout Error Codes

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

Error Codes (A=Accepted, R=Rejected):
000= (A) No errors found
001=(R) Missing/Invalid NPI
003=(R) Provider record must include taxonomy
004=(R) Numeric field contains characters
005=(R) Invalid Ownership Code. Must be 01-19, 88.
006=(R) Invalid Business Email Address format. Must contain "@" and ".".
007=(R) Invalid Physical Location Email Address format. Must contain "@" and ".".
009=(R) Invalid Plan ID
010=(R) Invalid License Type (must be 1, 2, 3, 4, 5.)
011=(R) Missing License or Accreditation Number
012=(R) Missing License Issuing ID
013=(R) Invalid License Effective Date
014=(R) Invalid License End Date or License End Date before License Effective Date
015=(R) Invalid MCO Enrollment Begin Date
016=(R) Invalid MCO Enrollment End Date or MCO Enrollment End Date before MCO Enrollment Begin Date
017=(R) Invalid MCO Enrollment Termination Code
018=(R) Invalid FIPS State or Parish
022=(R) Medicaid Assigned ID was not found on Provider Registry File
023=(R) Invalid Date of Birth Date
029=(R) Provider does not exist on Provider Registry
030=(R) Duplicate record was submitted

END OF SECTION

Appendix H

EDI Test Plan and File Exchange Schedule

EDI Test Plan

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

Tier I – Registration and Credentialing Phase

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

EDI must certify each MCO prior to the MMIS receipt of encounters via EDI. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the Molina Electronic Data Interchange (EDI), and that the transaction can be processed successfully with the resultant IRL, 999 Acceptance, or return transaction. X12 837 transactions (837I and 837P) must be in the 5010 format, not in the 4010 format. This phase of testing was designed to do the following:

- test connectivity with the Clearinghouse;
- validate Trading Partner IDs;
- validate the ability of the submitter to create and transmit X12 transactions with all required loops, segments, and data elements;
- validate the test submission with 999 Acceptance transactions; and
- generate IRL or paired transaction

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

Tier II – Claims Testing Phase

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

Tier III – Production Phase

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

The EDI Test Plan can be found on the following pages.

MCO EDI Test Plan - Tier I, II, & III

Tier I --- Registration/Credentialing Phase

ITEM NBR	ITEM DESCRIPTION	EXPECTATION	REQUIRED BY MCO	DUE DATE or ANTICIPATED COMPLETION DATE	ACTUAL COMPLETION DATE
1	Complete Registration with Molina Provider Enrollment Unit	Obtain unique Molina Provider ID Provider Type = 05, Provider Specialty=5Q Molina to establish a Submitter ID Number & Carrier Code .	ALL MCO'S TO COMPLETE ABBREVIATED PE50. UHC & AETNA NEED TO COMPLETE FULL PACKET.		
2	Register Provider ID on Molina's provider web site: www.lamedicaid.com.	Go to www.lamedicaid.com and click on the left-hand link: Provider Web Account Registration Instructions. The first account established is the administrator account, and it can be used to set-up multiple other user accounts (Max .500)	MCO		
3	Log on to Molina's provider web site to presence. Review the list of application links available on the PROVIDER APPLICATIONS AREA.	www.lamedicaid.com. Click the red PROVIDER LOGIN button at the top left of the main page.	MCO		
4a	Web application: Test e-CDI (electronic Clinical Data Inquiry)	Molina will create test cases/scenarios	MCO		
4b	Web application: Test e-MEVS (electronic Medicaid Eligibility Verification)	Molina will create test cases/scenarios	MCO		

4c	Establish FTP credentials with Molina: TEST and PROD	MCOs will be responsible for accessing files from Molina's FTP site during testing and in production. Molina's contact is Doug Cobb (Douglas.Cobb@MolinaHealthCare.com)	MCO		
4d	Test claims history file download	Molina FTP from Molina_folder Objective is to ensure that MCO can access each report: CCN - W-005, W-010, W-001	MCO		
4e	MCO to send TPL Discovery data to Molina	Molina FTP to_Molina folder	MCO		
4f	Obtain Test Provider Rates File from Molina FTP (CCR & Inpatient per diems)	Molina FTP from _Molina folder	MCO		
4g	Test upload of Provider Registry data	Molina FTP to_Molina folder	MCO		
4h	Test download of Provider Registry edit report from Molina FTP	Molina FTP from _Molina folder	MCO		
4i	Go live with Provider Registry	Move to Production	MCO		
4j	Test download of 820 file	Molina FTP from _Molina folder	MCO		
5a	Test upload of PCP linkages file	Molina FTP from _Molina folder	MCO		
5b	Test download of PCP linkages error file	Molina FTP from_Molina folder	MCO		
5c	Test upload of PA file	Molina FTP to_Molina folder	MCO		
5d	Test download of PA/Precert transaction file	Molina FTP from_Molina folder	MCO		
5e	Test download of Provider list	Molina FTP from_Molina folder	MCO		
5f	Test download of Molina TPL file	Molina FTP from_Molina folder	MCO		

5g	Test download of Molina diagnosis file	Molina FTP from_Molina folder	MCO		
5h	Test download of carrier code	Molina FTP from_Molina folder	MCO		
5i	Test Provider Supplemental Layout	T-MSIS related expanding on the provider registry to supply information to CMS	MCO		
6	Complete registration with Molina EDIFECS and begin Tier II Testing		MCO		

Tier II --- Claims Testing Phase (subject to change by DHH)

ITEM NBR	ITEM DESCRIPTION	EXPECTATION	REQUIRED BY MCO	DUE DATE or ANTICIPATED COMPLETION DATE	ACTUAL COMPLETION DATE
1a	**Ramp Manager Testing Begins 837 I, 837 P**	Test a small sample of each of the Claim Types that a MCO is accepting. (20-30 claims)	AETNA & UHC ONLY		
1b	Test Receipt of Inpatient	20-30 claims	AETNA & UHC ONLY		
1c	Test Receipt of Outpatient	20-30 claims	AETNA & UHC ONLY		
1d	Test Receipt of Home Health	20-30 claims	AETNA & UHC ONLY		
1e	Test Receipt of Rehab	20-30 claims	AETNA & UHC ONLY		
1f	Test Receipt of DME	20-30 claims	AETNA & UHC ONLY		
1g	Test Receipt of Pharmacy	Can be tested only in submitter self test and not ramp manager.	AETNA & UHC ONLY		
1h	Test Receipt of EMT	20-30 claims	ALL BYU MCO's		
1i	Test Receipt of NEMT	20-30 claims	ALL BYU MCO's		
1j	Test Receipt of Professional	20-30 claims	AETNA & UHC ONLY		
1k	Test Receipt of Dental	20-30 claims	N/A		
2	**Ramp Manager Testing Completed**		AETNA & UHC ONLY		
3a	**Submitter Self Testing Begins**	Test a full daily size file for 95% acceptance rate.	AETNA & UHC ONLY		

3b	Test Receipt of Inpatient	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3c	Test Receipt of Outpatient	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3d	Test Receipt of Home Health	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3e	Test Receipt of Rehab	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3f	Test Receipt of DME	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3g	Test Receipt of Pharmacy	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3h	Test Receipt of EMT	Full Daily Size File / Minimum Testing Threshold is 95 %	ALL MCO'S		
3i	Test Receipt of NEMT	Full Daily Size File / Minimum Testing Threshold is 95 %	ALL MCO'S		
3j	Test Receipt of Professional	Full Daily Size File / Minimum Testing Threshold is 95 %	AETNA & UHC ONLY		
3k	Test Receipt of Dental	Full Daily Size File / Minimum Testing Threshold is 95 %	N/A		
4	**Submitter Self Testing Completed**		AETNA & UHC ONLY		
5	File Exchanges - see Tab File Exchange	Discussion of all daily, weekly and monthly file exchanges	AETNA & UHC ONLY		

Tier III --- Production Phase (subject to change by DHH)

ITEM NBR	ITEM DESCRIPTION	EXPECTATION	REQUIRED BY MCO	DUE DATE/COMPLETION DATE	ACTUAL COMPLETION DATE
1	Begin Production	Within (60) days of operation the BYU MCO's systems shall be ready to submit encounter data to DHH's FI in HIPAA compliant provider - to payer to payer COB format.	ALL MCO'S		
2	Testing of Adjustments		AETNA & UHC ONLY		
3	Testing of Voids		AETNA & UHC ONLY		
4	Testing of Interest		AETNA & UHC		

	Payments on claims		ONLY		
5	DHH ability to access MCO systems (inquiry capabilities)		ALL MCO'S		

File Exchange Schedule

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

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

OUTBOUND FILES FROM MOLINA

File Name	File Description	HISTORY OF THE FILE	Frequency	Send On	File From:	File To:
LINKAGE_RESPONSE_{DAILY8}.TXT	Response transactions indicating whether the Bayou Health daily linkage update (initial enrollment and disenrollment) transactions received from Maximus were 'rejected' or 'processed' by the LMMIS system.		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	MOLINA	MAXIMUS
MLN-<DAILY8>-PRV-DAILY.ZIP	Daily Provider updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	MOLINA	MCNA
MLN-<DAILY8>-RECI-DAILY.ZIP	Daily Recipient updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	MOLINA	MCNA
PROVIDER_DAILY_UPDATE_{DAILY8}.ZIP	Daily Provider updated records extracts		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	MOLINA	MAXIMUS, MAGELLAN
RECIPIENT_DAILY_DELETED_{DAILY8}.ZIP	Daily file of recipient information for recipients that were deleted from the LMMIS system per MEDS activity.		Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	MOLINA	MAXIMUS

RECIPIENT_DAILY_UPDATE_{DAILY8}.ZIP	Daily Recipient updated records extracts	Exclude periods of eligibility the month after a recipient turns 22 years of age.	Daily	Each Working Monday through Thursday evening and Friday after Weekly Processing	MOLINA	MAXIMUS, MAGELLAN
RECIPIENT_WEEKLY_RETRO_YYYYMMDD.ZIP	Extract of retroactive recipient eligibility changes that may impact the coverage period in Magellan 1.0 or CSOC contract.		Weekly	Every Saturday, but occasionally on early Sunday	MOLINA	MAGELLAN
CSOC-RETURN-YYYYMMDD.txt	CSOC Return File		Daily	Every Work Day	MOLINA	MAGELLAN
TPL-ERROR-PLANID-CCYYMMDD.TXT	Weekly edit report of TPL records submitted by MCOs		Weekly	Every Thursday Night	MOLINA	MCO
CCN_PA_Precert_Transactions_CCYYMMDD.zip	Weekly PA Extract for MCO		Weekly	Each Tuesday by COB	MOLINA	MCO, MAGELLAN
CCN_Provider_Attestation_List_CCYYMMDD.zip	List of providers with at least one of the 13 3-digit codes used for ACA enhanced reimbursement (108, 137, 141, 208, 237, 241, 308, 337, 341, 408, 437, 441, and 500)		Weekly	Each Tuesday by COB	MOLINA	MCO

CCN_Provider_List_CCYYMMDD.zip	List of Medicaid providers enrolled since 2011		Weekly	Each Tuesday by COB	MOLINA	MCO, MAGELLAN
CCNPlanID_TPLCCYYMMDD2135.txt	Weekly TPL file for MCOs		Weekly	Each Tuesday by COB	MOLINA	MCNA
CCN-W_DENIALS_CPO90_<DAILY8>.txt (MCO NAME)	Weekly Denied Encounter Error Analysis and Encounter EOB Analysis CP-0-90-D Reports		Weekly	Every Thursday Night	MOLINA	MCO, MAGELLAN
CCN-W-001-PLANID-CCYYMMDD.txt	Weekly summarization of the errors incurred for BYU claims/encounters processing		Weekly	Each Tuesday by COB	MOLINA	MCO
CCN-W-005-PLANID-CCYYMMDD.txt	Weekly summarization of the edit codes for BYU claims/encounters processing		Weekly	Each Tuesday by COB	MOLINA	MCO
CCN-W-010-PLANID-CCYYMMDD.zip	Weekly list of all encounters and their error codes, including denied error codes, for BYU claims/encounters processing		Weekly	Each Tuesday by COB	MOLINA	MCO
CLAIMS_WEEKLY_{DAILY8}.ZIP	FFS Weekly claims extracts	Exclude Age 22 and older with DOS 12/01/2015	Weekly	Every Weekend	MOLINA	MAGELLAN
CLAIMS_WEEKLY_UPDATE_{DAILY8}.ZIP	FFS Weekly claims extracts		Weekly	Every Weekend	MOLINA	MAXIMUS

ENCNTRS_WEEKLY_{DAILY8}.ZIP	Encounter Weekly claims extracts	Exclude Age 22 and older with DOS 12/01/2015	Weekly	Every Weekend	MOLINA	MAGELLAN
MLN-<DAILY8>-CLMDENT-WKLY.ZIP	FFS and Encounters weekly Dental claims		Weekly	Every weekend	MOLINA	MCNA
MLN-<DAILY8>-PRV-WKLY.ZIP	Weekly full Provider extracts		Weekly	Every Weekend	MOLINA	MCNA
MLN-<DAILY8>-RECI-WKLY.ZIP	Weekly full Recipent extracts		Weekly	Every Weekend	MOLINA	MCNA
MLN-<RUNDT8>-WKLY-ENCRPT.ZIP	Weekly Denied Encounter Error Analysis and Encounter EOB Analysis CP-0-90-D Reports		Weekly	Every Thursday night	MOLINA	MCNA
PCP-ERROR-planID-YYYYMMDD.txt	Weekly PCP Linkage error file		Weekly	Each Tuesday by COB	MOLINA	MCO
PHARMACY_WEEKLY_{DAILY8}.ZIP	Pharmacy Weekly FFS/ENC claims extracts	Exclude Age 22 and older with DOS 12/01/2015	Weekly	Every Weekend	MOLINA	MAGELLAN

plansubidYYYYMMDD5010.835	ANSI ASC X12N 835 Remittance Advice (835) files		Weekly	Each Tuesday by COB	MOLINA	MCO
PROVIDER REGISTRY	Weekly Provider Registry edit reports		Weekly	Every Friday Night	MOLINA	MCO, MCNA, MAGELLAN
PlanNamedata-Plan Provider ID-YYYYMMDD.txt	Weekly list of all provider registry records		Weekly	Every Friday Night	MOLINA	MAXIMUS
PROVIDER_WEEKLY_COMPLETE_{DAILY8}.ZIP	Weekly full Provider extracts		Weekly	Every Weekend	MOLINA	MAGELLAN
PROVIDER_WEEKLY_UPDATE_{DAILY8}.ZIP	Weekly full Provider extracts		Weekly	Every Weekend	MOLINA	MAXIMUS
RECIPIENT_WEEKLY_COMPLETE_{DAILY8}.ZIP	Weekly full Recipent extracts	Exclude periods of eligibility the month after a recipient turns 22 years of age.	Weekly	Every Weekend	MOLINA	MAGELLAN
RECIPIENT_WEEKLY_UPDATE_{DAILY8}.ZIP	Weekly full Recipient extracts		Weekly	Every Weekend	MOLINA	MAXIMUS
SMO-W-001-PlanID-CCYYMMDD.txt	Weekly summarization of the errors incurred for encounters processing		Weekly	Each Tuesday by COB	MOLINA	MAGELLAN, MCNA
SMO-W-005-PlanID-CCYYMMDD.txt	Weekly summarization of the edit codes for encounters processing		Weekly	Each Tuesday by COB	MOLINA	MAGELLAN, MCNA
SMO-W-010-PlanID-CCYYMMDD.zip	Weekly list of all encounters and their error codes, including denied error codes, for encounter processing		Weekly	Each Tuesday by COB	MOLINA	MAGELLAN, MCNA

TPL-ERROR-PlanID-CCYYMMDD.TXT	Weekly edit report of TPL records submitted by MCOs		Weekly	Every Thursday Night	MOLINA	MAGELLAN, MCNA
Weekly 837 files (Inpatient, Outpatient, Professional)	Crossover 837 encounters files		Weekly	Weekly on Thursday by 12:00 noon CT	MOLINA	MAGELLAN
PCPLINKAGES-CCYYMMDD.TXT	MCO plan PCP Linkages file from Molina to Magellan		Weekly	COB each Monday	MOLINA	MAXIMUS
MMIS_PLAN_EXTRACT_<DAILY8>.TXT	Supplement to Fee Schedule		Weekly	File is available to the MCO on Fridays, is sent to the MCO's sFTP verified site address	MOLINA	MCO, MAGELLAN, MCNA
DHH_LEERS_EXPD_ccyymmdd.TXT	The ccyymmdd being the Friday date (ex20150123)	Molina began receving a LEERS file from OPH. The LEERS file contains data related to all of the birth deliveries in Louisiana. Molina forwards the LEERS file to each of the current plans on a weekly basis.The LEERS file is	Weekly	This file is sent every Friday evening	MOLINA	MCO

		plan specific-meaning, the file the plans receive only relates to recipients within each plan. The file is not a complete replacement but is a copy of the data received each week. the plans will use the LEERS file as a retrospective review to validate medical necessity for births less than 39 weeks gestation.				
179_BIRTH_HISTORY.TXT	Molina processing and forwarding of file to MCO		Quarterly	TBD	MOLINA	MCOs
WEEKLY_RECIP_RECON_RESP_{DAILY8}.TXT	Response file		Weekly	Every Tuesday	MOLINA	MAGELLAN

WEEKLY_RECIP_RECON_REPT_{DAILY8}.TXT	MM-O-310 report		Weekly	Every Tuesday COB	MOLINA	MAGELLAN
WEEKLY_RECIP_RECON_REPT_FILE_{DAILY8}.TXT	Unformatted (tab delimited) version of MM-O-310 report		Weekly	Every Tuesday COB	MOLINA	MAGELLAN
CAP-2177141-20160111-CSOC.txt	Monthly PMPM payments 820 files for CSoC		Monthly	On payment schedule	MOLINA	MAGELLAN
CAP-PLANID-CCYYMMDD.txt	Monthly PMPM payments 820 files for MCOs		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-BABY.TXT	Plan retro baby PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-DOC.TXT	Plan DOC recovery PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-DOD.TXT	Plan DOD recovery PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CAP-PLANID-YYYYMMDD-Medicare-Recovery.TXT	Plan Medicare recovery PMPM 820 file		Monthly	On payment schedule	MOLINA	MCO
CCN_Carrier_File_CCYYMMDD.txt	List of LMMIS TPL carrier code assignments		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN, MCNA
CCN_CLIA_CCYYMMDD.zip	List of all CLIA (clinical laboratory improvements amendment) registrations associated with laboratory providers enrolled with the Louisiana Medicaid MMIS.		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN

CCN_Diagnosis_Codes_CCYYMMDD.txt	List of all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Pre-cert) operation with Louisiana Medicaid MMIS		Monthly	COB on first work day of each month	MOLINA	MCO, MAGELLAN
CCNprovrate-PLANID-CCYYMMDD.txt	Provider negotiated rates file (per-diem, CCR, etc.)		Monthly	COB on first work day of each month	MOLINA	MCO
KICK-PLANID-CCYYMMDD.zip	Monthly maternity KICK payments 820 files for MCOs		Monthly	On payment schedule	MOLINA	MCO
Monthly 820 DOC recovery files	DOC recoveries 820 file		Monthly	On payment schedule	MOLINA	MCNA
Monthly 820 DOD recovery files	DOD recoveries 820 file		Monthly	On payment schedule	MOLINA	MCNA, MAGELLAN
Monthly 820 files	Monthly PMPM 820 file		Monthly	On payment schedule	MOLINA	MCNA, MAGELLAN
Monthly 820 retro files	Retro PMPM payments 820 file		Monthly	On payment schedule	MOLINA	MCNA, MAGELLAN
CAP-PLANID-YYYYMMDD-SSI-ADJ.TXT	Plan retro SSI adjustments PMPM 820 file		Quarterly	On payment schedule	MOLINA	MCO
KICK-RETRO-PLANID-YYYYMMDD.txt	Plan retro Kick payments 820 file		Quarterly	On payment schedule	MOLINA	MCO
ad-hoc PMPM adjustment 820 text file(s), filename TBD	Plan ad-hoc PMPM payments 820 file		AS NEEDED	As necessary	MOLINA	MCO

DHH_SPECIAL_RESPONSE_{DAILY8}.TXT	Response transactions indicating whether the specially requested and DHH-approved Bayou Health linkage update (initial enrollment and disenrollment) transactions received from Maximus were 'rejected' or 'processed' by the LMMIS system.		SPECIAL REQUEST	When Specially Requested by DHH	MOLINA	MAXIMUS
Magellan-Provider-Registry-CCYYMMDD.txt	Magellan Provider Registry to allow the plans knowledge of providers that provide services in mental health.		Monthly	1st Month of month beginning April 2015 and ending December 2015	MOLINA	MCO
DHH_LEERS_EXPD_CCYYMMDD.TXT	LEERS data from OPH		Weekly	Every Friday COB	MOLINA	MCO
CCN-PRTF-nnnnnnn-CCYYMMDD.txt	PRTF member file		Weekly	Every Tuesday COB	MOLINA	MCO
CCNnnnnnnnn_TPLFullCCYYMM.txt	TPL Reconciliation files for the BYU plans		Monthly	5th day of each month	MOLINA	MCO
PplanID_YYYYYMM.txt (ex: P999999_Y201509.TXT)	BYU Retro Cancels/Closures for month		Monthly	1st Monday of the month	MOLINA	MCO
STOLA_MOLINA_CHISHOLM_YYYYMM.TXT	Monthly Chisholm file		Monthly	Last day of the month or the 1st day of the next month, unless these fall on a weekend or holiday.	MOLINA	MAGELLAN

				Then it will be the next business day.		
MGLN-PA-YYYYYMMDD.txt	PA File Layout from Magellan		9/30/15, 10/25/15, 11/13/15 then daily from 11/30/15-12/14/15	Specific days then daily from 11/30-12/14	MOLINA	MCO
LEERS-YYYYMMDD.TXT	Expanded LEERs Elective deliveries file from ULM			Nightly on each Thursday	MOLINA	MCO

NOTE: subject to change by DHH

INBOUND FILES TO MOLINA

Molina is changing its delivery system from a PUSH to PULL. The 3 exisiting prepaid plans will still be able to PUSH until 6/30/15. Aetna & UHC will be PULL only.

File Name	File Description	Frequency	Send On	Turn Around Time:	File From:	File To:
LINKAGE_{DAILY8}.CSV	Bayou Health daily linkage update (initial enrollment and disenrollment) transactions received from Maximus, to be applied to the LMMIS system.	Daily	COB		MAXIMUS	MOLINA

STOLA_MOLINA_RECON_YYYYMMDD.TAB	The file date must have the Monday's date in the naming convention (YYYYMMDD).	Weekly	Every Monday COB	Every Tuesday COB	MAGELLAN	MOLINA
CCYYMMDD_PLANID_PR.txt	Weekly provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCO	MOLINA
CCYYMMDD_planID_SMO_PR.txt	Weekly provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MAGELLAN	MOLINA
CCYYMMDD_PlanID_SMO_PR.txt	Weekly provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCNA	MOLINA
CCYYMMDD_PLANID_Site_PR.txt	Weekly site provider registry records submited by the MCOs for processing	Weekly	Every Friday COB	First working day of following week COB	MCO	MOLINA
CCYYMMDD_PLANID_Provider_Suppl_WEEKLY.txt	Weekly provider supplemental records submitted by MCOs for TMSIS	Weekly	Every Friday COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PlanSubmitterID_MCO_PA_Weekly.txt	Weekly list of Prior Authorizations submitted by MCOs	Weekly	Every Friday COB	First working day of following week COB	PREPAID PLAN	MOLINA
CCYYMMDD_submitterID_MCO_PA_Weekly.txt	Weekly list of Prior Authorizations submitted by MCOs	Weekly	Every Friday COB	First working day of following week COB	MAGELLAN	MOLINA

TPL-BATCH-PLANID-CCYYMMDD.txt	TPL records submitted by MCOs for processing	Weekly	Every Thursday COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PlanSubmitterID_MCO_PA_History.txt	Monthly list of historical Prior Authorizations submitted by MCOs	Weekly	Every Friday COB until 2 years of history are submitted	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_submitterID_MCO_PA_History.txt	Monthly list of historical Prior Authorizations submitted by MCOs	Weekly	Every Friday COB until 2 years of history are submitted	First working day of following week COB	MAGELLAN	MOLINA
PCP-BATCH-planID-YYYYMMDD.txt	Plan PCP Linkage file	Weekly	Last working day of Week by COB	First working day of following week COB	MCO	MOLINA
Encounter files	837 and NCPDP encounter submission files	Weekly	By Thursday 12:00 noon CT. Note that NCPDP encounters may not be submitted on Thursday	On Check Write Schedule	MCO, MAGELLAN, MCNA	MOLINA
CCYYMMDD_PLANID_Provider_Suppl_Monthly.txt	Monthly provider supplemental records submitted by MCOs for TMSIS	Monthly	1st Friday of month COB	First working day of following week COB	MCO, MAGELLAN, MCNA	MOLINA
SPECLNK_{DAILY8}.CSV	Specially requested and DHH-approved Bayou Health linkage update (initial enrollment and disenrollment) transactions received from Maximus, to be	SPECIAL REQUEST	When Specially Requested by DHH		MAXIMUS	MOLINA

MGLN-PA-YYYYYMMDD.txt	PA file Layout	9/30/15, 10/25/15, 11/13/15 then daily from 11/30/15-12/14/15	Specific days then daily from 11/30-12/14		MAGELLAN	MOLINA
STOLA_MOLINA_CSOC_YYYYMMDD.TAB	LTC CSoC Segment File Layout	Every Workday then daily beginning 12/1/15			MAGELLAN	MOLINA
PRETERM_BIRTH_HISTORY.TXT	ULM file submission to Molina FTP site		Quarterly	TBD	ULM	MOLINA

NOTE: subject to change by DHH

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Appendix I

Helpful Websites

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

Website Address	Website Contents
http://aspe.hhs.gov/admnsimp/	This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.cms.gov	This is the **CMS home page**.
http://www.lamedicaid.com or http://www.lmmis.com	DHH FI Provider Web site You need a valid Louisiana Medicaid Provider ID or MCO ID in order to register on the web site. Provider Applications (such as those used to upload and download files) are available on this web site to authorized, registered providers or MCO organizations. Links available to CCN-P entities on the FI Provider Web site are: • 820 File Download • Claims File Download • Provider Enrollment File Download • Provider Registry Upload • Provider Registry Error Report Download • Third-Party Liability Data Entry

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

Website Address	Website Contents
	meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nubc.org	This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations.
http://www.nucc.org	This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information.
http://www.cms.hhs.gov/home/medicare.asp	This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions.

http://www.cms.hhs.gov/medicaid/hipaa/adminsim/hipaapls.asp	This is a **monthly newsletter published by CMS's Data and System Group within the Center for Medicaid and State Operations**. It is a very good source of information for HIPAA developments. If you cannot access the website with the direct address, use http://www.cms.gov. Click on Medicaid and search using the keywords "HIPAA Plus".

Appendix J
Common Data Element Values

Types of Service (TOS)

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

17	Home Health
18	Expanded Dental Services for Pregnant Women (EDSPW)
19	Personal Care Services (LTC)
20	Enhanced Outpatient Rehab Services
21	EPSDT, EPSDT Dental
22	Childnet (Early Steps)
23	Waiver - Children's Choice
24	Waiver - ADHC
25	Waiver - EDA
26	Waiver - PCA
27	Special Purpose Facility
28	Center Based Special Purpose Facility
29	American Indian
30	Acute Care Outpatient Services
31	Family Planning Waiver
32	Supports Waiver
33	New Opportunity Waiver (NOW)
34	DME Special Rates
35	Residential Options Waiver (ROW)
36	Community Mental Health Center
37	Small Rural Hospital Outpatient
38	Adult Residential Care (ARC)
39	State Hospital Outpatient Services
40	Sole Community Hospital

41	Psychiatric Residential Treatment Facility
42	Mental Health Rehabilitation
43	LaPOP, Louisiana Personal Options Program
44	Pediatric Day Health Care Facility (PDHC)
45	Coordinated Care Network - Pre-paid (CCN-P) - MCO
46	Coordinated Care Network - Shared Services (CCN-S)

Category of Service (COS)

State COS	Description
00	Inpatient Service in TB Hospital
01	Inpatient Service in General Hospital
02	Inpatient Service in Mental Hospital
03	SNF Service
04	ICF-DD
05	ICF-I Service
06	ICF-II Service
07	Physician Services
08	Outpatient Hospital Services
09	Clinic - Hemodialysis
10	Clinic - Alcohol & Substance Abuse
11	Clinic - Mental Health
12	Clinic - Ambulatory Surgical
13	Rehab Services
14	Adult Day Care
15	Independent Lab
16	Chiropractic Services

17	Home Health
18	Prescribed Drugs and Immunizations by Pharmacists
19	Habilitation
20	DME (Appliances)
21	Rural Health Clinics
22	Family Planning Service
23	Non-Emergency Medical Transportation
24	Medical Transportation
25	Adult Dental Services
26	EPSDT - Screening Services
27	EPSDT - Dental
28	EPSDT - Other
29	Homemaker Services
30	Other Medical Services
31	Default
32	Administrative Error State Funds Only
33	Recovery Unidentified Services
34	EPSDT Health Services Non-School Board
35	Medical TPL
36	Title XIX Health Insurance Payment
37	Case Management
38	FQHC
39	PCA
40	Personal Health Care Clinic Services

41	HMO Over 65
42	Rehab for Chronically Mentally Ill
43	Children's' Choice Waiver
44	EPSDT - Personal Care Services
45	Dental Services for Pregnant Women
46	EPSDT Health Services
47	VD Clinic
48	TB Clinic
49	Title XIX Part-A Premium
50	Psychology
51	Audiology
52	Physical Therapy
53	Multi-Specialty Clinic Services
54	Certified Registered Nurse (CRNA)
55	Private Duty Nurse
56	Occupational Therapy
57	CM - HIV
58	CM - CMI
59	CM - PW
60	Rehab - ICF/DD
61	CM - DD
62	DD Waiver
63	CM - Infants & Toddlers
64	Home Care Elderly Waiver

65	Head Injury Maintenance Waiver
66	Hospice / NF
67	Social Worker Services
68	Contractors / CM
69	Nurse Home Visits - First Time Mothers Program
70	NOW Waiver
71	LTC - Personal Care Services
72	PAS - Personal Care Services
73	Early Steps
74	Behavior Management Services
75	PACE
76	American Indian/Native Alaskans
77	Family Planning Waiver
78	Support Waiver
79	Community Mental Health Center
80	Residential Options Waiver (ROW)
81	Coordinated Care Network
91	Coded for internal purposes only
99	LTC Administrative Cost

Provider Type

Provider Type Code	Description
01	Fiscal Agent - Waiver
02	Transitional Support - Waiver
03	Children's Choice - Waiver
04	Pediatric Day Health Care (PDHC) facility
05	Managed Care Organization - Prepaid
06	NOW Professional (RN LPN PHD SW)
07	Case Mgmt - Infants & Toddlers
08	OAAS Case Mgmt - Elderly
09	Hospice Services
10	Comprehensive Community Support Services
11	Shared Living (Waiver)
12	Multi-Systemic Therapy
13	Pre-Vocational Habilitation (Waiver)
14	Adult Day Habilitation - Waiver
15	Environmental Modifications - Waiver
16	Personal Emergency Response Systems - Waiver
17	Assistive Devices - Waiver
18	Community Mental Health Center
19	Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group
20	Physician (MD) and Physician (MD) Group
21	Third Party Billing Agent/Submitter
22	Personal Care Attendant Waiver

23	Independent Lab
24	Personal Care Services
25	Mobile X-Ray/Radiation Therapy Center
26	Pharmacy
27	Dentist and Dental Group
28	Optometrist and Optometrist Group
29	(EarlySteps)
30	Chiropractor and Chiropractor Group
31	Psychologist
32	Podiatrist and Podiatrist Group
33	Prescribing Only Provider
34	Audiologist
35	Physical Therapist
36	Not in Use
37	Occupational Therapist
38	School-Based Health Center
39	Speech/LanguageTherapist
40	DME Provider
41	Registered Dietician
42	Non-Emergency Medical Transportation
43	Case Mgmt - Nurse Home Visit - 1st Time Mother
44	Home Health Agency
45	Case Mgmt - Contractor
46	Case Mgmt - HIV
47	Case Mgmt - CMI

48	Case Mgmt - Pregnant Woman
49	Case Mgmt - DD
50	PACE Provider
51	Ambulance Transportation
52	CCN-S Organization (Coordinated Care Network, Shared Savings)
53	Self Directed/Direct Support
54	Ambulatory Surgical Center
55	Emergency Access Hospital
56	Prescriber ONLY for MCO
57	OPH Registered Nurse
58	Not Assigned
59	Neurological Rehabilitation Unit (Hosp)
60	Hospital
61	Venereal Disease Clinic
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
64	Mental Health Hospital (Free-Standing)
65	Rehabilitation Center
66	KIDMED Screening Clinic
67	Prenatal Health Care Clinic
68	Substance Abuse and Alcohol Abuse Center
69	Hospital - Distinct Part Psychiatric Unit
70	EPSDT Health Services
71	Family Planning Clinic

72	Federally Qualified Health Center
73	Licensed Clinical Social Worker
74	Mental Health Clinic
75	Optical Supplier
76	Hemodialysis Center
77	Mental Health Rehabilitation Agency
78	Nurse Practitioner
79	Rural Health Clinic (Provider Based)
80	Nursing Facility
81	Case Mgmt - Ventilator Assisted Care Program
82	Personal Care Attendant - Waiver
83	Respite Care (Center Based)- Waiver
84	Substitute Family Care - Waiver
85	ADHC Home and Community Based Services
86	ICF/DD Rehabilitation
87	Rural Health Clinic (Independent)
88	ICF/DD - Group Home
89	Supervised Independent Living - Waiver
90	Certified Nurse-Midwife
91	CRNA or CRNA Group
92	Private Duty Nurse
93	Clinical Nurse Specialist
94	Physician Assistant
95	American Indian / Native Alaskan "638" Facilities

96	Psychiatric Residential Treatment Facility
97	Adult Residential Care
98	Supported Employment - Waiver
99	Greater New Orleans Community Health Connection
AA	Assertive Community Treatment Team
AB	Prepaid Inpatient Health Plan
AC	Family Support Organization
AD	Transition Coordination
AE	Respite Care Service Agency
AF	Crisis Receiving Center
AG	Behavioral Health Rehabilitation Agency
AH	Licensed Marriage & Family Therapy
AJ	Licensed Addition Counselor
AK	Licensed Professional Counselor
AL	Community Choice Waiver-Nurse
AM	Home Delivered Meals
AN	Caregiver Temporary Support
AQ	Non-Medical Group Home
AR	Therapeutic Foster Care
AS	OPH Clinic
AU	OPH Registered Dietician
AV	Extended Duty Dental Assistant
AW	Permanent Support Housing Agent
AX	Certified Behavior Analyst
AY	Dental Benefit Plan Manager

BC	Birth Center (Free Standing)
BI	Behavior Intervention
IP	HER Incentive Program
MI	Monitored In-Home Caregiving
MW	Licensed Mid-Wife
SP	Super Provider/OHCDS
XX	Error Provider

Provider Specialty, Sub-Specialty

Specialty Code	Description	Type: 1=Specialty, 2=Subspecialty
00	All Specialties	1
01	General Practice	1
02	General Surgery	1
03	Allergy	1
04	Otology, Laryngology, Rhinology	1
05	Anesthesiology	1
06	Cardiovascular Disease	1
07	Dermatology	1
08	Family Practice	1
09	Gynecology (DO only)	1
10	Gastroenterology	1
11	Not in Use	n/a
12	Manipulative Therapy (DO only)	1
13	Neurology	1
14	Neurological Surgery	1

15	Obstetrics (DO only)	1
16	OB/GYN	1
17	Ophthalmology, Otology, Laryngology, Rhinology (DO only)	1
18	Ophthalmology	1
19	Orthodontist	1
20	Orthopedic Surgery	1
21	Pathologic Anatomy; Clinical Pathology (DO only)	1
22	Pathology	1
23	Peripheral Vascular Disease or Surgery (DO only)	1
24	Plastic Surgery	1
25	Physical Medicine Rehabilitation	1
26	Psychiatry	1
27	Psychiatry; Neurology (DO only)	1
28	Proctology	1
29	Pulmonary Diseases	1
30	Radiology	1
31	Roentgenology, Radiology (DO only)	1
32	Radiation Therapy (DO only)	1
33	Thoracic Surgery	1
34	Urology	1
35	Chiropractor	1
36	Pre-Vocational Habilitation	1
37	Pediatrics	1
38	Geriatrics	1

39	Nephrology	1
40	Hand Surgery	1
41	Internal Medicine	1
42	Federally Qualified Health Centers	1
43	Not in Use	n/a
44	Public Health	1
45	NEMT – Non-profit	1
46	NEMT – Profit	1
47	NEMT – F+F	1
48	Podiatry – Surgical Chiropody	1
49	Miscellaneous (Admin. Medicine)	1
50	Day Habilitation	1
51	Med Supply / Certified Orthotist	1
52	Med Supply / Certified Prosthetist	1
53	Med Supply / Certified Prosthetist Orthotist	1
54	Med Supply / Not Included in 51, 52, 53	1
55	Indiv Certified Orthotist	1
56	Indiv Certified Protherist	1
57	Indiv Certified Protherist – Orthotist	1
58	Indiv Not Included in 55, 56, 57	1
59	Ambulance Service Supplier, Private	1
60	Public Health or Welfare Agencies & Clinics	1
61	Voluntary Health or Charitable Agencies	1
62	Psychologist Crossovers only	1

63	Portable X-Ray Supplier (Billing Independently)	1
64	Audiologist (Billing Independently)	1
65	Individual Physical Therapist	1
66	Dentist, DDS, DMS	1
67	Oral Surgeon – Dental	1
68	Pedodontist	1
69	Independent Laboratory (Billing Independently)	1
70	Clinic or Other Group Practice	1
71	Speech Therapy	1
72	Diagnostic Laboratory	1
73	Social Worker Enrollment	1
74	Occupational Therapy	1
75	Other Medical Care	1
76	Adult Day Care	1
77	Habilitation	1
78	Mental Health Rehab	1
79	Nurse Practitioner	1
80	Environmental Modifications	1
81	Case Management	1
82	Personal Care Attendant	1
83	Respite Care	1
84	Substitute Family Care	1
85	Extended Care Hospital	1
86	Hospitals and Nursing Homes	1
87	All Other	1

88	Optician / Optometrist	1
89	Supervised Independent Living	1
90	Personal Emergency Response Sys (Waiver)	1
91	Assistive Devices	1
92	Prescribing Only Providers	1
93	Hospice Service for Dual Elig.	1
94	Rural Health Clinic	1
95	Psychologist (PBS Program Only)	1
96	Psychologist (PBS Program and X-Overs)	1
97	Family Planning Clinic	1
98	Supported Employment	1
99	Provider Pending Enrollment	1
1A	Adolescent Medicine	2
1B	Diagnostic Lab Immunology	2
1C	Neonatal Perinatal Medicine	2
1D	Pediatric Cardiology	2
1E	Pediatric Critical Care Medicine	2
1F	Pediatric Emergency Medicine	2
1G	Pediatric Endocrinology	2
1H	Pediatric Gastroenterology	2
1I	Pediatric Hematology – Oncology	2
1J	Pediatric Infectious Disease	2
1K	Pediatric Nephrology	2
1L	Pediatric Pulmonology	2
1M	Pediatric Rheumatology	2

1N	Pediatric Sports Medicine	2
1P	Pediatric Surgery	2
1Q	Pediatric Neurology	2
1R	Pediatric Genetics	2
1S	BRG – Med School	2
1T	Emergency Medicine	1
1U	Pediatric Developmental Behavioral Health	2
1Z	Pediatric Day Health Care	1
2A	Cardiac Electrophysiology	2
2B	Cardiovascular Disease	2
2C	Critical Care Medicine	2
2D	Diagnostic Laboratory Immunology	2
2E	Endocrinology & Metabolism	2
2F	Gastroenterology	2
2G	Geriatric Medicine	2
2H	Hematology	2
2I	Infectious Disease	2
2J	Medical Oncology	2
2K	Nephrology	2
2L	Pulmonary Disease	2
2M	Rheumatology	2
2N	Surgery – Critical Care	2
2P	Surgery – General Vascular	2
2Q	Nuclear Medicine	1
2R	Physician Assistant	1

2S	LSU Medical Center New Orleans	2
2T	American Indian / Native Alaskan	2
2Y	OPH Genetic Disease Program	1
3A	Critical Care Medicine	2
3B	Gynecologic oncology	2
3C	Maternal & Fetal Medicine	2
3D	Community Choice Waiver – Respiratory Therapy	2
3E	Community Choices Waiver – PT and OT	2
3F	Community Choices Waiver – PT and S/L T	2
3G	Community Choices Waiver – PT and RT	2
3H	Community Choices Waiver – OT and S/L T	2
3J	Community Choices Waiver – OT and RT	2
3K	Community Choices Waiver – S/L T and RT	2
3L	Community Choices Waiver – PT, OT, & S/L T	2
3M	Community Choices Waiver – PT, OT & RT	2
3N	Community Choices Waiver – PT, S/L T & RT	2
3P	Organized Health Care Delivery System (OHCDS)	1
3Q	Community Choices Waiver – OT, S/L T & RT	2
3R	Community Choices Waiver – All Skilled Maintenance Therapies (PT, OT, S/L T, RT)	2
3S	LSU Medical Center Shreveport	2
3T	DBPM – Dental Benefit Plan Prescriber	1
3U	Community Choices Waiver – Assistive Devices – Home Health	2
3W	Supportive Housing Agency	1
3X	Extended Duty Dental Assistant	1

3Y	DBPM – Dental Benefit Plan Management	1
4A	Developmental Disability	1
4B	NOW RN	1
4C	NOW LPN	1
4D	NOW Psychologist	1
4E	NOW Social Worker	1
4G	New Provider Domain	1
4H	Conversion, Participant Domain	1
4J	Conversion, Provider Domain	1
4K	Home and Community-Based Services (HCBS)	1
4L	New, Participant Domain	1
4M	HER Managed Care (Behavior Health)	2
4P	OAAS	1
4R	Registered Dietician	1
4S	Ochsner Med School	2
4U	OPH Registered Dietician	1
4W	Waiver Services	
4X	Waiver-Only Transportation	1
4Y	EHR Managed Care (Medical)	2
5A	PCS-LTC	1
5B	PCS-EPSDT	1
5C	PAS	1
5D	PCS-LTC, PCS-EPSDT	1
5E	PCS-LTC, PAS	1

5F	PCS-EPSDT, PAS	1
5G	OCS-LTC, PCS-EPSDT, PAS	1
5H	Community Mental Health Center	
5I	Statewide Management Organization (SMO)	1
5J	Youth Support	1
5K	Family Support	1
5L	Both Youth and Family Support	1
5M	Multi-Systemic Therapy	
5N	Substance Abuse and Alcohol Abuse Center	
5P	PACE	1
5Q	CCN-P (Coordinated Care Network, Prepaid) - MCO	1
5R	CCN-S (Coordinated Care Network, Shared Savings)	
5S	Tulane Med School	2
5T	Community Choices Waiver (CCW)	1
5U	Individual	1
5V	Agency/Business	1
5W	Community Choices Waiver – Personal Assistance Service	2
5X	Therapeutic Group Homes	1
5Y	PRCS Addiction Disorder	1
5Z	Therapeutic Group Home Disorder	1
6A	Psychologist -Clinical	1
6B	Psychologist-Counseling	1
6C	Psychologist - School	1
6D	Psychologist - Developmental	1
6E	Psychologist - Non-Declared	1

6F	Psychologist - All Other	1
6H	LaPOP	1
6N	Endodontist	1
6P	Periodontist	1
6S	E Jefferson Fam Practice Ctr - Residency Program	2
6T	Community Choices Waiver – Physical Therapy	2
6U	Applied Behavioral Analyst	1
6W	Licensed Mid-Wife	1
7A	SBHC – NP – Part Time – less than 20 hrs week	1
7B	SBHC – NP – Full Time – 20 or more hrs week	1
7C	SBHC – MD – Part Time – less than 20 hrs week	1
7D	SBHC – MD – Full Time – 20 or more hrs week	1
7E	SBHC – NP + MD – Part Time – combined less than 20 hrs week	1
7F	SBHC – NP + MD – Full Time – combined less than 20 hrs week	1
7G	Community Choices Waiver – Speech/Language Therapy	2
7H	Community Choices Waiver – Occupational Therapy	2
7M	Retail Convenience Clinics	2
7N	Urgent Care Clinics	2
7P	ABA Therapy Psychologist	1
7R	Aquatic Therapy	1
7S	Leonard J Chabert Medical Center - Houma	2
7T	Art Therapy	1
7U	Art and Music	2
7V	Music Therapy	1

7X	Sensory Integration	1
7Y	Therapeutic Horseback Riding	1
7Z	Hippotherapy	1
8A	EDA & DD services	2
8B	EDA services	2
8C	DD services	2
8D	Community Choices Waiver – Caregiver Temporary Support	1
8E	CSoC/Behavioral Health	1,2
8F	Community Choices Waiver – Caregiver Temporary Support – Home Health	2
8G	Community Choices Waiver – Caregiver Temporary Support-Assisted Living	2
8H	Community Choices Waiver – Caregiver Temporary Support – ADHC	2
8J	Community Choices Waiver – Caregiver Temporary Support – Nursing Facility	2
8K	ADHC HCBS	1
8L	Hospital-based PRTF	1
8M	Community Choices Waiver – Home-Delivered Meals	1
8N	Community Choices Waiver – Nursing	2
8O	IP – Doctor of Osteopathic Medicine	1
8P	IP – Physician – MD	1
8Q	EAA Assesor, Inspector, Approver	2
8S	OLOL Medical School	2
9A	Community Choices Waiver – Nursing and Personal Assistance Services	2

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

Louisiana Medicaid Claim Type Codes

Date Modified : 11/03/2010

Claim Type	Description	Trans Type
01	Inpatient Hospital	837I, UB04
02	LTC/NH	837I, UB04
03	Outpatient	837I, UB04
04	Professional	837P, CMS 1500
05	Rehab	837P, CMS 1500
06	Home Health Outpatient	837I, UB04
07	EMT (Transportation)	837P, CMS 1500
08	NEMT (Transportation)	837P, CMS 1500
09	DME	837P, CMS 1500
10	Dental EPSDT	837D, ADA
11	Dental Adult	837D, ADA
12	Pharmacy	NCPDP D.0
13	EPSDT	837P, CMS 1500
14	Medicare Cross-over Institutional	837I, UB04
15	Medicare Cross-over Professional	837P, CMS 1500
16	Adult Day Care	837I, UB04

Louisiana Medicaid Region Codes

Region	Description
01	New Orleans
02	Baton Rouge
03	Thibodaux
04	Lafayette
05	Lake Charles
06	Alexandria
07	Shreveport
08	Monroe
09	Mandeville

Louisiana Medicaid Parish Codes

Parish Code	Recipient Parish Description	Recipient Medicaid Region
01	ACADIA	4
02	ALLEN	5
03	ASCENSION	2
04	ASSUMPTION	3
05	AVOYELLES	6
06	BEAUREGARD	5
07	BIENVILLE	7
08	BOSSIER	7
09	CADDO	7
10	CALCASIEU	5
11	CALDWELL	8
12	CAMERON	5
13	CATAHOULA	6
14	CLAIBORNE	7
15	CONCORDIA	6
16	DESOTO	7
17	EAST BATON ROUGE	2
18	EAST CARROLL	8
19	EAST FELICIANA	2
20	EVANGELINE	4
21	FRANKLIN	8

22	GRANT	6
23	IBERIA	4
24	IBERVILLE	2
25	JACKSON	8
26	JEFFERSON	1
27	JEFFERSON DAVIS	5
28	LAFAYETTE	4
29	LAFOURCHE	3
30	LASALLE	6
31	LINCOLN	8
32	LIVINGSTON	9
33	MADISON	8
34	MOREHOUSE	8
35	NATCHITOCHES	7
36	ORLEANS	1
37	OUACHITA	8
38	PLAQUEMINES	1
39	POINTE COUPEE	2
40	RAPIDES	6
41	RED RIVER	7
42	RICHLAND	8
43	SABINE	7
44	ST BERNARD	1
45	ST CHARLES	3
46	ST HELENA	9

47	ST JAMES	3
48	ST JOHN	3
49	ST LANDRY	4
50	ST MARTIN	4
51	ST MARY	3
52	ST TAMMANY	9
53	TANGIPAHOA	9
54	TENSAS	8
55	TERREBONNE	3
56	UNION	8
57	VERMILION	4
58	VERNON	6
59	WASHINGTON	9
60	WEBSTER	7
61	WEST BATON ROUGE	2
62	WEST CARROLL	8
63	WEST FELICIANA	2
64	WINN	6
65	East Jefferson	1
87	Texas	10
88	Mississippi	11
89	Arkansas	12
90	Texas Border County	10

91	Mississippi Border County	11
92	Arkansas Border County	12
99	Other Out-of-State	13

Louisiana Medicaid Pricing Action Code (PAC)

PAC	Description
MEDICAL	
250	Price at Level III – Anesthesia1
260	Price as for Anesthesia
810	Price manually, individual consideration (IC)
820	Deny
830	Price at Level I (U&C File)
850	Price at Level III - Louisiana BHSF set price on Procedure/Formulary File
860	Price at Level I and Level II (U&C File and Prevailing Fee File)
880	Maximum amount - Pend if billed charge is greater than Procedure/Formulary price
8F0	Maximum amount - Pay at billed amount

Appendix K

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

MCOs are required to submit to the FI on a daily basis, the Third Party Liability (TPL) Batch File Submission. The Batch File Submission and File Layout can be found on the following pages along with instructions and error codes.

The file name should be TPL-BATCH-NNNNNNN-YYYYMMDD.txt.

BAYOU HEALTH BATCH ELECTRONIC FILE LAYOUT for TPL INFORMATION.
Document Date: 11/20/2012
Edited: 01/20/2016 (Changes are highlighted)
Subject to Change

PART 1: PLAN FILE SUBMISSIONS

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

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

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

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

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

8	49-57	TPL_PRI_INSURED_SSN	char(9)	R	Enter a valid SSN
9	58-59	TPL_INITIATOR_CODE	char(2)	R	Value: **15=Amerigroup** **16=LaCARE** **17=LHC** **18=Magellan** **19=MCNA** **20=Aetna** **21=UHC Prepaid**
10	60-71	TPL_CASE_NAME_LAST	char(12)	O	Left justify
11	72-78	TPL_CASE_NAME_FIRST	char(7)	O	Left justify
12	79	TPL_CASE_NAME_MI	char(1)	O	Use a space if not available
13	80-92	TPL_CASE_ID	char(13)	O	Leave spaces if not used
14	93-96	TPL_CASELOAD_NO	char(4)	O	Leave spaces if not used
15	97-108	TPL_POLICY_HOLDER_NAME_LAST	char(12)	R	Left justify
16	109-115	TPL_POLICY_HOLDER_NAME_FIRST	char(7)	R	Left justify
17	116	TPL_POLICY_HOLDER_NAME_MI	char(1)	R	Use a space if not available
18	117-141	TPL_POLICY_HOLDER_STREET	char(25)	R	Left justify
19	142-161	TPL_POLICY_HOLDER_CITY	char(20)	R	Left Justify
20	162-163	TPL_POLICY_HOLDER_STATE	char(2)	R	USPS abbreviation
21	164-172	TPL_POLICY_HOLDER_ZIP	char(9)	R	Left Justify
22	173-181	TPL_POLICY_HOLDER_SSN	char(9)	O	Use all zeros if not available
23	182-234	TPL_EMPLOYER_GRP_MAINT_COVER	char(53)	O	Left Justify
24	235-259	TPL_EMPLOYER_CLAIM_FIL_STREET	char(25)	O	Left Justify
25	260-279	TPL_EMPLOYER_CLAIM_FIL_CITY	char(20)	O	Left Justify
26	280-281	TPL_EMPLOYER_CLAIM_FIL_STATE	char(2)	O	Left Justify
27	282-290	TPL_EMPLOYER_CLAIM_FIL_ZIP	char(9)	O	Left Justify
28	291-343	TPL_INSURANCE_NAME	char(53)	R	Left Justify
29	344-349	TPL_INSURANCE_NUMBER	char(6)	R	Use the appropriate Louisiana MMIS Carrier Code
30	350-374	TPL_INSURANCE_CLAIM_FIL_STREET	char(25)	R	Left Justify
31	375-394	TPL_INSURANCE_CLAIM_FIL_CITY	char(20)	R	Left Justify
32	395-396	TPL_INSURANCE_CLAIM_FIL_STATE	char(2)	R	USPS abbreviation
33	397-405	TPL_INSURANCE_CLAIM_FIL_ZIP	char(9)	R	Left Justify
34	406-418	TPL_POL_NBR	char(13)	R	Left Justify
35	419-433	TPL_GROUP_NBR	char(15)	O	Left Justify, leave blank if not used.

36	434-435	TPL_SCOPE_OF_COVERAGE_1	char(2)	R	See Scopes of Coverage in SCG.
37	436-437	TPL_SCOPE_OF_COVERAGE_2	char(2)	O	See Scopes of Coverage in SCG, if provided.
38	438	TPL_SCOPE_OF_COVERAGE_CD_1	char(1)	O	Leave space.
39	439	TPL_SCOPE_OF_COVERAGE_CD_2	char(1)	O	Leave space.
40	440-447	TPL_BEGIN_DATE_YYMMDD	char(8)	R	YYYYMMDD
41	448-455	TPL_END_DATE_YYMMDD	char(8)	R	YYYYMMDD
42	456-480	TPL_AGENT_NAME	char(25)	O	Left Justify
43	481-490	TPL_AGENT_PHONE	char(10)	O	Left Justify
44	491-515	TPL_AGENT_STREET	char(25)	O	Left Justify
45	516-535	TPL_AGENT_CITY	char(20)	O	Left Justify
46	536-537	TPL_AGENT_STATE	char(2)	O	Left Justify
47	538-546	TPL_AGENT_ZIP	char(9)	O	Left Justify
48	547-548	TPL_PARISH	char(2)	O	**Use a parish code value from 01-64 or 77.** See Parish Code table in SCG.
49	549	FILLER	char(1)	O	Leave space.
50	550-562	TPL_PRIV_INSUR_SUBMIT_ID	char(13)	O	Leave spaces.
51	563-567	TPL_PRIV_DOB	char(5)	O	Leave spaces.
52	568-569	TPL_PRIV_CAT	char(2)	O	Leave spaces.
53	570	TPL_PROCESS_TYPE	char(1)	R	Values: **1=new entry,** **3=update existing entry,**
54	571-577	TPL_SEQUENCE_NUMBER	char(7)	R	File record sequence number: The first record in the file should have number 0000001, the second 0000002, etc.
~~55~~	~~578-585~~	~~TPL_LAHIPP_BEGIN_DATE~~	~~char(8)~~	~~O~~	~~Leave spaces~~
~~56~~	~~586-593~~	~~TPL_LAHIPP_END_DATE~~	~~char(8)~~	~~O~~	~~Leave spaces~~

[Note: the previous 2 items (55 and 56) are removed and are not applicable.]

57	594-700	TPL_FILLER	char(107)	R	Leave all spaces.

END OF RECORD LAYOUT

PART 2: SUBMISSION EDIT PROCESS

Molina will capture your file, perform limited edits on it and use the file in the update process on the LMMIS TPL Resource File.

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

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

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

The error text file will have this layout:

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

ERROR CODES

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

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

2 Invalid value for Field 2 (TPL_CREATE_TIME). Field does not contain a valid time format.
3 Invalid value for Field 3 (TPL_RECORD_SOURCE_CD). A value other than 1 was found on the record.
4 Invalid value for Field 4 (TPL_PRI_INDIV_NAME_LAST). The value of the field was all spaces.
5 Invalid value for Field 5 (TPL_PRI_INDIV_NAME_FIRST). The value of the field was all spaces.
6 Invalid value for Field 6 (TPL_PRI_INDIV_NAME_MI). The value of the field was a space.
7 Invalid value for Field 7 (TPL_PRI_MED_ID_NO). The field contains spaces, or the field is not numeric, or the field is not 13 digits.
8 Invalid value for Field 8 (TPL_PRI_INSURED_SSN). The field contains spaces, or the field is not numeric, or the field is not 9 digits.
9 Invalid value for Field 9 (TPL_INITIATOR_CODE). Your assigned initiator code must correspond to your Plan ID.
10 Invalid value for Field 10 (TPL_CASE_NAME_LAST). This field is not edited, so you should not see edit error 010 in the edit response file.
11 Invalid value for Field 11 (TPL_CASE_NAME_FIRST). This field is not edited, so you should not see edit error 011 in the edit response file.
12 Invalid value for Field 12 (TPL_CASE_NAME_MI). This field is not edited, so you should not see edit error 012 in the edit response file.
13 Invalid value for Field 13 (TPL_CASE_ID). This field is not edited, so you should not see edit error 013 in the edit response file. However, if you send a not numeric or blank value in this field, it is changed to all zeroes.
14 Invalid value for Field 14 (TPL_CASELOAD_NO). This field is not edited, so you should not see edit error 013 in the edit response file. However, if you send a not numeric or blank value in this field, it is changed to all zeroes.
15 Invalid value for Field 15 (TPL_POLICY_HOLDER_NAME_LAST). This field is not edited, so you should not see edit error 015 in the edit response file.
16 Invalid value for Field 16 (TPL_POLICY_HOLDER_NAME_FIRST). This field is not edited, so you should not see edit error 016 in the edit response file.
17 Invalid value for Field 17 (TPL_POLICY_HOLDER_NAME_MI). This field is not edited, so you should not see edit error 017 in the edit response file.
18 Invalid value for Field 18 (TPL_POLICY_HOLDER_STREET). This field is not edited, so you should not see edit error 018 in the edit response file.
19 Invalid value for Field 19 (TPL_POLICY_HOLDER_CITY). This field is not edited, so you should not see edit error 019 in the edit response file.
20 Invalid value for Field 20 (TPL_POLICY_HOLDER_STATE). This field is not edited, so you should not see edit error 020 in the edit response file.
21 Invalid value for Field 21 (TPL_POLICY_HOLDER_ZIP). This field is not edited, so you should not see edit error 021 in the edit response file.
22 Invalid value for Field 22 (TPL_POLICY_HOLDER_SSN). This field is not edited, so you should not see edit error 022 in the edit response file.
23 Invalid value for Field 23 (TPL_EMPLOYER_GRP_MAINT_COVER). This field is not edited, so you should not see edit error 023 in the edit response file.
24 Invalid value for Field 24 (TPL_EMPLOYER_CLAIM_FIL_STREET). This field is not edited, so you should not see edit error 024 in the edit response file.
25 Invalid value for Field 25 (TPL_EMPLOYER_CLAIM_FIL_CITY). This field is not edited, so you should not see edit error 025 in the edit response file.
26 Invalid value for Field 26 (TPL_EMPLOYER_CLAIM_FIL_STATE). This field is not edited, so you should not see edit error 026 in the edit response file.
27 Invalid value for Field 27 (TPL_EMPLOYER_CLAIM_FIL_ZIP). This field is not edited, so you should not see edit error 027 in the edit response file.
28 Invalid value for Field 28 (TPL_INSURANCE_NAME). Value submitted is spaces.
29 Invalid value for Field 29 (TPL_INSURANCE_NUMBER). Value submitted is spaces or value is not found on LMMIS Carrier Code file. If

	TPL_PROCESS_TYPE=3 then value was not found on Recipient's TPL record.
30	Invalid value for Field 30 (TPL_INSURANCE_CLAIM_FIL_STREET). Value submitted is spaces.
31	Invalid value for Field 31 (TPL_INSURANCE_CLAIM_FIL_CITY). Value submitted is spaces.
32	Invalid value for Field 32 (TPL_INSURANCE_CLAIM_FIL_STATE). Value submitted is spaces.
33	Invalid value for Field 33 (TPL_INSURANCE_CLAIM_FIL_ZIP). Value submitted is spaces.
34	Invalid value for Field 34 (TPL_POL_NBR). Value is spaces or all 0s or all 9s.
35	Invalid value for Field 35 (TPL_GROUP_NBR). Value is spaces or all 0s or all 9s.
36	Invalid value for Field 36 (TPL_SCOPE_OF_COVERAGE_1). Not a valid scope of coverage.
37	Invalid value for Field 37 (TPL_SCOPE_OF_COVERAGE_2). Not a valid scope of coverage.
38	Invalid value for Field 38 (TPL_SCOPE_OF_COVERAGE_CD_1). Value should be a space.
39	Invalid value for Field 39 (TPL_SCOPE_OF_COVERAGE_CD_2). Value should be a space.
40	Invalid value for Field 40 (TPL_BEGIN_DATE_YYMMDD). Must be a valid date value. Must be greater than 19650101 and must be less than 20201231.
41	Invalid value for Field 41 (TPL_END_DATE_YYMMDD). Must be a valid date value and must be >= Field 40. If the value is 20991231 or 29991231 or 99999999 or is greater than 20201231 then it is automatically changed to 20201231.
42	Invalid value for Field 42 (TPL_AGENT_NAME). This field is not edited, so you should not see edit error 042 in the edit response file.
43	Invalid value for Field 43 (TPL_AGENT_PHONE). This field is not edited, so you should not see edit error 043 in the edit response file.
44	Invalid value for Field 44 (TPL_AGENT_STREET). This field is not edited, so you should not see edit error 044 in the edit response file.
45	Invalid value for Field 45 (TPL_AGENT_CITY). This field is not edited, so you should not see edit error 044 in the edit response file.
46	Invalid value for Field 46 (TPL_AGENT_STATE). A non-blank value was submitted and it does not represent a valid USPS state code.
47	Invalid value for Field 47 (TPL_AGENT_ZIP). A non-blank value was submitted and it is not a 5-digit or 9-digit number.
48	Invalid value for Field 48 (TPL_PARISH). A non-blank value was submitted and it is not a valid LMMIS parish code value.
49	Invalid value for Field 49 (FILLER). This field is not edited, so you should not see edit error 044 in the edit response file.
50	Invalid value for Field 50 (TPL_PRIV_INSUR_SUBMIT_ID). This field is not edited, so you should not see edit error 044 in the edit response file.
51	Invalid value for Field 51 (TPL_PRIV_DOB). This field is not edited, so you should not see edit error 044 in the edit response file.
52	Invalid value for Field 52 (TPL_PRIV_CAT). This field is not edited, so you should not see edit error 044 in the edit response file.
53	Invalid value for Field 53 (TPL_PROCESS_TYPE). Must be 1 or 3. If value is 1, then a record must not exist on the LMMIS TPL Resource File. If value is 3, then a record must exist on the LMMIS TPL Resource File.
54	Invalid value for Field 54 (TPL_SEQUENCE_NUMBER). Must be a number and must be unique in the file.

The above examples represent some of the error codes, all of which range from 001 to 056.

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

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

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

RULES for PROCESSING TPL RECORDS

1. If a TPL record exists for an individual on the MMIS System, based on Recipient ID (Field 7) and Policy Number (Field 34), then you should submit an update record (Field 53 value = 3) when you wish to update the record. The rule is that if a record already exists on the MMIS System, and you wish to update that record, then you should submit an update transaction (Field 53 value = 3).
2. If you submit a New Entry record (Field 53 value = 1) for a record that exists on the MMIS System, then the record will be rejected with error code 053. The rule is that you may not add a new record if one already exists on the MMIS System.
3. If you wish to "remove" a record that exists on the MMIS System, then you may submit an update record (Field 53 value = 3) with the end date (Field 041) equal to the begin date (Field 040). This will effectively cancel the record. There is no provision to physically delete a TPL record.
4. If you attempt to update a TPL record that does not exist on the MMIS System, based on Recipient ID (Field 7) and Policy Number (Field 34), then the record will be rejected with error code 053. Therefore, if a TPL record does not exist for an individual and you wish to add one, then submit a New Entry record (Field 53 value = 1).
5. For update records (Field 53 value = 3), the fields that you may update are highlighted in blue in the record layout of Part 1 of this document.

TPL Resource File—Medicare Coverage Additions/Updates
Document Date: 1/13/2015

DHH will maintain the Medicare files for all of its enrollees since CMS is the only valid source of verification of Medicare benefits. The MCO will receive Medicare information on its members' TPL Resource File from Molina; however, the MCO does not have the capability to make additions or updates to its member's Medicare coverage on the TPL Resource File. The MCO should forward any requests to add or update Medicare information for one of its member's TPL Resource File to DHH to process:

- The MCO should complete the **Medicaid Recipient Insurance Information Update Form-Traditional Medicare Only** form (located at http://www.lamedicaid.com/provweb1/Forms/forms.htm , under the "Online Forms" section).
- The completed form and any attachments should be sent, via secure email, to the Program Specialist within the DHH/MMIS/TPL Unit who is assigned maintenance of the TPL Resource and Carrier Files (and cc the Program Manager 1B in the DHH/MMIS/TPL Unit).

- DHH will verify the Medicare coverage with CMS and make the appropriate changes, if necessary. The DHH/MMIS/TPL Unit will respond to the MCO's email to advise of its findings and the action taken, if any.
- If changes are made by DHH, the updated data will be sent to the MCO on the following files:
  - Weekly incremental file: **CCN2377167_TPL201601042135.txtj**
  - Monthly full ("recon") file: **CCN2377167_TPLFULL20160104.txt**

Medicaid providers may submit requests to update the Medicare data directly to DHH using the form referenced above.

IMPORTANT NOTE: **This process does not apply to the addition or update of Medicare Advantage plans, which are treated in the same manner as private insurance for the purposes of maintenance of the TPL Resource File. (Requests for additions or updates involving the Medicare Advantage plans are to be processed by the MCO for its members.)**

END OF SECTION

TPL File Layout to Plan

TPL01 EB-OTHER-INS-DETAIL.

05 OTHER-INS-RECIP-ID-CURR PIC X(13).

05 OTHER-INS-RECIP-ID-ORIG PIC X(13).

05 OTHER-INS-TYPE PIC X(02).

88 PRIVATE-TPL VALUE 'PR'.

88 MEDICARE-PART-A VALUE 'MA'.

88 MEDICARE-PART-B VALUE 'MB'.

88 LAHIPP VALUE 'LH'.

05 OTHER-INS-COMPANY-NUMBER PIC X(06).

05 OTHER-INS-SCOPE-OF-COVERAGE PIC X(02).

05 OTHER-INS-MEDICARE-HIC-NO PIC X(12).

05 OTHER-INS-BEGIN-DATE PIC 9(08).

05 OTHER-INS-END-DATE PIC 9(08).

05 OTHER-INS-GROUP-NO PIC X(15).

05 OTHER-INS-POLICY-NO PIC X(13).

05 OTHER-INS-POLICY-HOLDER-NAME PIC X(20).

05 OTHER-INS-POLICY-HOLDER-SSN PIC X(09).

05 OTHER-INS-AGENT-NAME PIC X(25).

05 OTHER-INS-AGENT-PHONE PIC X(10).

05 OTHER-INS-AGENT-STREET PIC X(25).

05 OTHER-INS-AGENT-CITY PIC X(20).

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

05 OTHER-INS-AGENT-ZIP PIC X(09).

Scopes of Coverage

Scope of Coverage	Description
00	Not Available
01	Major Medical
02	Medicare Supplement
03	Hospital, Physician, Dental and Drugs
04	Hospital, Physician, Dental
05	Hospital, Physician, Drugs
06	Hospital, Physician
07	Hospital, Dental and Drugs
08	Hospital, Dental
09	Hospital, Drugs
10	Hospital Only
11	Inpatient Hospital Only
12	Outpatient Hospital Only
13	Physician, Dental and Drugs
14	Physician and Dental
15	Physician and Drugs
16	Physician Only
17	Dental and Drugs Only
18	Dental Only
19	Drugs Only
20	Nursing Home Only
21	Cancer Only
22	CHAMPUS/CHAMPVA
23	Veterans Administration

24	Transportation
25	HMO
26	Carrier declared Bankruptcy
27	Major Medical without maternity benefits
28	HMO/Insurance Premium Paid by Medicaid GHIPP Program
29	Skilled Nursing Care
30	Medicare HMO (Part C)
31	Physician Only HMO
32	Pharmacy (PBM)
33	HMO No Maternity

TPL Carrier Code File Layout

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

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

Cols 1-6: Carrier Code (Payer ID)

Col 7: delimiter, value is ^

Cols 8-60: Insurance company name

Col 61: delimiter, value is ^

Cols 62-86: Street Address 1

Col 87: delimiter, value is ^

Cols 88-112: Street Address 2

Col 113: delimiter, value is ^

Cols 114-133: City

Col 134: delimiter, value is ^

Cols 135-136: State (abbrev)

Col 137: delimiter, value is ^

Cols 138-146: zip+4

Col 147: delimiter, value is ^.

Appendix L
Capitation Fee Payments

On a monthly basis, DHH provides to the MCO, the following risk-adjusted capitated payments.

- PMPM Payment
- Maternity Kick Payments

The chart below provides the information utilized by DHH to make these payments to the MCO.

MCO Capitation Codes

	Combined Rate Cell		Cap Code
Description	**Code**	**Description**	
SSI	N01	0-2 Months	01N01
SSI	N02	3-11 Months	01N02
SSI	CHD	Child 1-20 Years	01CHD
SSI	ADT	Adult 21+ Years	01ADT
Family and Children	N01	0-2 Months	02N01
Family and Children	N02	3-11 Months	02N02
Family and Children	CHD	Child 1-20 Years	02CHD
Family and Children	ADT	Adult 21+ Years	02ADT
Breast and Cervical Cancer	BCC	BCC, All Ages Female	03BLL
LaCHIP Affordable Plan	LAP	All Ages	04LLL
HCBS Waiver	HCBS	Child 0-20 Years	05CHD
HCBS Waiver	HCBS	Adult 21+	05ADT
Chisholm Class Members	CCM	CCM, All Ages	06CCM
Foster Care Children	FLL	Foster Care, All Ages Male & Female	07FLL
Maternity Kick Payment	KLL	Maternity Kick Payment, All Ages	01KLL

Early Elective Delivery Kick Payment	EED	Early Elective Delivery Kick Payment	01KEE
NEMT	MTH	HCBS, All Ages	NEMTH
NEMT	MTC	CCM, All Ages	NEMTC
NEMT	MTO	Other, All Ages	NEMTO
SBH - Chisholm Class Members	CCM	SBH – Chisholm, All Ages Male & Female	1CCM
SBH – Dual Eligible	DE1	SBH – Dual Eligible, All Ages	2DE1
SBH – HCBS Waiver	CHD	SBH – 20 & Under, Male and Female	3CHD
SBH – HCBS Waiver	ADT	SBH – 21+ Years, Male and Female	3ADT
SBH – Other	OT1	SBH – Other, All Ages	4OT1

DHH determines the capitated payments based on member's category of assistance, and region code. Members are assigned to 1 of 9 parishes; however for rate payment purposes, DHH has mapped the current 9 region codes to 4 new region codes.

The Member Category of Assistance (COA); Member Region Code (RC); 4 New Region Codes; the 4-Region Code to 9-Region Code Crosswalk; and the Member Parish to Region Code Crosswalk can be found on the following pages.

Member Category of Aid (COA)

- COA Identification
  - 01=SSI
  - 02=Family and Children
  - 03=Breast and Cervical Cancer
  - 04=LaChip Affordable
  - 05=HCBS Waiver
  - 06=Chisholm Class Members
  - 07=Foster Care Children

- KI=Maternity Kick Payment
- ED=Early Elective Delivery Kick Payment, All Ages

Member Region Code (RC)

New 4-Region Codes

Region Code	Region Description	Includes Geographic Region
01	Gulf	New Orleans Thibodaux
02	Capital	Baton Rouge North Shore
03	South Central	Lafayette Lake Charles Alexandria
04	North	Shreveport Monroe

9-Region to 4- Region Code Crosswalk

Previous Region Code	Geographic Region Description	Grouped Regions Code	Grouped Regions Description
01	New Orleans	01	Gulf
02	Baton Rouge	02	Capital
03	Thibodaux	01	Gulf
04	Lafayette	03	South Central
05	Lake Charles	03	South Central
06	Alexandria	03	South Central
07	Shreveport	04	North
08	Monroe	04	North
09	North Shore	02	Capital

Member Parish to Region Code Crosswalk

Parish Code	Recipient Parish Description	Provider Parish Description	Provider Region	Recipient Medicaid Region	Recipient CCARE Region	DUR Region	BYU Region *	*Gulf=1 Capitol = 2 South Central=3 North = 4
01	Acadia	Acadia	4	4	4	3	3	
02	Allen	Allen	5	5	5	3	3	
03	Ascension	Ascension	2	2	2	2	2	
04	Assumption	Assumption	3	3	3	2	1	
05	Avoyelles	Avoyelles	6	6	6	3	3	
06	Beauregard	Beauregard	5	5	5	3	3	
07	Bienville	Bienville	7	7	7	4	4	
08	Bossier	Bossier	7	7	7	4	4	
09	Caddo	Caddo	7	7	7	4	4	
10	Calcasieu	Calcasieu	5	5	5	3	3	
11	Caldwell	Caldwell	8	8	8	4	4	
12	Cameron	Cameron	5	5	5	3	3	
13	Catahoula	Catahoula	6	6	6	4	3	
14	Claiborne	Claiborne	7	7	7	4	4	
15	Concordia	Concordia	6	6	6	4	3	
16	Desoto	Desoto	7	7	7	4	4	
17	East Baton Rouge	East Baton Rouge	2	2	2	2	2	

18	East Carroll	East Carroll	8	8	8	4
19	East Feliciana	East Feliciana	2	2	2	2
20	Evangeline	Evangeline	4	4	4	3
21	Franklin	Franklin	8	8	8	4
22	Grant	Grant	6	6	6	4
23	Iberia	Iberia	4	4	4	2
24	Iberville	Iberville	2	2	2	2
25	Jackson	Jackson	8	8	8	4
26	Jefferson	Jefferson	1	1	1	1
27	Jefferson Davis	Jefferson Davis	5	5	5	3
28	Lafayette	Lafayette	4	4	4	3
29	Lafourche	Lafourche	3	3	3	2
30	LaSalle	LaSalle	6	6	6	4
31	Lincoln	Lincoln	8	8	8	4
32	Livingston	Livingston	9	9	9	2
33	Madison	Madison	8	8	8	4
34	Morehouse	Morehouse	8	8	8	4
35	Natchitoches	Natchitoches	7	7	7	4
36	Orleans	Orleans	1	1	1	1
37	Ouachita	Ouachita	8	8	8	4
38	Plaquemines	Plaquemines	1	1	1	1
39	Pointe Coupee	Pointe Coupee	2	2	2	2
40	Rapides	Rapides	6	6	6	4
41	Red River	Red River	7	7	7	4
42	Richland	Richland	8	8	8	4
43	Sabine	Sabine	7	7	7	4
44	St Bernard	St Bernard	1	1	1	1
45	St Charles	St Charles	3	3	3	1
46	St Helena	St Helena	9	9	9	2
47	St James	St James	3	3	3	2
48	St John	St John	3	3	3	2
49	St Landry	St Landry	4	4	4	3
50	St Martin	St Martin	4	4	4	3
51	St Mary	St Mary	3	3	3	3
52	St Tammany	St Tammany	9	9	9	1
53	Tangipahoa	Tangipahoa	9	9	9	1
54	Tensas	Tensas	8	8	8	4
55	Terrebonne	Terrebonne	3	3	3	2

56	Union	Union	8	8	8	4	4
57	Vermilion	Vermilion	4	4	4	3	3
58	Vernon	Vernon	6	6	6	4	3
59	Washington	Washington	9	9	9	1	2
60	Webster	Webster	7	7	7	4	4
61	West Baton Rouge	West Baton Rouge	2	2	2	2	2
62	West Carroll	West Carroll	8	8	8	4	4
63	West Feliciana	West Feliciana	2	2	2	2	2
64	Winn	Winn	6	6	6	3	3
65	East Jefferson			1	1	1	1
66	N. O. /Algiers			0		1	
67	N. O. /Uptown			0		1	
68	N. O. /Downtown			0		1	
69	N. O. /Gentilly			0		1	
70	Baton Rouge			0			
71	Orleans Region			0			
72	Alexandria			0			
73	Monroe Regional			0			
74	Region IX			0			
75	Shreveport			0			
76	Lafayette			0			
77	Out Of State	N/A	N/A	N/A	N/A		2
78	Lake Charles			0			
79	Thibodaux			0			
80	Hammond			0			
81	New Orleans			0			
82	Baton Rouge			0			
83	Thibodaux			0			
84	Lafayette			0			
85	Lake Charles			0			
86	Alexandria			0			
87	Shreveport	Texas	10	0	Prov: OOS, not a border county		
88	Monroe	Mississippi	11	0	Prov: OOS, not a border		

					county	
89	Natchitoches	Arkansas	12	0	Prov: OOS, not a border county	
90	OCS Field Servi.	Texas Counties	10	0	Prov: Border county	
91	Region I	Mississippi Counties	11	0	Prov: Border county	
92	B.R. Region Med.	Arkansas Counties	12	0	Prov: Border county	
93	Region III			0		
94	Region IV			0		
95	Region V			0		
96	Region VI			0		
97	Region VII			0		
98	Region VIII			0		
99	O. Juvenile Serv	Other o-o-s	13	0	Prov: OOS, not a border county	

Member Border Cities by Zip Code to Parish/Region Code Crosswalk

City	Zip code	MEDS Parish Code	Managed Care Region Code	Managed Care Region Code and Description
Natchez, MS	39120	15- Concordia	03	South Central
Natchez, MS	39121	15- Concordia	03	South Central
Burkeville, TX	75932	58- Vernon	03	South Central
Jasper, TX	75951	58- Vernon	03	South Central
Kirbyville, TX	75956	6- Beauregard	03	South Central
Newton, TX	75966	58- Vernon	03	South Central
Buna, TX	77612	6- Beauregard	03	South Central
Lumberton, TX	77657	10- Calcasieu	03	South Central
Junction City, AR	71749	56- Union	04	North
Junction City, AR	71749	56- Union	04	North
Osyka, MS	39657	53- Tangipahoa	02	Capital
Chatawa, MS	39632	53- Tangipahoa	02	Capital
Picayune, MS	39466	52- St. Tammany	02	Capital
Nicholson, MS	39463	52- St. Tammany	02	Capital
Pearlington, MS	39572	52- St. Tammany	02	Capital

Louisiana Medicaid Recipient Aid Category Codes

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

30	1115 HIFA Waiver	LaChoice and LHP and GNOCHC
40	Family Planning	Family Planning Waiver

Louisiana Medicaid Recipient Type Case Codes

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

022	LTC Spend-Down MNP (Income > Facility Fee)	0
023	SSI Transfer of Resource(s)/LTC	1
024	Transfer of Resource(s)/LTC	0
025	LTC Spend-Down MNP	0
026	SSI/EDA Waiver	1
027	EDA Waiver	0
028	Tuberculosis (TB)	0
029	Foster Care IV-E - Suspended SSI	0
030	Regular Foster Care Child	0
031	IV-E Foster Care	0
032	YAP (Young Adult Program)	0
033	OYD - V Category Child	0
034	MNP - Regular Foster Care	0
035	YAP/OYD	0
036	YAP (Young Adult Program)	0
037	OYD (Office of Youth Development)	0
038	OCS Child Under Age 18 (State Funded)	0
039	State Retirees	0
040	SLMB (Specified Low-Income Medicare Beneficiary)	0
041	OAA, ANB or DA (GERI HP-ICF(I) SSI-No)	0
042	OAA, ANB or DA (GERI HP-ICF(I) SSI Pay)	1
043	New Opportunities Waiver - SSI	1
044	OAA, ANB or DA (GERI HP-ICF(2) SSI-Pay)	1
045	SSI PCA Waiver	1
046	PCA Waiver	0
047	Illegal/Ineligible Aliens Emergency Services	0

048	QI-1 (Qualified Individual - 1)	0
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	0
050	PICKLE	0
051	LTC MNP/Transfer of Resources	0
052	Breast and/or Cervical Cancer	0
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	0
054	Reinstated Section 4913 Children	0
055	LACHIP Phase 3	0
056	Disabled Widow/Widower (DW/W)	0
057	BPL (Walker vs. Bayer)	0
058	Section 4913 Children	0
059	Disabled Adult Child	0
060	Early Widow/Widowers	0
061	SGA Disabled W/W/DS	0
062	SSI/Public ICF/DD	1
063	LTC Co-Insurance	0
064	SSI/Private ICF/DD	1
065	Private ICF/DD	0
066	AFDC- Private ICF DD - 3 Month Limit	0
067	AFDC or IV-E(1) Private ICF DD	0
068	SSI-M (Determination of disability for Medicaid Eligibility)	1
069	Roll-Down	0
070	New Opportunities Waiver, non-SSI	0
071	Transitional Medicaid	0
072	LAMI Psuedo Income	0
073	Recipient (65 Plus) Eligible SSI/Ven Pay Hospital	1

074	Description not available	0
075	TEFRA	0
076	SSI Children's Waiver - Louisiana Children's Choice	1
077	Children's Waiver - Louisiana Children's Choice	0
078	SSI (Supplemental Security Income)	1
079	Denied SSI Prior Period	0
080	Terminated SSI Prior Period	1
081	Former SSI	1
082	SSI DD Waiver	1
083	Acute Care Hospitals (LOS > 30 days)	0
084	LaCHIP Pregnant Woman Expansion (185-200%)	0
085	Grant Review	0
086	Forced Benefits	0
087	CHAMP Parents	0
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	0
089	Recipient Eligible for Pay-Habitation and Other	0
090	LTC (Long Term Care)	0
091	A, B, D Recipient in Geriatric SNF; No SSI Pay	0
092	AFCD, GA, A, B, D in SNF; No AFDC Pay	0
093	DD Waiver	0
094	QDWI (Qualified Disabled/Working Individual)	0
095	QMB (Qualified Medicare Beneficiary)	0
097	Qualified Child Psychiatric	0
098	AFDC, GA, A, B, D ICF(2) No AFDC/Other Pay	0
099	Public ICF/DD	0
100	PACE SSI	1
101	PACE SSI-related	0

102	GNOCHC Adult Parent	0
103	GNOCHC Childless Adult	0
104	Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	0
109	LaChoice, Childless Adults	0
110	LaChoice, Parents with Children	0
111	LHP, Childless Adults	0
112	LHP, Parents with Children	0
113	LHP, Children	0
115	Family Planning, Previous LAMOMS eligibility	0
116	Family Planning, New eligibility / Non LaMOM	0
117	Supports Waiver SSI	1
118	Supports Waiver	0
119	Residential Options Waiver - SSI	1
120	Residential Options Waiver - NON-SSI	0
121	SSI/LTC Excess Equity	1
122	LTC Excess Equity	0
123	LTC Spend Down MNP Excess Equity	0
124	LTC Spend Down MNP Excess Equity(Income over facility fee)	0
125	Disability Medicaid	0
127	LaChip Phase IV: Non-Citizen Pregnant Women Expansion	0
130	LTC Payment Denial/Late Admission Packet	0
131	SSI Payment Denial/Late Admission	1
132	Spendown Denial of Payment/Late Packet	0
133	Family Opportunity Program	0
134	LaCHIP Affordable Plan	0
136	Private ICF/DD Spendown Medically Needy Program	0

137	Public ICF/DD Spendown Medically Needy Program	0
138	Private ICF/DD Spendown MNP/Income Over Facility Fee	0
139	Public ICF/DD Spendown MNP/Income Over Facility Fee	0
140	SSI Private ICF/DD Transfer of Resources	1
141	Private ICF/DD Transfer of Resources	0
142	SSI Public ICF/DD Transfer of Resources	1
143	Public ICF/DD Transfer of Resources	0
144	Public ICF/DD MNP Transfer of Resources	0
145	Private ICF/DD MNP Transfer of Resources	0
146	Adult Residential Care/SSI	1
147	Adult Residential Care	0
148	Youth Aging Out of Foster Care (Chaffee Option)	0
149	New Opportunities Waiver Fund	0
150	SSI New Opportunities Waiver Fund	1
151	ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	0
152	ELE School Lunch (Express Lane Eligibility -School Lunch)	0
153	SSI - Community Choices Waiver	1
154	Community Choices Waiver	0
155	HCBS MNP Spend down	0
178	Disabled Adults authorized for special hurricane Katrina assistance	0
200	CsoC-SED MEDICAID CHILD -MEDS TC and sgmt TC CSoC Waiver Children - 1915(c) waiver. Children under age 22, meeting a hospital and nursing facility LOC of CSoC will be eligibile up to 300% of FBR, using institutional eligibility criteria. LOC 60=hospital, 61=NF.	0
201	LBHP1915(i) NON MEDICAID ADULT 19 &OLDER CSoC Waiver Adults - 1915(i) only; non-Medicaid. Adults over the age of 18, not otherwise eligible for Medicaid,	0

	meeting the 1915(i) LON criteria up to 150% of FPL.	
202	CSoC 1915(i)-LIKE MEDICAID CHILD sgmt 1915(i)-like Children (aka 1915(b)(3) children): temp type case on LTC segment if recipient is in LTC/NH/ICF. Otherwise Medicaid eligible children under age 22, meeting a LON of CSoC and eligible for additional services under 1915(b)(3) savings.	0
203	LBHP1915(i) MEDICAID ADULT 19 &OLDER sgmt CSoC Waiver Adults - 1915(i): temp type case on LTC segment if recipient is in LTC/NH/ICF. Adults over the age of 21, otherwise eligible for Medicaid, meeting the 1915(i) LON criteria.	0
204	LBHP1115-NON-MEDICAID ADULTS 19 & OLDER 1115 waiver for 1915(i) persons whose income is below 150% of FTPL and meeting the LON criteria. These individuals do not have to meet a category of assistance. The new aid cat/type case combination will be 40/204 and the segment temp type case will be 204.	0
205	LBHP Spenddown (Adult)	

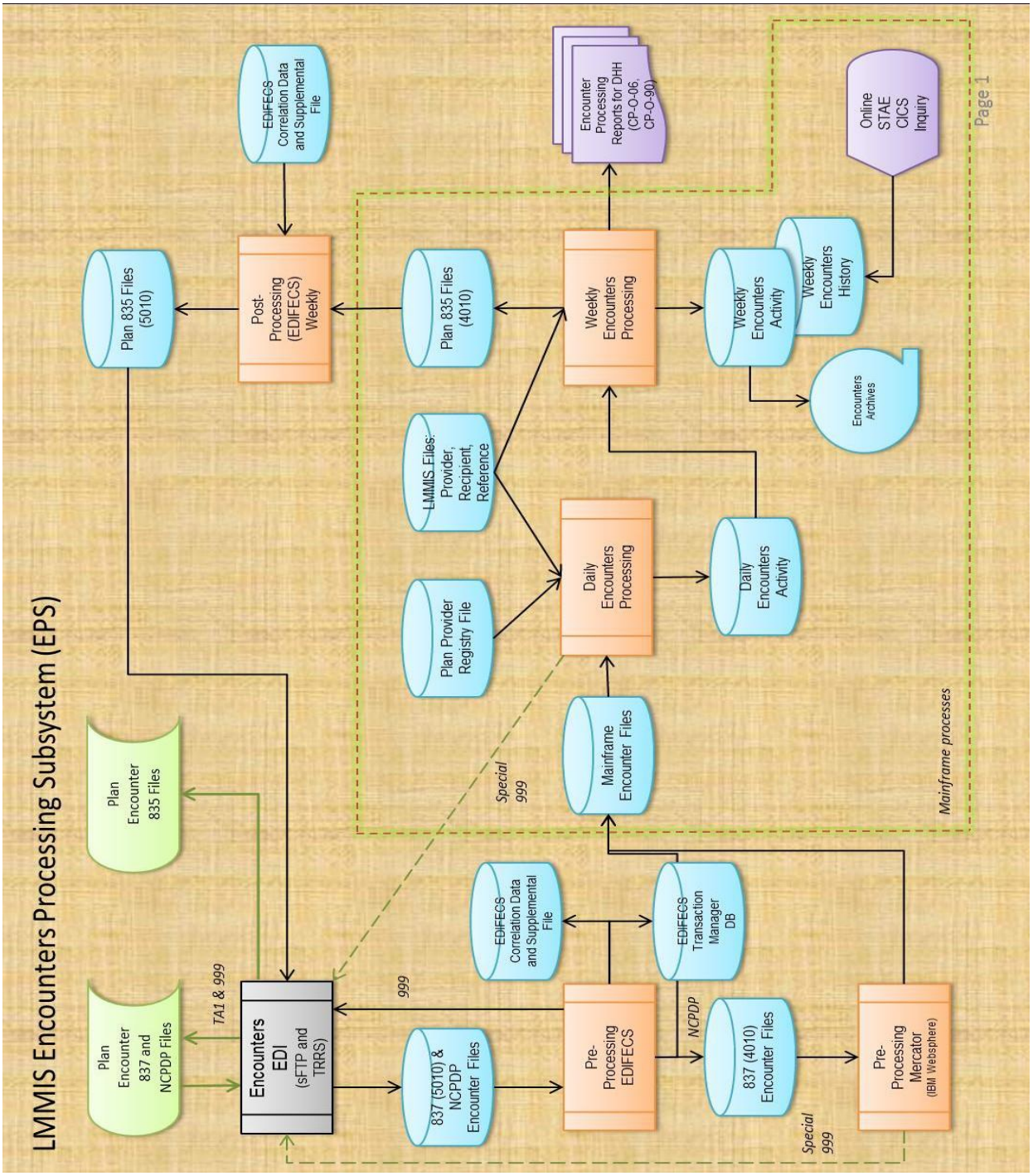
Appendix M

Claims Summary Report

On a monthly basis, MCOs are required to submit to DHH a Claims Summary Report. The report along with instructions can be found on the makingmedicaid.com website.

Appendix N

Encounter Processing Flow



Appendix O
Encounter Data Certification Form

The Encounter Data Certification Form is located on the following pages.

BAYOUHEALTH
Your Health | Your Choice

LA DEPARTMENT OF HEALTH AND HOSPITALS
ENCOUNTER DATA CERTIFICATION FORM

Please Type or Print Clearly

Managed Care Organization	**Name of Preparer/Title**
For The Period Ending **_____, 20____**	**Contact Phone Number/Email Address**

Managed Care Data Certification Statement

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

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

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

Date Form Submitted:_____

Please circle as appropriate. Original Submission? Y N Void? Y N
Resubmission of Corrected or Voided Encounters ? Y N

Signature

This certification must be signed by the Chief Executive Officer or Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Officer or Chief Financial Officer. Please check here if a delegated authority is certifying this submission		
Date	MCO Chief Executive Officer/Delegate Name & Title	Signature
Date	MCO Financial Officer/Delegate Name & Title Officer/Delegate Name & Title	Signature

Appendix P

Batch Pharmacy Encounters Companion Guide

The Batch Pharmacy Encounters Companion Guide is a Supplement to this Managed Care Organization System Companion Guide. Therefore, revisions will only be made to the Pharmacy Guide itself.

Appendix Q

Pharmacy Encounters Supplemental File Layout

Subject to change

PART 1: PLAN FILE SUBMISSIONS

The plan Submission File is a non-delimited ASCII text file. Records are variable length, up to a maximum of 1,447 bytes. File should be submitted weekly by Friday COB (5:00 p.m. CT).

File should be submitted to Molina's Non-EDI FTP server in the Plan's To_Molina Folder.

Plan File submission naming convention:

BYU-nnnnnnn-RX-ENC-SUPPLEMENTAL- YYYYMMDD.txt

Where NNNNNNN is the MCO Plan ID and YYYYMMDD is the date of submission.

Submission File Record Layout

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
1	1	7	Numeric	7	N/A		Plan Submitter ID. See comments.	Submitter identification number assigned to the plan. See comments.	AMG=4508063 ACLA=4508073 LHCC=4508067 Aetna=4508985 UHC=4508989
2	8	17	Numeric	10	N/A		NNNNNNNNNN, left fill with zeros.	This is a sequential record number in the submission file. The first record should have value 0000000001, the 2nd should have value 0000000002, etc.	File Submission Record Number
3	18	47	Char	30	N/A		Plan ICN submitted on encounter	Please send the same plan ICN you send on the NCPDP encounter record.	
4	48	57	Numeric	10	201-B1	Service Provider ID	10 digit NPI. Left fill with zeros if applicable.	NPI assigned to pharmacy	Must be on the Plan's Provider Registry
5	58	67	Char	10	N/A	Service Provider Taxonomy	10 character taxonomy, if known.	Taxonomy for the pharmacy if known	If not known, send 10 spaces.
6	68	75	Numeric	8	401-D1	Date of Service	YYYYMMDD	Date of service of the claim	Date of service of the claim
7	76	83	Numeric	8	N/A	Date Received	YYYYMMDD	N/A	Date that the plan or its PBM contractor received the claim.
8	84	84	Numeric	1	N/A	Encounter Status	1=original claim paid by plan 2=void of previous paid claim.	N/A	You should send claims that are paid and voided.
9	85	85	Numeric	1	N/A	Encounter Modifier	1=original claim 4=void of previous paid claim.	N/A	
10	86	86	Numeric	1	***111-AM***	***Segment Identification***	***Value=1***	***Patient***	

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
11	87	88	Char	2	307-C7	Place of Service	Use value 01.		Required if value=01 (Pharmacy) and 384-4X=12 (PRTF)
12	89	90	Char	2	384-4X	Patient Residence	If PRTF then use value 12; otherwise use value 00.		Required if value=12 (PRTF) and 307-C7=01 (Pharmacy)
13	91	91	Numeric	1	***111-AM***	***Segment Identification***	***Value=4***	***Insurance***	
14	92	104	Numeric	13	302-C2	Cardholder ID	Medicaid ID Number of the recipient, left fill with zeros if necessary.	Insurance ID assigned to the cardholder	13 digit LA Medicaid ID
15	105	105	Numeric	1	***111-AM***	***Segment Identification***	***Value=7***	***Claim***	
16	106	117	Char	12	402-D2	Prescription/Service Reference Number	12 digit Rx number	Reference number assigned by the provider for the dispensed drug provided	The pharmacy's file number for this prescription.
17	118	128	Char	11	407-D7	Product/Service ID	11 digit NDC. Left fill with zeros if necessary.	National Drug Code	For Compounds populate with zeros.
18	129	139	Numeric	11	442-E7	Quantity Dispensed	NNNNNNN.NNN, include the decimal. Left fill with zeros.	Quantity dispensed expressed in metric decimal units	
19	140	141	Numeric	2	406-D6	Compound Code	01=Not a compound 02=Compound.	Code indicating whether or not the prescription is a compound	If value is 02 then at least one Compound Segment 10 is required (see fields 85-89 below).
20	142	143	Numeric	2	420-DK	Submission Clarification Code	00=Not 340B 20=340B.	Code indicating that the pharmacist is clarifying the submission.	Required if value=20 (340B Program Indicator) if the product dispensed or administered was purchase under the Federal 340B program. Otherwise use 00.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
21	144	145	Numeric	2	308-C8	Other Coverage Code	00=Not specified by patient 01=No other coverage 02=Other coverage exists - payment collected 03=Other coverage billed - claim not covered 04=Other coverage exists - payment not collected.	Indicates whether the Medicaid recipient has other health insurance coverage.	If you specify a value other than 00 or 01 then we require at least one COB Segment.
22	146	146	Numeric	1	***111-AM***	***Segment Identification***	***Value=3***	***Prescriber***	
23	147	156	Numeric	10	411-DB	Prescriber ID	NPI	National Provider ID assigned to the prescriber.	Must be on the Plan's Provider Registry
24	157	166	Char	10	N/A	Prescriber Taxonomy, if known	Taxonomy.	Prescriber taxonomy, if known.	If not known, send 10 spaces.
25	167	168	Numeric	2	***111-AM***	***Segment Identification***	***Value=11***	***Pricing***	
26	169	178	Numeric	10	409-D9	Ingredient Cost Submitted	NNNNNNN.NN, include the decimal, left fill with zeros.	For a compound, this is the sum of all individual ingredient costs	
27	179	188	Numeric	10	412-DC	Dispensing Fee Submitted	NNNNNNN.NN, include the decimal, left fill with zeros.		
28	189	193	Numeric	5	481-HA	Flat Sales Tax Submitted	NN.NN, include the decimal, left fill with zeros.	This is submitted provider fee field from the pharmacy to the MCO	Must be numeric and not less than zero.
29	194	203	Numeric	10	426-DQ	Usual and Customary Charge	NNNNNNN.NN, include the decimal, left fill with zeros.	The usual and customary charge for the prescription	
30	204	213	Numeric	10	430-DU	Gross Amount Due	NNNNNNN.NN, include the decimal, left fill with zeros.	Gross Amount Due	
31	214	223	Numeric	10	N/A	Amount BYU Plan paid the PBM	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount that the BYU plan paid their PBM contractor	

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
32	224	225	Numeric	2	423-DN	Basis of Cost Determination	01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 08 = 340B Disproportionate Share Pricing 09 = Other 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	Code indicating the method by which Ingredient Cost Submitted was calculated	
33	226	227	Numeric	2	***111-AM***	***Segment Identification***	***Value=23***	***Response Pricing***	
34	228	237	Numeric	10	505-F5	Patient Pay Amount	NNNNNNN.NN, include the decimal, left fill with zeros.		
35	238	247	Numeric	10	506-F6	Ingredient Cost Paid	NNNNNNN.NN, include the decimal, left fill with zeros.	Drug ingredient cost paid included in "Total Amount Paid"(509-F9)	Paid to pharmacy provider
36	248	257	Numeric	10	507-F7	Dispensing Fee Paid	NNNNNNN.NN, include the decimal, left fill with zeros.	Dispensing fee paid included in "Total Amount Paid"(509-F9)	Required if this is used in the calculation of final reimbursement to Pharmacy provider
37	258	262	Numeric	5	558-AW	Flat Sales Tax Amount Paid	NN.NN, include the decimal, left fill with zeros.	Flat sales tax paid which is included in the "Total Amount Paid"(509-F9)	This is a state mandated provider fee paid by the MCO to the Pharmacy provider. Must reflect $0.10. May be zero if there is secondary TPL (field 42 Other Payer information).

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
38	263	272	Numeric	10	509-F9	Total Amount Paid	NNNNNNN.NN, include the decimal, left fill with zeros.	Total amount paid by the claims processor to the pharmacy provider.	This paid amount should not include fees that would be considered a payment for access to a network.
39	273	274	Numeric	2	522-FM	Basis of Reimbursement Determination	00=Not specified 01=Ingredient cost paid as submitted 02=Ingredient cost reduced to AWP pricing 03=Ingredient cost reduced to AWP less X% pricing 04=Usual & Customary Paid as submitted 05=Paid lower of Ingredient Cost Plus Fees versus Usual & Customary 06=MAC Pricing Ingredient Cost paid 07=MAC Pricing Ingredient Cost Reduced to MAC 08=Contract Pricing 09=Acquisition Pricing 10=ASP (Average Sales Price) – The average sales price (ASP) is a cost basis required by and reported to CMS for pricing Medicare Part B drugs. 11=AMP (Average Manufacturer Price) – The average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade; calculated net of chargebacks, discounts, rebates, and	Code indicating the method by which the drug cost was calculated.	Required if Ingredient Cost Paid (506-F6) is greater than zero (0). Required if Basis of Cost Determination (423-DN) is submitted on billing.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
							other benefits tied to the purchase of the drug product, regardless of whether these incentives are paid to the wholesaler or the retailer. 12=34ØB/Disproportionate Share/Public Health Service Pricing – The 34ØB Drug Pricing Program from the Public Health Service Act, sometimes referred to as "PHS Pricing" or "6Ø2 Pricing" is a federal program that requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price. 13=WAC (Wholesale Acquisition Cost) – A cost as defined in Title XIX, Section 1927 of the Social Security Act. 14=Other Payer-Patient Responsibility Amount – Indicates reimbursement was based on the Other Payer-Patient Responsibility Amount.		
40	275	284	Numeric	10	523-FN	Amount Attributed to Sales Tax	NNNNNNN.NN, include the decimal, left fill with zeros.		Required when TPL or COB is involved
41	285	285	Numeric	1	***111-AM***	***Segment Identification***	***Value=5***	***COB/Other Payments***	**1st COB set**

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
42	286	295	Char	10	340-7C	Other Payer ID 1	Left justify	MCOs to send Louisiana assigned Carrier Codes	If no other payer, then use 10 spaces. DO NOT REPORT YOUR PLAN PAYMENT AMOUNT IN A COB LOOP. If you need to submit a segment and you do not know the payer ID (carrier code), then use 000000.
43	296	297	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-1	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If no other payer, then use value 00.
44	298	307	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-1	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If no other payer, then use value zeros.
45	308	309	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-2	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
46	310	319	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-2	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
47	320	321	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-3	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
48	322	331	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-3	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
49	332	333	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-4	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
50	334	343	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-4	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
51	344	345	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-5	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
52	346	355	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-5	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
53	356	357	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 1-6	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
54	358	367	Numeric	10	431-DV	Other Payer Amount Paid Amount 1-6	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
55	368	368	Numeric	1	***111-AM***	***Segment Identification***	***Value=5***	***COB/Other Payments***	**2nd COB set**
56	369	378	Char	10	340-7C	Other Payer ID 2	Left justify	MCOs to send Louisiana assigned Carrier Codes	If no other payer, then use 10 spaces. DO NOT REPORT YOUR PLAN PAYMENT AMOUNT IN A COB LOOP. If you need to submit a segment and you do not know the payer ID (carrier code), then use 000000.
57	379	380	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-1	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
58	381	390	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-1	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
59	391	392	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-2	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
60	393	402	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-2	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
61	403	404	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-3	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
62	405	414	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-3	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
63	415	416	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-4	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
64	417	426	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-4	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
65	427	428	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-5	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
66	429	438	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-5	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
67	439	440	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 2-6	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
68	441	450	Numeric	10	431-DV	Other Payer Amount Paid Amount 2-6	NNNNNNN.NN, include the decimal	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
69	451	451	Numeric	1	***111-AM***	***Segment Identification***	***Value=5***	***COB/Other Payments***	**3rd COB set**
70	452	461	Char	10	340-7C	Other Payer ID 3	Left justify	MCOs to send Louisiana assigned Carrier Codes	If no other payer, then use 10 spaces. DO NOT REPORT YOUR PLAN PAYMENT AMOUNT IN A COB LOOP. If you need to submit a segment and you do not know the payer ID (carrier code), then use 000000.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
71	462	463	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-1	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
72	464	473	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-1	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
73	474	475	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-2	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
74	476	485	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-2	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
75	486	487	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-3	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
76	488	497	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-3	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
77	498	499	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-4	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
78	500	509	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-4	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
79	510	511	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-5	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
80	512	521	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-5	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
81	522	523	Numeric	2	342 HC	Other Payer Amount Paid Qualifier 3-6	01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 09=Compound Preparation Cost 10=Sales Tax	Code qualifying the Other Payer Amount Paid	If not available, then use value zeros.
82	524	533	Numeric	10	431-DV	Other Payer Amount Paid Amount 3-6	NNNNNNN.NN, include the decimal, left fill with zeros.	Amount of any payment known by the pharmacy from other sources	If not available, then use value zeros.
Other Information in the common portion of the file									

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
83	534	534	Numeric	1	461-EU	Prior Authorization Type	0 = Not specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from Copay and/or Coinsurance 5 = Exemption from RX 6 = Family Plan Indic. 7 = AFDC (Aid to Families with Dependent Children) 8 = Payer Defined Exemption 9 = Emergency Preparedness		
84	535	583	Char	49	N/A	FILLER	USE SPACES		For future expansion if needed.
Compound Drug Information									
85	584	585	Numeric	2	***111-AM***	***Segment Identification***	***Value=10***	***Compound***	***May have repeating compound products up to a maximum of 24, including the 1st compound product. See Note 1 below. If the record is not a compound drug, then do not include fields 85-89.***
86	586	596	Numeric	11	489-TE	Compound Product ID-1	11 digit NDC. Left fill with zeros if necessary.	NDC of an ingredient used in a compound	

Field ID	Start Column	End Column	Type	Length	NCPDP Field# N/A=Not applicable	NCPDP Field Name, when applicable, and other information.	Value set or Format	NCPDP Value Definition	Comments
87	597	607	Numeric	11	448-ED	Compound Ingredient Quantity-1	NNNNNNN.NNN, include the decimal, left fill with zeros.	Amount Expressed in metric decimal units of the product included in the compound mixture	
88	608	617	Numeric	10	449-EE	Compound Ingredient Drug Cost-1	NNNNNNN.NN, include the decimal, left fill with zeros.	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in (Field 448-ED)	
89	618	619	Numeric	2	490-UE	Compound Ingredient Basis of Cost Determination-1	01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 08 = 340B Disproportionate Share Pricing 09 = Other 10 = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	

Note 1: For compounds, you should repeat fields 85 through 89 for each additional compound product, up to a maximum of 24 products including the 1st compound product. Each additional production should add an additional 36 bytes and should be included using the same layout as fields 85-89 (which represent the 1st product).

Note 2: If the claim is not a compound, then do not include fields 85-89.

Part 2: Edit Response File

Molina will edit your submission file for correctness, and return an edit response file to the From_Molina folder on the non-EDI FTP server.
The Edit Response File is a delimited ASCII text file.
Records are fixed length, 58 bytes
The edit response file will have the filename: BYU-nnnnnnn-RX-ENC-EDIT-yyyymmdd.TXT
Where nnnnnnn is the plan's submitter ID (assigned by Molina) and yyyymmdd is the date of submission.
If you do not receive an edit file, then that is an indication that Molina did not receive your submission file.
If you receive an empty response file, then that is an indication that all records on the submitted file are accepted with no errors.
Each field will be edited for a correct value. If a field is found to have an error in the value, then you will see an error code on the edit response file with the field ID.
So, for example, if a record has incorrect values in fields 4 and 9, you will see edit errors 004 and 009 on the edit response file.
Records that have errors will not be accepted into Molina's system. You may correct records that are in error and resubmit them on a later submission file.
The layout for the edit response file is shown below:

Edit Response File Record Layout

Field ID	Columns				Value set or Format	Comments
1	1-7				Plan Submitter ID. See comments.	AMG=4508063 ACLA=4508073 LHCC=4508067 Aetna=4508985 UHC=4508989
2	8-17				File Submission Record Number	This is the file submission record number that you sent in the submission file. It identifies the record in error. See field 2 in the submission record layout above.
3	18				Value = ^	
4	19-21				1st error code	
5	22				Value = ^	
6	23-25				2nd error code	
7	26				Value = ^	
8	27-29				3rd error code	
9	30				Value = ^	
10	31-33				4th error code	
11	34				Value = ^	
12	35-37				5th error code	
13	38				Value = ^	
14	39-41				6th error code	
15	42				Value = ^	
16	43-45				7th error code	
17	46				Value = ^	
18	47-49				8th error code	

19	50				Value = ^	
20	51-53				9th error code	
21	54				Value = ^	
22	55-57				10th error code	
23	58				Value = ^	
24	59-88				Plan ICN	This is the plan ICD submitted on the record. It may be up to 30 characters in length
25	89				Value = ^	End of Record

ERROR CODES

Code	Description
001	Invalid value for Plan Submitter ID
002	Field has a zero value or a non-numeric value or is not unique in the submission file
003	Field value is missing (has value=spaces)
004	NPI is not numeric or is not 10 digits or is not on Plan Registry
005	Taxonomy may be spaces, but if a non-blank value is submitted, it must be 10 characters
006	Date is not valid or does not make sense (is prior to plan contract or is a future date based on the date of the submission)
007	Date is not valid or does not make sense (is prior to plan contract or is a future date based on the date of the submission) Also, date value must be on or after the DOS.
008	Must be value 1 or 2
009	Must be value 1 or 4. If value is 1 then field 008 value must be 1. If value is 4, then field 008 value must be 2.
010	Must be value 1
011	Must be value 01
012	Must be value 00 or 12
013	Must be value 4
014	Value must be a valid recipient ID, must be 13 digits, and must be linked to the plan on the DOS
015	Must be value 7
016	Must be a number and must be 12 digits
017	Must be a number and must be 11 digits
018	Must be a valid numeric value with the decimal
019	Must be value 01 or 02. If value is 02, then at least one compound segment must be present in the record.
020	Must be value 00 or 20
021	Must be a value in the range 00 to 04.
022	Must be value 3
023	NPI is not numeric or is not 10 digits or is not on Plan Registry
024	Taxonomy may be spaces, but if a non-blank value is submitted, it must be 10 characters
025	Must be value 11
026	Must be a valid numeric value with the decimal
027	Must be a valid numeric value with the decimal
028	Must be a valid numeric value with the decimal and must not be less than zero.
029	Must be a valid numeric value with the decimal
030	Must be a valid numeric value with the decimal
031	Must be a valid numeric value with the decimal
032	Must be a value in the range 01 to 12
033	Must be value 23

034	Must be a valid numeric value with the decimal
035	Must be a valid numeric value with the decimal
036	Must be a valid numeric value with the decimal
037	If value is not 00.10, then you will get this error. May be zero if there is secondary TPL submitted on the record.
038	Must be a valid numeric value with the decimal
039	Must be a value in the range 00 to 14.
040	Must be a valid numeric value with the decimal
041	Must be value 5
042	Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, DHH decided edit 042 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.
043	Must be a value in the range 01 to 10.
044	Must be a valid numeric value with the decimal
045	Must be a value in the range 01 to 10. May be zero.
046	Must be a valid numeric value with the decimal
047	Must be a value in the range 01 to 10. May be zero.
048	Must be a valid numeric value with the decimal
049	Must be a value in the range 01 to 10. May be zero.
050	Must be a valid numeric value with the decimal
051	Must be a value in the range 01 to 10. May be zero.
052	Must be a valid numeric value with the decimal
053	Must be a value in the range 01 to 10. May be zero.
054	Must be a valid numeric value with the decimal
055	Must be value 5
056	Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, DHH decided edit 042 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.
057	Must be a value in the range 01 to 10. May be zero.
058	Must be a valid numeric value with the decimal
059	Must be a value in the range 01 to 10. May be zero.
060	Must be a valid numeric value with the decimal
061	Must be a value in the range 01 to 10. May be zero.
062	Must be a valid numeric value with the decimal
063	Must be a value in the range 01 to 10. May be zero.
064	Must be a valid numeric value with the decimal
065	Must be a value in the range 01 to 10. May be zero.
066	Must be a valid numeric value with the decimal
067	Must be a value in the range 01 to 10. May be zero.
068	Must be a valid numeric value with the decimal
069	Must be value 5
070	Must be a valid carrier code if submitted. Do not submit your plan payment ID 99999x. Do not submit interest INT99x. Effective 1/27/2016, DHH decided edit 042 is not a rejection edit. If you see this edit on your response, then it means you submitted a payer ID that starts with 99999 or INT99, which is a valid rejection.
071	Must be a value in the range 01 to 10. May be zero.

072	Must be a valid numeric value with the decimal
073	Must be a value in the range 01 to 10. May be zero.
074	Must be a valid numeric value with the decimal
075	Must be a value in the range 01 to 10. May be zero.
076	Must be a valid numeric value with the decimal
077	Must be a value in the range 01 to 10. May be zero.
078	Must be a valid numeric value with the decimal
079	Must be a value in the range 01 to 10. May be zero.
080	Must be a valid numeric value with the decimal
081	Must be a value in the range 01 to 10. May be zero.
082	Must be a valid numeric value with the decimal
083	Must be a numeric value between 0 and 9.
084	Must be spaces.
085	Must be value 10. If a compound segment is included and field 019 is not value 02, then you will get this error.
086	Must be numeric and 11 digits, and must be a valid NDC
087	Must be a valid numeric value with the decimal
088	Must be a valid numeric value with the decimal
089	Must be a value in the range 01 to 12

Note: Field edits 085 through 089 will repeat for additional compound segments when submitted on the record, accordingly.

So, the 2nd compound segment may experience edits 090 through 094; the 3rd compound segment may experience edits 095 through 099, etc.

Appendix R
Louisiana Health Information Exchange (LaHIE)

LaHIE Interface

As part of the American Recovery and Reinvestment Act (ARRA) of 2009, the Office of the National Coordinator for Health Information Technology (ONC) granted 56 awards totaling $548 million to help states and territories advance health information exchange among providers and hospitals in their designated areas. The Louisiana Health Care Quality Forum received $10.6 million in 2010 and serves as the designated, neutral entity to build and support a health information exchange (HIE) in our state.

Known as LaHIE, the exchange allows authorized providers and organizations to electronically access and share health-related information through a secure and confidential network for the purpose of improving patient safety, quality of care and health outcomes.

The State Health Information Exchange Program aims to ensure that every eligible health care provider has at least one option for health information exchange that meets the requirements of the Medicare and Medicaid EHR Incentive Programs, as defined by CMS in 2010. To this end, LaHIE will create and implement up-to-date privacy and security requirements for HIE; coordinate with Medicaid and state public health programs to establish an integrated approach; monitor and track meaningful use HIE capabilities; set strategy to meet gaps in HIE capabilities; and ensure consistency with national standards.

The visit registry will begin with patient matching, service location, service date/time and chief complaints. This feature will enhance care coordination, increase patient safety, reduce redundant tests and avoid unnecessary admissions.

The ADT message includes basic information about a patient's visit to a hospital or emergency room. Information identifies the treating facility, patient demographics including contact information, next-of-kin with contact information, patient's primary care provider and insurance information, as well as information related to allergies, diagnoses, and procedures performed during the visit. The ADT message is generated when a patient is admitted to a hospital or emergency department, discharged from a hospital or emergency department, transferred to another facility, or any demographic information is updated.

For more information: http://www.lhcqf.org/lahie-specs

Appendix S

Prior Authorization Requests Data Elements

(MCO to FI)

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

DHH requires the following from the MCO:

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

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

Field Name	Usage Notes	Date Type	Purpose
Plan submitter ID	MCO 7-digit Submitter Id (45_____).	Int (Primary Key)	Health Plans Submitter ID
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Number		varchar(30)	The PA Authorization Number
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Line Number		int	The PA line Number
Delimiter	'^'	char(1)	Column Separator
Authorization Type	5 Rehabilitation Services 6 Home Health Care 09 DME 12 Pharmacy 16 Personal Care Service 17 Medical -- (Procedures and Diagnostics test) 18 Transportation 40 Imaging 70 LTC 71 Pediatric Day Health Care 88 Hospice 90 Specialized Behavioral Health 99 Other	Char(2)	Prior Authorization Type
Delimiter	'^'	char(1)	Column Separator
Medicaid Recipient ID		char(13)	Current Medicaid Recipient ID
Delimiter	'^'	char(1)	Column Separator
Provider NPI		Char(10)	Requesting provider NPI
Delimiter	'^'	char(1)	Column Separator
Provider Taxonomy		char(10)	Requesting provider taxonomy
Delimiter	'^'	char(1)	Column Separator
CPT / NDC/HICL/ THERAPEUTIC CLASS	If it's pharmacy PA then NDC or HICL or THERAPEUTIC CLASS	char(13)	Requested service code (CPT or NDC, HICL OR THERAPEUTIC CLASS)
Delimiter	'^'	char(1)	Column Separator

CPT Modifiers 1		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 2		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 3		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
CPT Modifiers 4		char(2)	CPT modifier up to 4
Delimiter	'^'	char(1)	Column Separator
Refering Provider NPI		char(10)	Referring Provider NPI
Delimiter	'^'	char(1)	Column Separator
Plan Authorization Status	A=authorized D=Denied R=Reduced authorized N=No Decision, Pending V=Void	char(1)	The Prior Authorization Line status
Delimiter	'^'	char(1)	Column Separator
Auth begin date	Format=CCYYMMDD	int	The beginning date of service associated with the PA Request
Delimiter	'^'	char(1)	Column Separator
Auth end date	Format=CCYYMMDD	int	The ending date of service associated with the PA Request
Delimiter	'^'	char(1)	Column Separator
Requested Units		int	Maximum Units Requested by Provider
Delimiter	'^'	char(1)	Column Separator
Auth Units		int	Maximum Units authorized by plan
Delimiter	'^'	char(1)	Column Separator
Auth amount ($)		Money	Maximum dollar amount authorized by plan
Delimiter	'^'	char(1)	Column Separator

Auth received date	Format=CCYYMMDD	Int	The date health Plan received PA request
Delimiter	'^'	char(1)	Column Separator
Auth notice date	Format=CCYYMMDD	int	The date health Plan notice the decision
Delimiter	'^'	char(1)	Column Separator
Auth Denied Reason	1 Not Medically Appropriate 2 Not a Covered Benefit 3 Administrative - Lack of Information 4 Reduced Authorized 5 Other	Char(2)	Reasons if PA was Denied
Delimiter	'^'	char(1)	Column Separator

Appendix T

Supplement to Fee Schedule

On a weekly basis, DHH, thru the Fiscal Intermediary, provides a Supplement to Fee Schedule File to each of the MCOs. This delimited text file provides information contained in DHH's Procedure Formulary files but is not shown on the fee schedules. The fields in the text file are in the same position as the Fee Schedule Extract, therefore, the MCO is required to utilize the delimited file to create an excel document.

The file name is MMIS_PLAN_EXTRACT_<DAILY8>.TXT (with <DAILY8>being in the format of YYYYMMDD). The file is available to the MCO on Fridays is sent to the MCO's sFTP verified site address.

The Extract Record Layout, Sample of the Fee Schedule Extract, and Data Elements Dictionary can be found on the following pages.

Extract Record Layout

```
                                                                |
|                TABLE OF CONTENTS FOR LAYOUT REPORT      PAGE    1    |
| 05/28/2014                                                           |
+----------------------------------------------------------------------+
|                                                                      |
|                      PROC-RECORD.................................1   |
|                                                                      |
+----------------------------------------------------------------------+
```

LAYOUT REPORT PAGE 1

LEVEL	DATA-NAME	LENGTH	TYPE	FROM	TO
01	PROC-RECORD	450	GROUP	1	450
05	PROC-MEDICAL-CODE	13	GROUP	1	13
10	PROC-CPT-CODE	5	X	1	5
10	PROC-CPT-TOS-CODE	2	X	6	7
10	PROC-CPT-MOD1	2	X	8	9
10	PROC-CPT-MOD2	2	X	10	11
10	PROC-CPT-MOD3	2	X	12	13
05	PROC-PROC-NAME	36	X	14	49
05	PROC-ACTIVE-DATES	9	GROUP	50	58
10	PROC-ACT-DT	8	N	50	57
10	PROC-ACT-DATE REDEFINES PROC-ACT-DT	8	GROUP	50	57
15	PROC-ACT-CC	2	X	50	51
15	PROC-ACT-YR	2	X	52	53
15	PROC-ACT-MO	2	X	54	55
15	PROC-ACT-DA	2	X	56	57
10	PROC-ACT-CODE	1	X	58	58
05	PROC-AGE	4	GROUP	59	62
10	PROC-MIN-AGE	2	X	59	60
10	PROC-MAX-AGE	2	X	61	62
05	PROC-SEX	1	X	63	63
05	PROC-PA-IND	1	X	64	64
05	PROC-PROV-RANGE	28	GROUP	65	92
10	PROC-PROVID OCCURS 7 TIMES TO 92	4	GROUP	65	68
25	PROC-FROM	2	X	65	66

LAYOUT REPORT PAGE 2

LEVEL	DATA-NAME	LENGTH	TYPE	FROM	TO
25	PROC-TO	2	X	67	68
05	PROC-MAX-UVSP	3	X	93	95
05	PROC-SURGERY-IND	1	X	96	96
05	PROC-CLAIM-TYPE-RESTRICT	6	GROUP	97	102
10	PROC-CT-RESTRICT	2	X	97	98
	OCCURS 3 TIMES TO 102				
05	PROC-PRICING-ACTION	11	GROUP	103	113
	OCCURS 6 TIMES TO 168				
10	PROC-PRICING-ACTION-CODE	3	X	103	105
10	PROC-PRICING-EFF-DATE	8	N	106	113
05	PROC-AUTO-ERROR	3	GROUP	169	171
	OCCURS 6 TIMES TO 186				
10	PROC-AUTO-ERROR-CODE	3	N	169	171
05	PROC-DATE-MAX-CHARGE	15	GROUP	187	201
	OCCURS 8 TIMES TO 306				
10	PROC-MAX-CHARGE	7	SNE	187	193
	PIC S9(5)V99				
10	PROC-CHARGE-EFFECT-DATE	8	GROUP	194	201
15	PROC-CHARGE-BEGIN-CC	2	X	194	195
15	PROC-CHARGE-BEGIN-YY	2	X	196	197
15	PROC-CHARGE-BEGIN-MM	2	X	198	199
15	PROC-CHARGE-BEGIN-DD	2	X	200	201
05	PROC-SVC	22	GROUP	307	328
10	PROC-SVC-EFF-YEAR	4	N	307	310
10	PROC-SVC-SAME-ANY-PROV	1	X	311	311
10	PROC-SVC-DAILY-LIMIT	2	N	312	313
10	PROC-SVC-MAX-NUM	4	N	314	317
10	PROC-SVC-DOLLAR-AMT	4	N	318	321

LAYOUT REPORT PAGE 3

LEVEL	DATA-NAME	LENGTH	TYPE	FROM	TO
10	PROC-SVC-TIME-LIMIT	4	GROUP	322	325
15	PROC-SVC-YR-IND	1	X	322	322
15	PROC-SVC-DAYS	3	N	323	325
10	PROC-SVC-ERR-CODE	3	X	326	328
05	PROC-BASE-UNITS-PRICE	17	GROUP	329	345
	OCCURS 5 TIMES TO 413				
10	PROC-BASE-UNITS	2	X	329	330
10	PROC-UNIT-PRICE	7	SNE	331	337
	PIC S9(5)V99				
10	PROC-UNIT-EFF-DATE	8	N	338	345
05	FILLER	37	X	414	450

Sample Fee Schedule Extract

A001003 NONEMER AMB DUAL ENT MEDICARE DENIED19950201C00990
5959000000000000000000000000001
8201995040185019890821000000000000000000000000000000000000000000000000299000000000000000
0000818419911101000775019890821000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A001009 AMBULANCE,BLS,BASE RATE,EMERG.,1WAY 19950215C00990
5959000000000000000000000000001
8201995040185019890821860197804010000000000000000000000000000000000000299000000000000000
0001653319940101001605119930101001556819920101001486919910201001420219910101001136 2
1990040100095001989082100085001987081700000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A002003 AMBULANCE SERVICE BLS PER MILE 19950201C00990
5959000000000000000000000000999
8201995040185019870101000000000000000000000000000000000000000000000000299000000000000000
0000021119911101000020019890821000018019870101000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A002009 AMBULANCE SERVICE,BLS PER MILE, 19950201C00990
5959000000000000000000000000001
8201995040185019840102000000000000000000000000000000000000000000000000299000000000000000
0000038119940101000037019930101000035919920101000034319910201000032819910101000025 0
1990070100002001984010200000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A002109 AMBULANCE SERVICE, OUTSIDE STATE PE 19901214C00990
0099000000000000000000000000999
8201984010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A003009 AMB.,CONVENTIONAL AIR SERVICE,1 WAY 20010607C00990
5959000000000000000000000000001
8202001070182020010401850199507078101982010100000000000000000000000248198250000000000
0010000019950707000000000000000000000000000000000000000000000000000000000000000000000000

0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000

A004009 AMB.,AIR HELICOPTER SERVICE,TRANSPRT20010607C00990

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A005009 AMBULANCE SERVICE, EMERGENCY, WATER,20010607C00990

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A006009 AMBULANCE SERVICE, WAITING TIME, ONE19860926C00990

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A007009 AMBULANCE SERVICE, OXYGEN, ADMINIST 19860926C00990

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A008003 PER MILE,VOLUNTEER,NO VESTED INTREST19930219C00990

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A009003 PER MILE,VOLUNTEER,INTRT.IND.,NEIGHB19930219C00990

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A010003 TAXI INTRACITY PRIMARY AREA 19980403C00990
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A011003 NONPROFIT NEMT PICK-UP FEE 1ST TRIP 19930519C00990
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A011009 NON-EMERGENCY TRANSPORTATION AND BU 19901120C00990
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A011503 NONPROFIT NEMT PICK-UP FEE 2ND TRIP 19980403C00990
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A012003 NONPROFIT NEMT MILEAGE FEE 1ST TRIP 19940708C00990
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A012503 NONPROFIT NEMT MILEAGE FEE 2ND TRIP 19980403C00990
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A013009 NON-EMERGENCY TRANSPORTATION: WHEEL-19860926C00990
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9951203 HOME VISIT, HEMODIALYSIS 20020815C00990 0099000000000000000000000000001
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9953903 HOME VISIT, NOS 20041214C00990 0099000000000000000000000000001
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9955103 HOME INFUS, PAIN MGMT, IV/SC 20020815C00990
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9955203 HM INFUS PAIN MGMT, EPID/ITH 20020815C00990
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9955303 HOME INFUSE, TOCOLYTIC TX 20020815C00990 0099000000000000000000000000001
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9955403 HOME INFUS, HORMONE/PLATELET 20020815C00990
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9955503 HOME INFUSE, CHEMOTHERAPHY 20020815C00990
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9955603 HOME INFUS, ANTIBIO/FUNG/VIR 20020815C00990
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9955703 HOME INFUSE, ANTICOAGULANT 20020716S00990
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8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
00000000 0000000 0000000 0000000 0000000 0000000 0000000 0000000
000000000000000000000 000000000000000 000000000000000 000000000000000
000000000000000 000000000000000

9955803 HOME INFUSE, IMMUNOTHERAPY 20020815C00990
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9955903 HOME INFUS, PERITON DIALYSIS 20020815C00990
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9956003 HOME INFUS, ENTERO NUTRITION 20020815C00990
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9956103 HOME INFUSE, HYDRATION TX 20020815C00990
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9956203 HOME INFUS, PARENT NUTRITION 20020815C00990
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9956303 HOME ADMIN, PENTAMIDINE 20020815C00990
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9956403 HME INFUS, ANTIHEMOPHIL AGNT 20020815C00990
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9956503 HOME INFUS, PROTEINASE INHIB 20020815C00990
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8202002010100000000000000000000000000000000000000000000000000000000000299000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000

9956603 HOME INFUSE, IV THERAPY 20020815C00990 0099000000000000000000000000001
8202002010100000000000000000000000000000000000000000000000000000000000000000000000000000000
0000000000000

Data Element Dictionary

Data Elements	Description
Procedure Code	5 digits or alpha preceded HCPCS procedure code
Type of Service	2 digit Type of Service code See Type of Service for possible values
Modifier 1	2 character Procedure code modifier. For possible values see Proc Code Modifiers
Modifier 2	2 character Procedure code modifier. For possible values see Proc Code Modifiers
Modifier 3	2 character Procedure code modifier. For possible values see Proc Code Modifiers
Procedure Name	up to 36 characters of the procedure name.
Activity Date	Date of last update activity on this record. Format CCYYMMDD
Activity Code	A, C, R show manual updates; S show system update
Age Minimum/Maximum Restriction	Restriction based on recipient age (minimum and maximum age) 00-99=None.
Sex Restriction	Sex restriction for this procedure. Value '1' = Male, Value '2' = Female; 0 = none
PA Indicator	Indicates if a procedure requires prior authorization. Value = 'R' means that a PA is required
Provider Specialty Range	Range of provider specialty or specialties, which are approved for payment of the procedure code. (For example 00-99 = all specialties; for specialties 24-24 limits services to plastic surgeons only) See Provider Specialties for possible values. Note: Space allocated for 7 ranges in record
UVS	Maximum number of units, visits, or services billable on a single line
Surgery Indicator	A code indicating that a procedure is a Ambulatory surgical procedure
Claim Type Restriction	Claim type restriction for procedure code. Used to restrict procedure code to specific claim types. For possible values see Claim Types. Note: Space allocated for 3 types in one record
Pricing Action Code	Dictates method of pricing to the system. For possible values see Pricing Action Codes. Note: Space allocated for 6 code/date combinations in record
Pricing Action Code Effective Date	Effective date of Pricing Action Code. Format CCYYMMDD Note: Space allocated for 6 pricing code/date combinations in record
Auto Error Code	A code used to automatically Pend/Deny a claim for a procedure. See Auto Errors for values that are typically applied. For complete list see list on the LaMedicaid site. Note: Space allocated for 6 error codes in record
Max Charge	The maximum allowable fee which will be paid for a procedure or service. Complete with dollars, decimal point, and cents. Note: Space allocated for 8 charge/date combinations in record
Max Charge Effective Date	Date max charge change becomes effective. Format CCYYMMDD Note: Space allocated for 8 charge/date combinations in record

Service Limits

Effective Year	The year in which this service limit became effective. Format CCYY
Prov Same or Any	A code used to indicate whether a service limitation for a procedure applies to the same or different providers. Values: Y for same provider, N for any provider,
Daily Limit	Number of times a service may be provided per day.
Maximum Number	Maximum number of provided services allowed for the service limit time period.
Maximum Dollars	Maximum dollars payable for the service limit time period.
Year Indicator	The time period, in years, for a service limitation on a procedure
Days Indicator	The time period, in days, for a service limitation on a procedure.
Service Error Code	Error to be applied If the service limit is exceeded. See Service Errors for possible values. For complete list see list on the LaMedicaid site.

Anesthesia

Anesthesia Units	A unit of value which indicates the base units for an anesthesia service. Note: Space allocated for 5 unit/price/date combinations in record
Anesthesia Price	Anesthesia price used in anesthesia payment calculations. Note: Space allocated for 5 unit/price/date combinations in record
Anesthesia Effective Date	Date anesthesia units become effective (Anesthesia codes only). Format CCYYMMDD Note: Space allocated for 5 unit/price/date combinations in record

Appendix U

Hospice Enrollment File Layout

(FI to MCO)

DHH thru its FI provides to the MCO a copy of the Hospice data that is maintained on the FI's file. The file contains data for Hospice recipients that are enrolled with the MCO.

The text file is available to the MCO weekly on Mondays by 12:00 PM CST and can be retrieved from the FI's non-EDI FTP server in the "From" Molina folder. The naming convention is Hospice_File_YYYYMMDD.text.

The Hospice Enrollment File Layout can be found on the following page.

Record Columns	Description	Data Type and length
Cols 1-13:	Recipient Current Medicaid ID number	Character 13 bytes
Cols 14-26:	Recipient Original Medicaid ID number	Character 13 bytes
Cols 27-34:	Hospice Entitlement Date	Numeric 8 bytes, format=YYYYMMDD
Cols 35-42:	Hospice begin date	Numeric 8 bytes, format=YYYYMMDD
Cols 43-50:	Hospice end date	Numeric 8 bytes, format=YYYYMMDD
Cols 51-55:	Recipient primary diagnosis (ICD-9)	Character 5 bytes
Cols 56-60:	Recipient secondary diagnosis (ICD-9)	Character 5 bytes
Cols 61-63:	Hospice closure Code	Character 3 bytes
Cols 64-70:	Hospice provider ID	Character 7 bytes
Cols 71-72:	Hospice type	Character 2 bytes
Cols 73-73:	Hospice period Ind	Character 1 byte
Cols 74-80:	Recipient primary diagnosis (ICD-10)	Character 7 bytes
Cols 81-87:	Recipient secondary diagnosis (ICD-10)	Character 7 bytes
Cols 88-90:	Recipient Plan ID	Character 3 bytes

Appendix V

Hospice Linkage Information File Layout

MCO TO FI

The MCO is not required to submit a weekly Hospice File to the FI at this time.

Appendix W

Receive Date for Historical Encounter Data File Layout

FI to MCO

Cols	Item	Format
1-13	Molina ICN	character 13
14	^	caret delimiter
15-44	Plan ICN	character 30 padded with spaces on right
45	^	caret delimiter
46-53	Received Date	character 8 YYYYMMDD

End of record

Appendix X

Retro Cancellation/Closure File Layout

FI to MCO

On a monthly basis DHH provides to the MCO a a file of linkages that have been cancelled or closed.

The MCO is required to utilize the file accordingly as well as in conjunction with the 834 file (received daily, weekly, and monthly) to assist in identifying these linkages. This file may be retrieved from the FI's non-EDI server.

The file name is PPLANID_YYYYMM.txt (where "P" is the MCO Plan ID).

The Retro Cancellation/Closure File Layout can be found below.

RECIP	PIC X(13).	Recipient ID
FILLER	PIC X(01) VALUE ':'.	
RECIP-LAST	PIC X(06).	1st 6 characters of Last name
FILLER	PIC X(01) VALUE ':'.	
BYU-PLAN	PIC 9(07).	Plan Provider ID
FILLER	PIC X(01) VALUE ':'.	
BYU-BEG	PIC 9(08).	BYU Begin Date
FILLER	PIC X(01) VALUE ':'.	
BYU-END	PIC 9(08).	BYU End Date
FILLER	PIC X(01) VALUE ':'.	
BYU-ADD	PIC 9(08).	BYU Add Date
FILLER	PIC X(01) VALUE ':'.	
BYU-CHG	PIC 9(08).	BYU Change Date
FILLER	PIC X(01) VALUE ':'.	
DIS-ENROLL	PIC X(03).	Dis-enroll reason
FILLER	PIC X(01) VALUE ':'.	
DOB	PIC 9(08).	If Date of Birth > 20120201 this field is populated.
FILLER	PIC X(01) VALUE ':'.	

Appendix Y

Magellan Provider Registry

FI to MCO

DHH's FI makes available to the MCO the Magellan Provider Registry. This file is uploaded to and may be retrieved from the MCO's non-EDI folder on the FI's sFTP site on the first Monday of each month.

The file name is Magellan-Provider-Registry-YYYYMMDD.txt. The Magellan Provider Registry file layout can be found on the following pages.

Header (no header required)

Trailer (no trailer required)

Format fixed width

Detail

No.	Data Item	Siz	Type	Start	End	Format/notes
1	SMO_ID	7	number	1	7	
2	PSEUDO_MEDICAID_PROV_ID	7	number	8	14	
3	PSEUDO_CHK_DIGIT_PROV_ID	7	number	15	21	
4	NPI	10	number	22	31	
5	ENTITY_TYPE	1	varchar	32	32	
6	REPLACEMENT_NPI	20	varchar	33	52	
7	PROVIDER_NAME	40	varchar	53	92	
8	PROVIDER_MAIL_ADDR_1	30	varchar	93	122	
9	PROVIDER_MAIL_ADDR_2	30	varchar	123	152	
10	PROVIDER_MAIL_CITY	30	varchar	153	182	
11	PROVIDER_MAIL_STATE	2	varchar	183	184	
12	PROVIDER_MAIL_ZIP	10	varchar	185	194	
13	PROVIDER_MAIL_COUNTRY	10	varchar	195	204	
14	PROVIDER_MAIL_PHONE	10	varchar	205	214	
15	PROVIDER_MAIL_FAX	10	varchar	215	22	

					4	
16	PROVIDER_BUS_ADDR_1	30	varchar	225	254	
17	PROVIDER_BUS_ADDR_2	30	varchar	255	284	
18	PROVIDER_BUS_CITY	30	varchar	285	314	
19	PROVIDER_BUS_STATE	2	varchar	315	316	
20	PROVIDER_BUS_ZIP	10	varchar	317	326	
21	PROVIDER_BUS_COUNTRY	10	varchar	327	336	
22	PROVIDER_BUS_PHONE	10	varchar	337	346	
23	PROVIDER_BUS_FAX	10	varchar	347	356	
24	TAXONOMY_1	10	varchar	357	366	
25	TAXONOMY_2	10	varchar	367	376	
26	TAXONOMY_3	10	varchar	377	386	
27	OTHER_PROVIDER_ID	7	varchar	387	393	Louisiana Medicaid Provider Id
28	PROVIDER_TYPE	2	number	394	395	
29	PROVIDER_SPECIALTY	2	varchar	396	397	
30	NPPES_ENUM_DATE	8	varchar	398	405	
31	NPPES_LAST_UPDATE_DATE	8	number	406	413	
32	NPPES_DEACT_REASON_CODE	20	number	414	433	
33	NPPES_DEACT_DATE	8	varchar	434	44	

					1	
34	NPPES_REACT_DATE	8	number	442	449	
35	PROVIDER_GENDER_CODE	1	number	450	450	
36	PROVIDER_LICENSE_NO	20	varchar	451	470	
37	PROVIDER_LICENSE_STATE	2	varchar	471	472	
38	OFFICIAL_CONTACT_NAME	50	varchar	473	522	
39	OFFICIAL_CONTACT_TITLE	30	varchar	523	552	
40	OFFICIAL_CONTACT_PHONE	10	varchar	553	562	
41	PANEL_OPEN_IND	1	varchar	563	563	
42	LANGUAGE_IND_1	1	varchar	564	564	
43	LANGUAGE_IND_2	1	varchar	565	565	
44	LANGUAGE_IND_3	1	varchar	566	566	
45	LANGUAGE_IND_4	1	varchar	567	567	
46	LANGUAGE_IND_5	1	varchar	568	568	
47	AGE_RESTRICTION_IND	1	varchar	569	569	
48	PCP_LINKAGE_MAX	5	varchar	570	574	
49	PCP_LINKAGE_SMO	5	number	575	579	
50	PCP_LINKAGE_OTHER	5	number	580	584	
51	SMO_ENROLLMENT_IND	1	number	585	58	

					5	
52	SMO_ENROLLMENT_IND_EFF_DATE	8	varchar	586	593	
53	FAMILY_ONLY_IND	1	number	594	594	
54	PROVIDER_SUB_SPECIALTY_1	2	varchar	595	596	
55	PROVIDER_SUB_SPECIALTY_2	2	varchar	597	598	
56	PROVIDER_SUB_SPECIALTY_3	2	varchar	599	600	
57	SMO_CONTRACT_NAME_NO	30	varchar	601	630	
58	SMO_CONTRACT_BEGIN_DATE	8	varchar	631	638	
59	SMO_CONTRACT_TERM_DATE	8	number	639	646	
60	PROVIDER_PARISH_1	2	number	647	648	
61	PROVIDER_PARISH_2	2	varchar	649	650	
62	PROVIDER_PARISH_3	2	varchar	651	652	
63	PROVIDER_PARISH_4	2	varchar	653	654	
64	PROVIDER_PARISH_5	2	varchar	655	656	
65	PROVIDER_PARISH_6	2	varchar	657	658	
66	PROVIDER_PARISH_7	2	varchar	659	660	
67	PROVIDER_PARISH_8	2	varchar	661	662	
68	PROVIDER_PARISH_9	2	varchar	663	664	
69	PROVIDER_PARISH_10	2	varchar	665	66	

					6	
70	PROVIDER_PARISH_11	2	varchar	667	668	
71	PROVIDER_PARISH_12	2	varchar	669	670	
72	PROVIDER_PARISH_13	2	varchar	671	672	
73	PROVIDER_PARISH_14	2	varchar	673	674	
74	PROVIDER_PARISH_15	2	varchar	675	676	
75	FILLER	4	varchar	677	680	

Appendix Z

Chisholm Electronic File Layout for CSOC Information

Document Date: 11/17/2015
Subject to Change

PART 1: FILE SUBMISSIONS

File is received by Molina from Statistical Research (SRI) on a monthly basis at the beginning of each month to reflect the data for the prior month. The file will be sent to each plan and will contain only the data fields shown below.

Molina File submission naming convention: STOLA_MOLINA_CHISHOLM_YYYYMM.TXT

YYYYMM is the month of the data on the file.
The submission file has a fixed-length record format. Each record is 114 characters in length, and uses the following record layout. The file does not use delimiters and is formatted as an ASCII text file. File will be moved to the "from Molina" folder for your retrieval.

Field NBR	Columns	Field	Format/Length	Notes
1	1-25	Recipient Last Name	Char(25)	Last Name of the Recipient
2	26-50	Recipient First Name	Char(25)	First Name of the Recipient
3	51-60	Primary Diagnosis	Char(10)	Diagnosis for the child reported in ICD-9 format. Left justified. This field will be ICD-10 format effective with the November file.

4	**61-69**	**SSN**	**Char(9)**	**SSN of the Recipient**
5	**70-70**	**Filler**	**Char(1)**	**Space**
6	**71-80**	**Date of Birth**	**Char(10)**	**Date of Birth of the Recipient. In the format of MM/DD/CCYY.**
7	**81-85**	**Filler**	**Char(5)**	**Spaces**
8	**86-98**	**Recipient Medical ID**	**Char(13)**	**Medical Recipient ID as reported from SRI**
9	**99-99**	**Filler**	**Char(1)**	**Space**
10	**100-101**	**Parish**	**Char(2)**	**Parish of recipient**
11	**102-114**	**Original Recipient Medical ID**	**Char(13)**	**Original recipient ID obtained from Molina file**

Appendix AA

LEERS File Layout

FI to MCO

On a weekly basis the FI makes available to the MCO the DHH LEERS File. This file contains specific data related to all of the deliveries for enrollees linked to the MCO. The data is used to validate that each delivery was not prior to 39 weeks, or if prior to 39 weeks, that it was medically necessary.

The MCO is required to retrieve the file from the FI's server in the individual MCO files. The file naming convention is DHH_LEERS_EXPD_CCYYMMDD.TXT. The file layout can be found on the following pages.

MEDICAID CCN Interface

Field Name	Field Size	Field Position	Description	Value
ML_FULL_NAME	30	1-30	Mother's Last Name	Character
FILLER	1	31	FILLER	^
MSSN	9	32-40	Mother's SSN	Numeric; All 8 is None; All 9 is Unknown
FILLER	1	41	FILLER	^
PAY_SPECIFY	16	42-57	Mother's 13-digit Medicaid Recipient ID or 16-digit Medicaid Card Control Number	Numeric; All 9 is unknown
FILLER	1	58	FILLER	^
MDOB	4	59-66	Mother's DOB	YYYYMMDD
FILLER	1	67	FILLER	^
MRCITY	30	68-97	Mother's Resident City	Character
FILLER	1	98	FILLER	^
MRSTATE	2	99-100	Mother's Resident State	Character; State Postal Abbreviation
FILLER	1	101		^
MRZIP	5	102-106	Mother's Resident Zip	Numeric
FILLER	1	107	FILLER	^
IDOB	8	108-115	Child's DOB	YYYYMMDD
FILLER	1	116	FILLER	^
FNPI	10	117-126	Facility NPI Number	Numeric
FILLER	1	127	FILLER	^
HOSPNAME	40	128-167	Facility Name	Character
FILLER	1	168	FILLER	^
Under39	1	169	Under 39 weeks Gestation?	(Y/N)
FILLER	1	170	FILLER	^
NBO_MEDICAL	1	171	Was Delivery Medically indicated?	(Y/N/R); R=Needs Medical Review
FILLER	1	172	FILLER	^

BWGT	4	173-176	Birth Weight of Infant	Numeric; All 9 is unknown
FILLER	1	177	FILLER	^
OWGEST	2	178-179	Gestational age of infant	Numeric; All 9 is unknown
FILLER	1	180	FILLER	^
CIG_BP_DP	1	181	Smoking during preganancy history	(Y/N)
FILLER	1	182	FILLER	^
PRV_PRETERM	1	183	History of preterm birth?	(Y/N)
FILLER	1	184	FILLER	^
PRV_OPPPO	1	185	History of other poor pregnancy outcome?	(Y/N)
FILLER	1	186	FILLER	^
DIAB	1	187	Gestational or other diabetes?	(Y/N)
FILLER	1	188	FILLER	^
HTENSION	1	189	Hypertension (pre-pregnancy or gestational)?	(Y/N)
FILLER	1	190	FILLER	^
39 Week	1	191	39-Week: Spontaneous Active Labor	(Y/N)
FILLER	1	192	FILLER	^
39 Week	1	193	39-Week: Abnormal Fetal Heart Rate or Fetal Distress	(Y/N)
FILLER	1	194	FILLER	^
39 Week	1	195	39-Week: Abruption	(Y/N)
FILLER	1	196	FILLER	^
39 Week	1	197	39-Week: Cardiovascular Disease other than Hypertensive Disorder	(Y/N)
FILLER	1	198	FILLER	^
39 Week	1	199	39-Week: Chronic Pulmonary Disease	(Y/N)
FILLER	1	200	FILLER	^
39 Week	1	201	39-Week: Chorioamnionitis	(Y/N)
FILLER	1	202	FILLER	^
39 Week	1	203	39-Week: Coagulation Defects in Pregnancy	(Y/N)

FILLER	1	204	FILLER	^
39 Week	1	205	39-Week: Fetal malformation or congenital anomaly or disorder	(Y/N)
FILLER	1	206	FILLER	^
39 Week	1	207	39-Week: HIV	(Y/N)
FILLER	1	208	FILLER	^
39 Week	1	209	39-Week: Intrauterine growth restriction	(Y/N)
FILLER	1	210	FILLER	^
39 Week	1	211	39-Week: Isoimmunization	(Y/N)
FILLER	1	212	FILLER	^
39 Week	1	213	39-Week: Maternal renal or liver disease	(Y/N)
FILLER	1	214	FILLER	^
39 Week	1	215	39-Week: Placenta or vasa previa	(Y/N)
FILLER	1	216	FILLER	^
39 Week	1	217	39-Week: Polyhydraminios or Oligohydramnios	(Y/N)
FILLER	1	218	FILLER	^
39 Week	1	219	39-Week: Previously scarred uterus other than low transverse	(Y/N)
FILLER	1	220	FILLER	^
39 Week	1	221	39-Week: Premature rupture of the membranes (PROM)	(Y/N)
FILLER	1	222	FILLER	^
39 Week	1	223	39-Week: Preterm Premature rupture of the membranes (Preterm PROM or PPROM)	(Y/N)
FILLER	1	224	FILLER	^
39 Week	1	225	39-Week: Diabetes - Prepregnancy	(Y/N)
FILLER	1	226	FILLER	^
39 Week	1	227	39-Week: Diabetes - Gestational	(Y/N)
FILLER	1	228	FILLER	^

39 Week	1	229	39-Week: Hypertension - Prepregnancy	(Y/N)
FILLER	1	230	FILLER	^
39 Week	1	231	39-Week: Hypertension - Gestational	(Y/N)
FILLER	1	232	FILLER	^
39 Week	1	233	39-Week: Hypertension - Eclampsia	(Y/N)
FILLER	1	234	FILLER	^
39 Week	1	235	39-Week: Fetal Presentation at Birth - Breech	(Y/N)
FILLER	1	236	FILLER	^
39 Week	1	237	39-Week: Fetal Presentation at Birth - Other (Non-cephalic, does NOT include vertex or cephalic)	(Y/N)
FILLER	1	238	FILLER	^
39 Week	1	239	39-Week: No Reason Listed, Need Medical Review	(Y/N)
FILLER	1	240	FILLER	^
39 Week	1	241	39-Week: No medical reason	(Y/N)
FILLER	1	242	FILLER	^
SF_NO	18	243-260	State File Number (only for registered records)	119YYYYVVV00CCC Y=Year; V=Volume; C=Certificate
FILLER	1	261	FILLER	^
SEX	1	262	Infant's Sex	(M,F,N)
FILLER	1	263	FILLER	^
NICU	1	264	NICU Admission?	(Y,N)
FILLER	1	265	FILLER	^

Appendix AB

Psychiatric Residential Treatment Facility File Layout

FI to MCO

On a weekly basis, DHH's FI to the MCO the Psychiatric Residential Treatment Facility file layout. This file identifies Medicaid members in a PRTF.

The file is placed on the FI's non-EDI FTP server in each MCO's "From FI" folder. The file name is CC-PRTF-NNNNNNN-MMMMMMDD.txt where nnnnnnn is the MCO's Plan ID.

The file layout can be found on the following page.

Item	Columns	Description	Type	Length
1	1-13	Recipient's Medicaid ID	char	13
2	14	delimiter, value is ^	char	1
3	15-22	PRTF begin date	num	8, format=yyyymmdd
4	23	delimiter, value is ^	char	1
5	24-31	PRTF end date	num	8, format=yyyymmdd
6	32	delimiter, value is ^	char	1
7	33-42	PRTF NPI	char	10
8	43	delimiter, value is ^	char	1
9	44-52	Recipient's SSN	char	9
10	53	delimiter, value is ^	char	1
11	54-61	Recipient's DOB	num	8, format=yyyymmdd
12	62	delimiter, value is ^	char	1
13	63-70	PRTF auth date	num	8, format=yyyymmdd
14	71	delimiter, value is ^	char	1
15	72-78	Plan ID	num	7
16	79	delimiter, value is ^	char	1

End of Record

Appendix AC

Third Party Liability (TPL) Batch Full Reconciliation File Layout

FI TO MCO

The Third Party Liability (TPL) Batch Full Reconciliation File is made available by DHH's FI to the MCOs on a monthly basis. MCOs are required to utilize the file to review their TPL information for completeness with what DHH MMIS has on record, and then make necessary corrections.

The file is placed in the MCOs' From_FI folder on the FI's non-EDI FTP server with the following file naming convention: CCNnnnnnnn_TPLFULLYYYYMMYY.txt (where nnnnnnn is your MCO ID and YYYYMMDD is the date of the file).

The TPL Batch Full Reconciliation File layout can be found on the following page.

Field Nbr	***Column(s)***	***Field Identification***	***Format/Length***	***Notes***
1	1-13	Member Medicaid ID (current)	char 13	
2	14-26	Member Medicaid ID (original)	char 13	
3	27-28	Insurance Type Indicator	char 2	PR=Private TPL, MA=Medicare Part A, MB=Medicare Part B, LH=LaHIPP (no longer used).
4	29-34	Insurance Company Number	char 6	Louisiana Medicaid Carrier Code.
5	35-36	Scope of Coverage	char 2	See DED for Scopes of Coverage; Note that value 30=Medicare Part C (Medicare HMO).
6	37-48	Medicare HIC Number	char 12	
7	49-56	Insurance Begin Date	num 6	format=yyyymmdd.
8	57-64	Insurance End Date	num 6	format=yyyymmdd.
9	65-79	Insurance Group Number	char 15	
10	80-92	Insurance Policy Number	char 13	
11	93-112	Insurance Policy Holder Name	char 20	
12	113-121	Insurance Policy Holder SSN	char 9	
13	122-146	Agent Name	char 25	
14	147-156	Agent Phone Number	char 10	
15	157-181	Agent Street	char 25	
16	182-201	Agent City	char 20	
17	202-203	Agent State	char 2	
18	204-212	Agent Zip	char 9.	

END OF RECORD LAYOUT

Appendix AD

Behavioral Health Provider Types, Specialties, and Taxonomy

The following pages contain a complete list of Behavioral Health Provider Types, Specialties, and Taxonomy. The MCO may utilize this list when assigning and/or confirming these data elements.

Service	Provider Description	PT	PS	PSS	Taxonomy	Taxonomy Description
Crisis Stabilization	Respite Care Services Agency/Center Based Respite	AE	8E		385HR2055X	Respite Care Facility, Mental Illness
	Crisis Receiving Center	AF	8E		261QM0801X	Ambulatory Health Care Facilities/Clinic/ Center, Mental Health
Behavioral Health Rehabilitation Services	Mental Health Rehabilitation Agency (Legacy MHR)	77	78		251S00000X	Agencies Community/Behavioral Health
	Mental Health Clinic (Legacy MHC)	74	70	8E	261QM0801X	Ambulatory Health Care Facilities/Clinic/ Center, Mental Health
	Behavioral Health Rehab Provider Agency (opened after 3.1.12)	AG	8E		251S00000X	Agencies Community/Behavioral Health
	Assertive Community Treatment Team (ACT Services)	AA	8E		251S00000X	Agencies Community/Behavioral Health
	Multi-Systemic Therapy Agency (MST Services)	12	5M		251S00000X	Agencies Community/Behavioral Health
Therapeutic Group Home	Therapeutic Group Home	AT	5X		320800000X	Community Based Residential Treatment Facilities, Mental Illness
Addiction Services Outpatient	Substance Abuse and Alcohol Abuse Center (Outpatient)	68	70		261QR0800X	Ambulatory Health Care Facilities/Clinic/ Center, Substance Use Disorder
	Mental Health Clinic (Legacy MHC)	74	70		261QM0801X	Ambulatory Health Care Facilities/Clinic/ Center, Mental Health
	Licensed Addiction Counselor	AJ	8E		101YA0400X	Behavioral Health & Social Service Providers Counselor Addiction Substance Use Disorder
Psychiatric Residential Treatment Facility	Psychiatric Residential Treatment Facility	96	9B		323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
	Psychiatric Residential Treatment Facility Addiction	96	8U		323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility

	Psychiatric Residential Treatment Facility Other Specialization	96	8R		323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
	Psychiatric Residential Treatment Facility Hospital Based	96	8L		323P00000X	Residential Treatment Facilities Psychiatric Residential Treatment Facility
Psychiatric Inpatient	Free Standing Psychiatric Hospital	64	86		283Q00000X	Hospitals/Psychiatric Hospital
	Distinct Part Psychiatric Unit	69	86		273R00000X	Hospital Units/Psychiatric Unit
Outpatient Therapy	Mental Health Rehabilitation Agency (Legacy MHR)	77	78		251S00000X	Agencies Community/Behavioral Health
	Mental Health Clinic (Legacy MHC)	74	70		261QM0801X	Ambulatory Health Care Facilities/Clinic/ Center, Mental Health
	Psychologist - Clinical	31	6A		103TC0700X	Behavioral Health & Social Service Providers/Psychologist, Clinical
	Psychologist - Counseling	31	6B		103TC1900X	Behavioral Health & Social Service Providers/Psychologist, Counseling
	Psychologist - School	31	6C		103TS0200X	Behavioral Health & Social Service Providers/Psychologist, School
	Psychologist - Developmental	31	6D		103TM1800X	Behavioral Health & Social Service Providers/Psychologist, Developmental
	Psychologist - Non-Declared (General)	31	6E		103T00000X	Behavioral Health & Social Service Providers/Psychologist
	Psychologist - Other	31	6F		103T00000X	Behavioral Health & Social Service Providers/Psychologist
	Medical Psychologist	31	6G		103TP0016X	Behavioral Health & Social Service Providers/Psychologist, Prescribing (Medical)
	Behavioral Health Rehab Agency (opened after 3.1.12)	AG	8E		251S00000X	Agencies Community/Behavioral Health
	Substance Abuse and Alcohol Abuse Center (Outpatient)	68	70		261QR0800X	Ambulatory Health Care Facilities/Clinic/ Center, Substance Use Disorder
	Federally Qualified Health Center	72	42	8E	261QF0400X	Ambulatory Health Care Facilities/Clinic/

					Center, Federally Qualified Health Center
	Licensed Clinical Social Worker	73	73	1041C0700X	Behavioral Health & Social Service Providers/ Social Worker, Clinical
	Licensed Professional Counselor	AK	56	101YP2500X	Behavioral Health & Social Service Providers Counselor Professional
	Licensed Marriage and Family Therapist	AH	8E	106H00000X	Behavioral Health & Social Service Providers Marriage & Family Therapist
	Doctor of Osteopathic Medicine	19	26	2084P0800X	Allopathic & Osteopathic Physicians/ Psychiatry
	Doctor of Osteopathic Medicine	19	27	2084N0400X	Allopathic & Osteopathic Physicians/ Psychiatry and Neurology, Neurology
	Psychiatrist	19	26	2084P0800X	Allopathic & Osteopathic Physicians/ Psychiatry
	Advanced Practice Registered Nurse	78	26	364SP0808X	Physician Assistants & Advanced Practice N Psychiatric/Mental Health
	Clinical Nurse Specialist	93	26	364SP0808X	Physician Assistants & Advanced Practice N Psychiatric/Mental Health
	Physician Assistant	94	26	364SP0808X	Physician Assistants & Advanced Practice N Psychiatric/Mental Health
Substance Use Residential	Substance Use Residential Treatment Facility	AZ	8U	324500000X	Residential Treatment Facilities Substance Abuse Rehabilitation Facility

Appendix AE

Magellan Prior Authorization (PA) File Layout

(FI to MCO)

DHH provides to the MCO, thru its FI a Prior Authorization File of all open prior authorizations as received from the Statewide Management Organization (SMO) for Behavioral Health. The FI identifies the enrollees linked to the MCO, creates and loads the file to the MCO's non-EDI folder on the FI's sFTP server from which the MCO is required to retrieve it.

NOTE: The schedule for the file TBD.

The file name is MGLN-PA-nnnnnnn-20151001.txt (where nnnnnnn is the Plan ID and 20151001 is the date the file was created).

The Magellan Prior Authorization File Layout can be found on the following pages.

Field Common Name	Field File Name	Field Description	Notes	Type	Data Length	Columns
Authorization MAT Number	AUTH_MAT_NUM	Magellan authorization number	Closed cases only on post-transition CRs	CHAR	9	1-9
Member Magellan ID	MEMB_MAG_ID	Magellan member identifier	Bypass cases are "999999999"	CHAR	13	10-22
Member Medicaid ID	MEMB_MED_NUM	Medicaid Recipient ID		INT	13	23-35
Member SSN	MEMB_SSN			INT	9	36-44
Member First Name	MEMB_FNAM			CHAR	15	45-59
Member Last Name	MEMB_LNAM			CHAR	25	60-84
Member Middle Initial	MEMB_MNAM			CHAR	1	85-85
Member Date of Birth	MEMB_DOB			DATE	8	86-93
Member Gender	MEMB_GENDER	M/F		CHAR	1	94-94
Facility NPI	FACIL_NPI	10-digit Provider NPI number		INT	10	95-104
Facility Tax ID	FACIL_TAXID	9-digit Tax ID		INT	9	105-113

Facility Name	FACIL_NAME			CHAR	50	114-163
Facility Address 1	FACIL_ADD1			CHAR	50	164-213
Facility Address 2	FACIL_ADD2			CHAR	50	214-263
Facility City	FACIL_CITY			CHAR	25	264-288
Facility State	FACIL_STATE			CHAR	4	289-292
Facility Zip 1	FACIL_ZIP1			INT	5	293-297
Facility Zip 2	FACIL_ZIP2			INT	4	298-301
Facility In/Out Network Status	FACIL_NET	INN/OON		CHAR	3	302-304
Provider NPI	PROVID_NPI	10-digit Provider NPI number		INT	10	305-314
Provider Tax ID	PROVID_TAXID	9-digit Tax ID		INT	9	315-323
Provider Name	PROVID_NAME			CHAR	50	324-373
Provider Address 1	PROVID_ADD1			CHAR	50	374-423
Provider Address 2	PROVID_ADD2			CHAR	50	424-473
Provider City	PROVID_CITY			CHAR	25	474-498
Provider State	PROVID_STATE			CHAR	4	499-502
Provider Zip 1	PROVID_ZIP1			INT	5	503-507

Provider Zip 2	PROVID_ZIP2			INT	4	508-511
Provider In/Out Network Statue	PROVID_NET	INN/OON		CHAR	3	512-514
Primary Diagnosis	PRIMARY_DX	ICD9/10 Code		CHAR	10	515-524
Secondary Diagnosis	SECONDARY_DX	ICD9/10 Code		CHAR	10	525-534
Tertiary Diagnosis	TERTIARY_DX	ICD9/10 Code		CHAR	10	535-544
Diagnosis Type	DIAG_TYPE	Indicates ICD9 or 10		INT	2	545-546
Level of Care	LVL_OF_CARE	Full text of Final Outcome		CHAR	50	547-596
Place of Service	PLS_OF_SVC	Full text of Place of Service		CHAR	50	597-646
Problem Type	PROB_TYPE	Full text of Problem Type		CHAR	50	647-696
Admission Date	ADMIT_DT	Initial Admission Date		DATE	8	697-704
Admission Type	ADMIT_TYPE	Urgent/Emergent/Routine		CHAR	1	705-705
Authorization Start Date	START_DT	Initial Authorization Start Date	Start date of the authorization, not necessarily this particular CR	DATE	8	706-713
Authorization End Date	END_DT	Authorization End Date	Final End date of the authorization, not necessarily this particular CR	DATE	8	714-721
Closing Resolution	CLOSE_RESOL	Full text of Closing Resolution	Closed cases only on post-transition CRs	CHAR	50	722-771

Denial Reason	DENY_REASON	Full text of Denial Reason	Denials only on post-transition CRs	CHAR	50	772-821
Authorization Status	AUTH_STATUS	Authorized/Denied	Denials only on post-transition CRs	CHAR	1	822-822
Units Requested	UNIT_REQ	Units Requested in this CR		INT	3	823-825
Units Approved	UNIT_APPR	Units Approved in this CR		INT	3	826-828
CPT 1 Code	CPT1_CODE	First CPT Code of CR		CHAR	5	829-833
CPT 1 Units	CPT1_UNITS	Units for this CPT code in this CR		INT	3	834-836
CPT 1 Modifier 1	CPT1_MOD1			CHAR	2	837-838
CPT 1 Modifier 2	CPT1_MOD2			CHAR	2	839-840
CPT 2 Code	CPT2_CODE	Second CPT Code of CR		CHAR	5	841-845
CPT 2 Units	CPT2_UNITS	Units for this CPT code in this CR		INT	3	846-848
CPT 2 Modifier 1	CPT2_MOD1			CHAR	2	849-850
CPT 2 Modifier 2	CPT2_MOD2			CHAR	2	851-852
CPT 3 Code	CPT3_CODE	Third CPT Code of CR		CHAR	5	853-857
CPT 3 Units	CPT3_UNITS	Units for this CPT code in this CR		INT	3	858-860

CPT 3 Modifier 1	CPT3_MOD1			CHAR	2	861-862
CPT 3 Modifier 2	CPT3_MOD2			CHAR	2	863-864
CPT 4 Code	CPT4_CODE	Fourth CPT Code of CR		CHAR	5	865-869
CPT 4 Units	CPT4_UNITS	Units for this CPT code in this CR		INT	3	870-872
CPT 4 Modifier 1	CPT4_MOD1			CHAR	2	873-874
CPT 4 Modifier 2	CPT4_MOD2			CHAR	2	875-876

Appendix AF

LEER 17P Preterm Birth History FILE LAYOUT
Document Date: 02/04/2016
Subject to Change

PART 1: ULM FILE SUBMISSIONS

File submissions should occur quarterly. Exact time each quarter is yet to be determined.
File submission will be to the Molina FTP site in the following folder: SAS_WORK\ULM\DATA\HEDIS\Preterm_Birth_Mothers
This file will be archived by Molina and put in the SAS_PROD\Outbound folder where it will be captured for the processing on the mainframe computer by Molina.

ULM File submission naming convention: **Preterm_Birth_History.txt**
The submission file has a fixed-length record format. Each record is 76 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields are optional (O). If a field is optional, then a value of spaces is acceptable. The file does use delimiters (^) and is formatted as an ASCII text file.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-13	Original Recipient ID	num(13)	R	Original Medicaid recipient ID of the mother.
2	14-14	delimiter	char(1)	R	Constant value of “^”.
3	15-27	Current Recipient ID	num(13)	R	Current Medicaid recipient ID of the mother. This could be the same as field 1.
4	28-28	delimiter	char(1)	R	Constant value of “^”
5	29-36	Date of Birth	num(8)	R	The Date of Birth of the infant. In the format of YYYYMMDD.

6	37-37	delimiter	char(1)	R	Constant value of "^".
7	38-39	Infants Gestational Age	num(2)	R	Gestaional age of the child in weeks.
8	40-40	delimiter	char(1)	R	Constant value of "^".
9	41-41	Plurity Number	num(1)	R	Plurity of Birth. 1 = Singleton 2 = Twins 3 = More than 2
10	42-42	delimiter	char(1)	R	Constant value of "^".
11	43-57	State File Number	char(15)	R	Should match to State File number reported on the LEERS data file. Format of: 119YYYYVVV00CCC Y=Year; V=Volume; C=Certificate NOTE: The length of this field on the LEER data file is 18 with 3 spaces at the end of the field. Also for data prior to LEERS the number can be a 4 or 6 digit number.
12	58-58	delimiter	char(1)	R	Constant value of "^".
13	59-59	Abruption Ind	char(1)	O	Abruption occurred during This pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
14	60-60	delimiter	char(1)	R	Constant value of "^".
15	61-61	Hypertension Ind	char(1)	O	Hypertension occurred during this pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.

16	62-62	delimiter	char(1)	R	Constant value of "^".
17	63-68	Birth History Measurement Begin Period	char(6)	R	The starting time frame for the data collection (Measurement Year). In the format of YYYYMM.
18	69-69	delimiter	char(1)	R	Constant value of "^".
19	70-75	Birth History Measurement End Period	char(6)	R	The ending time frame for the data collection (Measurement Year). In the format of YYYYMM.
20	76-76	delimiter	char(1)	R	Constant value of "^".

END OF RECORD LAYOUT

PART 2: Molina Processing and forwarding of file to MCO's

Molina will capture the file sent by ULM. Molina will run the information against the plan enrollment and based on the Birth History Begin and End Period determine which plan, if any , that the mother was enrolled. Plan enrollment for the "B" (Behavioral Health Program) will be ignore for this selection process. Depending on which plan the recipient was enrolled in during the time period all data for that recipient will be forwarded to that MCO.

File submission by Molina will be to the Molina FTP site in the following folder: FTADATA\Data*plan node*\from_molina
plan node will be AETNA; LHC; UHCMCO; LACARE; and AMERIGROUP
The return text file will use the naming convention: **17P_Birth_History.txt**
An e-mail will be sent to each plan when the file has been transmitted.

Below is the format of the return file. The file has a fixed-length record format. Each record is 76 characters in length, and uses the following record layout. This is an exact copy of the file from ULM..

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-13	Original Recipient ID	num(13)	R	Original Medicaid recipient ID of the mother.
2	14-14	delimiter	char(1)	R	Constant value of "^".
3	15-27	Current Recipient ID	num(13)	R	Current Medicaid recipient ID of the mother. This could be the same as field 1.
4	28-28	delimiter	char(1)	R	Constant value of "^"
5	29-36	Date of Birth	num(8)	R	The Date of Birth of the infant. In the format of YYYYMMDD.
6	37-37	delimiter	char(1)	R	Constant value of "^".
7	38-39	Infants Gestational Age	num(2)	R	Gestaional age of the child in weeks.
8	40-40	delimiter	char(1)	R	Constant value of "^".
9	41-41	Plurity Number	num(1)	R	Plurity of Birth.

					1 = Singleton 2 = Twins 3 = More than 2
10	42-42	delimiter	char(1)	R	Constant value of "^".
11	43-57	State File Number	char(15)	R	Should match to State File number reported on the LEERS data file. Format of: 119YYYYVVV00CCC Y=Year; V=Volume; C=Certificate NOTE: The length of this field on the LEER data file is 18 with 3 spaces at the end of the field. Also for data prior to LEERS the number can be a 4 or 6 digit number.
12	58-58	delimiter	char(1)	R	Constant value of "^".
13	59-59	Abruption Ind	char(1)	O	Abruption occurred during This pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
14	60-60	delimiter	char(1)	R	Constant value of "^".
15	61-61	Hypertension Ind	char(1)	O	Hypertension occurred during this pregnancy. At this time this field is for Future Use. Value of Y, N or spaces.
16	62-62	delimiter	char(1)	R	Constant value of "^".
17	63-68	Birth History Measurement Begin Period	char(6)	R	The starting time frame for the data collection (Measurement

					Year). In the format of YYYYMM.
18	69-69	delimiter	char(1)	R	Constant value of “^”.
19	70-75	Birth History Measurement End Period	char(6)	R	The ending time frame for the data collection (Measurement Year). In the format of YYYYMM.
20	76-76	delimiter	char(1)	R	Constant value of “^”.

END OF RECORD LAYOUT

Appendix AG

LEER Elective Deliveries FILE LAYOUT.
Document Date: 03/09/2016
Subject to Change

PART 1: OPH FILE SUBMISSIONS

File submissions should occur nightly on each Thursday.
File submission will be to the DHH FTP site in the following folder: MEDCAD\OUTGOING

OPH/Vital Records File submission naming convention: **LEERS-YYYYMMDD.TXT**
Whereas the YYYYMMDD represents the date of the file
The submission file has a fixed-length record format. Each record is 345 characters in length, and uses the following record layout. As noted, specific fields are required (R) and other fields might be optional (O). If a field is optional, then a value of spaces is acceptable, unless otherwise noted. The file does use delimiters (^) and is formatted as an ASCII text file.
This is the third version of this extract as the original transmission was 189 characters in length, the second was 265 characters in length. Additional data was added to the end of each version of the file.

Field Nbr	*Column(s)*	*Field*	*Format/Length*	*R=Required O=Optional*	*Notes*
1	1-30	Recipient's Last Name	Char(30)	R	Recipient's Last Name
2	31-31	delimiter	char(1)	R	Constant value of "^,"
3	32-40	Recipient's SSN	num(9)	R	SSN. All 8 is None; all 9 is Unknown.
4	41-41	delimiter	char(1)	R	Constant value of "^".
5	42-57	Recipient's Medicaid ID	char(16)	R	Recipient ID number (position 1-13) or CCN (position 1-16). All 9 is Unknown.

6	58-58	delimiter	char(1)	R	Constant value of “^”.
7	59-66	Recipient’s Date of Birth	num(8)	R	The Date of Birth of the mother. In the format of YYYYMMDD.
8	67-67	delimiter	char(1)	R	Constant value of “^”.
9	68-97	Recipient’s Resident City	char(30)	R	City of Residence.
10	98-98	delimiter	char(1)	R	Constant value of “^”.
11	99-100	Recipient’s Resident State	char(2)	R	State of Residence. State Postal Abbreviation.
12	101-101	delimiter	char(1)	R	Constant value of “^”.
13	102-106	Recipient’s Resident Zip	num(5)	R	Zip Code of Resdence.
14	107-107	delimiter	char(1)	R	Constant value of “^”.
15	108-115	Child’s Date of Birth	num(8)	R	The Date of Birth of the child. In the format of YYYYMMDD.
16	116-116	delimiter	char(1)	R	Constant value of “^”.
17	117-126	Facility NPI number	num(10)	R	National Provider Identificaiton Number for the Facility.
18	127-127	delimiter	char(1)	R	Constant value of “^”.
19	128-167	Facility Name	char(40)	R	Name of the Facility.
20	168-168	delimiter	char(1)	R	Constant value of “^”.
21	169-169	39-Week Gestation	char(1)	R	Was the Gestation under 39 weeks. Y-Yes; N-No.
22	170-170	delimiter	char(1)	R	Constant value of “^”.
23	171-171	Deliver Medically Indicated	char(1)	R	Was the Delivery medicated indicated. Y-Yes; N-No; R-Needs Medical Review.
24	172-172	delimiter	char(1)	R	Constant value of “^”.
25	173-176	Birth Weight	num(4)	R	Weight of Infant at Birth.

					All 9 is Unknown.
26	177-177	delimiter	char(1)	R	Constant value of “^”.
27	178-179	Gestational age	num(2)	R	Gestational Age of Infant at birth.
					All 9 is Unknown.
28	180-180	delimiter	char(1)	R	Constant value of “^”.
29	181-181	Smoking indicator	char(1)	R	Indicates if mother was smoking during pregnancy history. Y-Yes; N-No.
30	182-182	delimiter	char(1)	R	Constant value of “^”.
31	183-183	Preterm Birth	char(1)	R	History of Preterm Birth. Y-Yes; N-No.
32	184-184	delimiter	char(1)	R	Constant value of “^”.
33	185-185	Poor Pregnancy Outcome	char(1)	R	History of other Poor Pregnancy Outcome. Y-Yes; N-No.
34	186-186	delimiter	char(1)	R	Constant value of “^”.
35	187-187	Diabetes	char(1)	R	Gestational or other Diabetes. Y-Yes; N-No.
36	188-188	delimiter	char(1)	R	Constant value of “^”.
37	189-189	Hypertension	char(1)	R	Gestational or Pre-Pregnancy Hypertension. Y-Yes; N-No.
38	190-190	delimiter	char(1)	R	Constant value of “^”.
39	191-191	39 Week: Labor	char(1)	R	Spontaneous Active Labor. Y-Yes; N-No.
40	192-192	delimiter	char(1)	R	Constant value of “^”.
41	193-193	39 Week: Fetal Heart Rate/Distress	char(1)	R	Abnormal Fetal Heart Rate or

					Distress.
					Y-Yes; N-No.
42	194-194	delimiter	char(1)	R	Constant value of “^”.
43	195-195	39 Week: Abruption	char(1)	R	Abruption.
					Y-Yes; N-No.
44	196-196	delimiter	char(1)	R	Constant value of “^”.
45	197-197	39 Week: Cardiovascular Disease	char(1)	R	Cardiovascular Disease other than
					Hypertenseive Disorder.
					Y-Yes; N-No.
46	198-198	delimiter	char(1)	R	Constant value of “^”.
47	199-199	39 Week: Pulmonary Disease	char(1)	R	Chronic Pulmonary Disease.
					Y-Yes; N-No.
48	200-200	delimiter	char(1)	R	Constant value of “^”.
49	201-201	39 Week: Chorioamnionitis	char(1)	R	Chorioamnionitis.
					Y-Yes; N-No.
50	202-202	delimiter	char(1)	R	Constant value of “^”.
51	203-203	39 Week: Coagulation	char(1)	R	Coagulation Defects in Pregnancy.
					Y-Yes; N-No.
52	204-204	delimiter	char(1)	R	Constant value of “^”.
53	205-205	39 Week: Malformation	char(1)	R	Fetal Malformation or Congenital
					anomaly or disorder.
					Y-Yes; N-No.
54	206-206	delimiter	char(1)	R	Constant value of “^”.
55	207-207	39 Week: HIV	char(1)	R	HIV.
					Y-Yes; N-No.
56	208-208	delimiter	char(1)	R	Constant value of “^”.
57	209-209	39 Week: Growth Restriction	char(1)	R	Intrauterine Growth Restriction.
					Y-Yes; N-No.
58	210-210	delimiter	char(1)	R	Constant value of “^”.
59	211-211	39 Week: Isoimmunization	char(1)	R	Isoimmunization.

					Y-Yes; N-No.
60	212-212	delimiter	char(1)	R	Constant value of “^”.
61	213-213	39 Week: Renal or Liver Disease	char(1)	R	Maternal Renal or Liver Disease.
					Y-Yes; N-No.
62	214-214	delimiter	char(1)	R	Constant value of “^”.
63	215-215	39 Week: Placenta	char(1)	R	Placenta or vasa previa.
					Y-Yes; N-No.
64	216-216	delimiter	char(1)	R	Constant value of “^”.
65	217-217	39 Week: Polyhydraminios	char(1)	R	Polyhydraminios or Oligohydramnios.
					Y-Yes; N-No.
66	218-218	delimiter	char(1)	R	Constant value of “^”.
67	219-219	39 Week: Previously Scarred	char(1)	R	Previously scarred Uterus other than
					Low transverse.
					Y-Yes; N-No.
68	220-220	delimiter	char(1)	R	Constant value of “^”.
69	221-221	39 Week: PROM	char(1)	R	Premature rupture of the membranes
					(PROM).
					Y-Yes; N-No.
70	222-222	delimiter	char(1)	R	Constant value of “^”.
71	223-223	39 Week: Preterm PROM	char(1)	R	Preterm Premature rupture of the
					Membranes (PPROM).
					Y-Yes; N-No.
72	224-224	delimiter	char(1)	R	Constant value of “^”.
73	225-225	39 Week: Diabetes -Prepregnancy	char(1)	R	Diabetes – Prepregnancy.
					Y-Yes; N-No.
74	226-226	delimiter	char(1)	R	Constant value of “^”.
75	227-227	39 Week: Diabetes-Gestational	char(1)	R	Diabetes - Gestational.
					Y-Yes; N-No.
76	228-228	delimiter	char(1)	R	Constant value of “^”.

77	229-229	39 Week: Hypertension-Prepregnancy	char(1)	R	Hypertension – PrePregnancy. Y-Yes; N-No.
78	230-230	delimiter	char(1)	R	Constant value of "^".
79	231-231	39 Week: Hypertension-Gestational	char(1)	R	Hypertension - Gestational. Y-Yes; N-No.
80	232-232	delimiter	char(1)	R	Constant value of "^".
81	233-233	39 Week: Hypertension-Eclampsia	char(1)	R	Hypertension - Eclampsia. Y-Yes; N-No.
82	234-234	delimiter	char(1)	R	Constant value of "^".
83	235-235	39 Week: Fetal Presentation - Breech	char(1)	R	Fetal Presentation at Birth – Breech. Y-Yes; N-No.
84	236-236	delimiter	char(1)	R	Constant value of "^".
85	237-237	39 Week: Fetal Presentation - Other	char(1)	R	Fetal Presentation at Birth – Other (Non-cephalic, does Not include vertex or cephalic). Y-Yes; N-No.
86	238-238	delimiter	char(1)	R	Constant value of "^".
87	239-239	39 Week: Need Medical Review	char(1)	R	No reason given; Need Medical Review. Y-Yes; N-No.
88	240-240	delimiter	char(1)	R	Constant value of "^".
89	241-241	39 Week: No Medical Reason	char(1)	R	No Medical Reason. Y-Yes; N-No.
90	242-242	delimiter	char(1)	R	Constant value of "^".
91	243-260	State File Number	char(18)	R	Unique number assigned by Vital Records when birth record is registered. Format of 119YYYYVVV00CCC

					Y=Year; V=Volume; C-
Certificate					
92	261-261	delimiter	char(1)	R	Constant value of "^".
93	262-262	Infant Sex	char(1)	R	Infant's Sex.
					M-Male; F-Female; N-Not
Yet					
					Determined.
94	263-263	delimiter	char(1)	R	Constant value of "^".
95	264-264	NICU Admission	char(1)	R	Was this NICU admission.
					Y-Yes; N-No.
96	265-265	delimiter	char(1)	R	Constant value of "^".
97	266-266	Augmentation of Labor	char(1)	R	Was Augmention used in
delivery.					
					Y-Yes; N-No.
98	267-267	delimiter	char(1)	R	Constant value of "^".
99	268-268	Induction of Labor	char(1)	R	Was Induction used in
delivery.					
					Y-Yes; N-No.
100	269-269	delimiter	char(1)	R	Constant value of "^".
101	270-270	Final Route - Cesarean	char(1)	R	Was Method of Delivery
Cesarean.					
					Y-Yes; N-No.
102	271-271	delimiter	char(1)	R	Constant value of "^".
103	272-272	Final Route – Vaginal/Forceps	char(1)	R	Was Forceps used for
Delivery.					
					Y-Yes; N-No.
104	273-273	delimiter	char(1)	R	Constant value of "^".
105	274-274	Final Route – Vaginal/Spontaneous	char(1)	R	Was Delivery Spontaneous.
					Y-Yes; N-No.
106	275-275	delimiter	char(1)	R	Constant value of "^".
107	276-276	Final Route – Vaginal/Vacuum	char(1)	R	Was Vacuum used for
Delivery.					
					Y-Yes; N-No.

108	277-277	delimiter	char(1)	R	Constant value of “^”.
109	278-307	Method of Delivery - Other	char(30)	R	Specify the Method of Delivery. Free Form Text.
110	308-308	delimiter	char(1)	R	Constant value of “^”.
111	309-309	Cephalic Presentation (Vertex)	char(1)	R	Was this Cephalic Presentation at Birth. Y-Yes; N-No.
112	310-310	delimiter	char(1)	R	Constant value of “^”.
113	311-311	Breech Presentation	char(1)	R	Was this Breech Presentation at Birth. Y-Yes; N-No.
114	312-312	delimiter	char(1)	R	Constant value of “^”.
115	313-313	Other Presentation	char(1)	R	Was Method of Presentation via Other methods. Y-Yes; N-No.
116	314-314	delimiter	char(1)	R	Constant value of “^”.
117	315-316	Plurality	num(2)	R	Number of births from this Pregnancy. Numeric (00–99) with 99 being Unknown.
118	317-317	delimiter	char(1)	R	Constant value of “^”.
119	318-319	Previous Live Birth – Living (Parity)	num(2)	R	Number of previous Live Births that are now Living (Not including this child). Numeric (00–99) with 99 being Unknown.
120	320-320	delimiter	char(1)	R	Constant value of “^”.

121	321-322	Previous Live Birth – Now Dead (Parity)	num(2)	R	Number of previous Live Births that are now Dead (Not including this child). Numeric (00–99) with 99 being Unknown.
122	323-323	delimiter	char(1)	R	Constant value of “^”.
123	324-325	Previous Other Pregnancy Outcomes (Parity)	num(2)	R	Number of previous Other Pregnancy Outcomes. Numeric (00–99) with 99 being Unknown.
124	326-326	delimiter	char(1)	R	Constant value of “^”.
125	327-327	Previous C-Section	char(1)	R	Did mother have previous C-Section. Y-Yes; N-No.
126	328-328	delimiter	char(1)	R	Constant value of “^”.
127	329-330	Number of Previous C-Section	num(2)	R	Number of Previous C-Sections. Numeric (00–99) with 99 being Unknown.
128	331-331	delimiter	char(1)	R	Constant value of “^”.
129	332-332	Eclampsia	char(1)	R	Was there Eclampsia. Y-Yes; N-No.
130	333-333	delimiter	char(1)	R	Constant value of “^”.
131	334-334	Pre-Pregnancy Hypertension	char(1)	R	Was there Pre-Pregnancy Hypertension. Y-Yes; N-No.
132	335-335	delimiter	char(1)	R	Constant value of “^”.
133	336-336	Gestational Hypertension	char(1)	R	Was there Gestational

Hypertension.					
					Y-Yes; N-No.
134	337-337	delimiter	char(1)	R	Constant value of “^”.
135	338-338	Pre-Pregnancy Diabetes	char(1)	R	Was there Pre-Pregnancy
Diabetes.					
					Y-Yes; N-No.
136	339-339	delimiter	char(1)	R	Constant value of “^”.
137	340-340	Gestational Diabetes	char(1)	R	Was there Gestational
Diabetes.					
					Y-Yes; N-No.
138	341-341	delimiter	char(1)	R	Constant value of “^”.
139	342-342	Premature Rupture of Membranes	char(1)	R	Was there Premature
rupture of					
					membranes during onset of
labor.					
					Y-Yes; N-No.
140	343-343	delimiter	char(1)	R	Constant value of “^”.
141	344-344	Steriods Used for Fetal Lung	char(1)	R	Was Steroid
(Glucocorticoids) used					
					for Fetal Lung Maturation
prior to					
					Delivery.
					Y-Yes; N-No.
142	345-345	delimiter	char(1)	R	Constant value of “^”.

END OF RECORD LAYOUT

PART 2: Molina Processing and forwarding of file to MCO's

Molina will capture the file sent by OPH. Molina will process the file to capture the Original Recipient ID as that should be the uniform key for every recipient. Molina will also run the information against the plan enrollment and based the Date of Birth of the child determine which plan, if any, for which the mother was enrolled. This will be used to separate the data that is to be sent to the five MCO's. Only information that shows enrollment in the plan is sent to each plan. With this version of the layout all births for the mother will be sent for each recipient, so in the case of twins born on the same day both records will be sent. Or if there are multiple births in the data extract period then both records will be sent to the plan if the recipient is enrolled with that plan at the time of each birth.

File submission by Molina will be to the Molina FTP site in the following folder: FTADATA\Data*plan node*\from_molina
plan node will be AETNA; LHC; UHCMCO; LACARE; and AMERIGROUP
The return text file will use the naming convention: **DHH_LEERS_EXPD_VER3_yyyymmdd.TXT**

Below is the format of the return file. The file has a fixed-length record format. Each record is 345 characters in length, and uses the following record layout. This is an exact copy of the file from **OPH/Vital Records**.

Field Nbr	***Column(s)***	***Field***	***Format/Length***	***R=Required O=Optional***	***Notes***
1	1-30	Recipient's Last Name	Char(30)	R	Recipient's Last Name
2	31-31	delimiter	char(1)	R	Constant value of "^,"
3	32-40	Recipient's SSN	num(9)	R	SSN. All 8 is None; all 9 is Unknown.
4	41-41	delimiter	char(1)	R	Constant value of "^".
5	42-57	Recipient's Medicaid ID	char(16)	R	Recipient ID number (position 1-13) or CCN (position 1-16). All 9 is Unknown.
6	58-58	delimiter	char(1)	R	Constant value of "^".
7	59-66	Recipient's Date of Birth	num(8)	R	The Date of Birth of the mother. In the format of YYYYMMDD.
8	67-67	delimiter	char(1)	R	Constant value of "^".

9	68-97	Recipient's Resident City	char(30)	R	City of Residence.
10	98-98	delimiter	char(1)	R	Constant value of "^".
11	99-100	Recipient's Resident State	char(2)	R	State of Residence. State Postal Abbreviation.
12	101-101	delimiter	char(1)	R	Constant value of "^".
13	102-106	Recipient's Resident Zip	num(5)	R	Zip Code of Resdence.
14	107-107	delimiter	char(1)	R	Constant value of "^".
15	108-115	Child's Date of Birth	num(8)	R	The Date of Birth of the child. In the format of YYYYMMDD.
16	116-116	delimiter	char(1)	R	Constant value of "^".
17	117-126	Facility NPI number	num(10)	R	National Provider Identificaiton Number for the Facility.
18	127-127	delimiter	char(1)	R	Constant value of "^".
19	128-167	Facility Name	char(40)	R	Name of the Facility.
20	168-168	delimiter	char(1)	R	Constant value of "^".
21	169-169	39-Week Gestation	char(1)	R	Was the Gestation under 39 weeks. Y-Yes; N-No.
22	170-170	delimiter	char(1)	R	Constant value of "^".
23	171-171	Deliver Medically Indicated	char(1)	R	Was the Delivery medicated indicated. Y-Yes; N-No; R-Needs Medical Review.
24	172-172	delimiter	char(1)	R	Constant value of "^".
25	173-176	Birth Weight	num(4)	R	Weight of Infant at Birth. All 9 is Unknown.
26	177-177	delimiter	char(1)	R	Constant value of "^".
27	178-179	Gestational age	num(2)	R	Gestational Age of Infant at birth. All 9 is Unknown.

28	180-180	delimiter	char(1)	R	Constant value of “^”.
29	181-181	Smoking indicator	char(1)	R	Indicates if mother was smoking during pregnancy history. Y-Yes; N-No.
30	182-182	delimiter	char(1)	R	Constant value of “^”.
31	183-183	Preterm Birth	char(1)	R	History of Preterm Birth. Y-Yes; N-No.
32	184-184	delimiter	char(1)	R	Constant value of “^”.
33	185-185	Poor Pregnancy Outcome	char(1)	R	History of other Poor Pregnancy Outcome. Y-Yes; N-No.
34	186-186	delimiter	char(1)	R	Constant value of “^”.
35	187-187	Diabetes	char(1)	R	Gestational or other Diabetes. Y-Yes; N-No.
36	188-188	delimiter	char(1)	R	Constant value of “^”.
37	189-189	Hypertension	char(1)	R	Gestational or Pre-Pregnancy Hypertension. Y-Yes; N-No.
38	190-190	delimiter	char(1)	R	Constant value of “^”.
39	191-191	39 Week: Labor	char(1)	R	Spontaneous Active Labor. Y-Yes; N-No.
40	192-192	delimiter	char(1)	R	Constant value of “^”.
41	193-193	39 Week: Fetal Heart Rate/Distress	char(1)	R	Abnormal Fetal Heart Rate or Distress. Y-Yes; N-No.
42	194-194	delimiter	char(1)	R	Constant value of “^”.
43	195-195	39 Week: Abruption	char(1)	R	Abruption. Y-Yes; N-No.

44	196-196	delimiter	char(1)	R	Constant value of "^".
45	197-197	39 Week: Cardiovascular Disease	char(1)	R	Cardiovascular Disease other than Hypertenseive Disorder. Y-Yes; N-No.
46	198-198	delimiter	char(1)	R	Constant value of "^".
47	199-199	39 Week: Pulmonary Disease	char(1)	R	Chronic Pulmonary Disease. Y-Yes; N-No.
48	200-200	delimiter	char(1)	R	Constant value of "^".
49	201-201	39 Week: Chorioamnionitis	char(1)	R	Chorioamnionitis. Y-Yes; N-No.
50	202-202	delimiter	char(1)	R	Constant value of "^".
51	203-203	39 Week: Coagulation	char(1)	R	Coagulation Defects in Pregnancy. Y-Yes; N-No.
52	204-204	delimiter	char(1)	R	Constant value of "^".
53	205-205	39 Week: Malformation	char(1)	R	Fetal Malformation or Congenital anomaly or disorder. Y-Yes; N-No.
54	206-206	delimiter	char(1)	R	Constant value of "^".
55	207-207	39 Week: HIV	char(1)	R	HIV. Y-Yes; N-No.
56	208-208	delimiter	char(1)	R	Constant value of "^".
57	209-209	39 Week: Growth Restriction	char(1)	R	Intrauterine Growth Restriction. Y-Yes; N-No.
58	210-210	delimiter	char(1)	R	Constant value of "^".
59	211-211	39 Week: Isoimmunization	char(1)	R	Isoimmunization. Y-Yes; N-No.
60	212-212	delimiter	char(1)	R	Constant value of "^".
61	213-213	39 Week: Renal or Liver Disease	char(1)	R	Maternal Renal or Liver Disease. Y-Yes; N-No.

62	214-214	delimiter	char(1)	R	Constant value of “^”.
63	215-215	39 Week: Placenta	char(1)	R	Placenta or vasa previa. Y-Yes; N-No.
64	216-216	delimiter	char(1)	R	Constant value of “^”.
65	217-217	39 Week: Polyhydraminios	char(1)	R	Polyhydraminios or Oligohydramnios. Y-Yes; N-No.
66	218-218	delimiter	char(1)	R	Constant value of “^”.
67	219-219	39 Week: Previously Scarred	char(1)	R	Previously scarred Uterus other than Low transverse. Y-Yes; N-No.
68	220-220	delimiter	char(1)	R	Constant value of “^”.
69	221-221	39 Week: PROM	char(1)	R	Premature rupture of the membranes (PROM). Y-Yes; N-No.
70	222-222	delimiter	char(1)	R	Constant value of “^”.
71	223-223	39 Week: Preterm PROM	char(1)	R	Preterm Premature rupture of the Membranes (PPROM). Y-Yes; N-No.
72	224-224	delimiter	char(1)	R	Constant value of “^”.
73	225-225	39 Week: Diabetes -Prepregnancy	char(1)	R	Diabetes – Prepregnancy. Y-Yes; N-No.
74	226-226	delimiter	char(1)	R	Constant value of “^”.
75	227-227	39 Week: Diabetes-Gestational	char(1)	R	Diabetes - Gestational. Y-Yes; N-No.
76	228-228	delimiter	char(1)	R	Constant value of “^”.
77	229-229	39 Week: Hypertension-Prepregnancy	char(1)	R	Hypertension – PrePregnancy. Y-Yes; N-No.
78	230-230	delimiter	char(1)	R	Constant value of “^”.
79	231-231	39 Week: Hypertension-Gestational	char(1)	R	Hypertension - Gestational.

					Y-Yes; N-No.
80	232-232	delimiter	char(1)	R	Constant value of “^”.
81	233-233	39 Week: Hypertension-Eclampsia	char(1)	R	Hypertension - Eclampsia. Y-Yes; N-No.
82	234-234	delimiter	char(1)	R	Constant value of “^”.
83	235-235	39 Week: Fetal Presentation - Breech	char(1)	R	Fetal Presentation at Birth – Breech. Y-Yes; N-No.
84	236-236	delimiter	char(1)	R	Constant value of “^”.
85	237-237	39 Week: Fetal Presentation - Other	char(1)	R	Fetal Presentation at Birth – Other (Non-cephalic, does Not include vertex or cephalic). Y-Yes; N-No.
86	238-238	delimiter	char(1)	R	Constant value of “^”.
87	239-239	39 Week: Need Medical Review	char(1)	R	No reason given; Need Medical Review. Y-Yes; N-No.
88	240-240	delimiter	char(1)	R	Constant value of “^”.
89	241-241	39 Week: No Medical Reason	char(1)	R	No Medical Reason. Y-Yes; N-No.
90	242-242	delimiter	char(1)	R	Constant value of “^”.
91	243-260	State File Number	char(18)	R	Unique number assigned by Vital Records when birth record is registered. Format of 119YYYYVVV00CCC Y=Year; V=Volume; C-Certificate
92	261-261	delimiter	char(1)	R	Constant value of “^”.
93	262-262	Infant Sex	char(1)	R	Infant’s Sex. M-Male; F-Female; N-Not

Yet					
					Determined.
94	263-263	delimiter	char(1)	R	Constant value of “^”.
95	264-264	NICU Admission	char(1)	R	Was this NICU admission.
					Y-Yes; N-No.
96	265-265	delimiter	char(1)	R	Constant value of “^”.
97	266-266	Augmentation of Labor	char(1)	R	Was Augmention used in
delivery.					
					Y-Yes; N-No.
98	267-267	delimiter	char(1)	R	Constant value of “^”.
99	268-268	Induction of Labor	char(1)	R	Was Induction used in
delivery.					
					Y-Yes; N-No.
100	269-269	delimiter	char(1)	R	Constant value of “^”.
101	270-270	Final Route - Cesarean	char(1)	R	Was Method of Delivery
Cesarean.					
					Y-Yes; N-No.
102	271-271	delimiter	char(1)	R	Constant value of “^”.
103	272-272	Final Route – Vaginal/Forceps	char(1)	R	Was Forceps used for
Delivery.					
					Y-Yes; N-No.
104	273-273	delimiter	char(1)	R	Constant value of “^”.
105	274-274	Final Route – Vaginal/Spontaneous	char(1)	R	Was Delivery Spontaneous.
					Y-Yes; N-No.
106	275-275	delimiter	char(1)	R	Constant value of “^”.
107	276-276	Final Route – Vaginal/Vacuum	char(1)	R	Was Vacuum used for
Delivery.					
					Y-Yes; N-No.
108	277-277	delimiter	char(1)	R	Constant value of “^”.
109	278-307	Method of Delivery - Other	char(30)	R	Specify the Method of
Delivery.					
					Free Form Text.
110	308-308	delimiter	char(1)	R	Constant value of “^”.

111	309-309	Cephalic Presentation (Vertex)	char(1)	R	Was this Cephalic Presentation at Birth. Y-Yes; N-No.
112	310-310	delimiter	char(1)	R	Constant value of "^".
113	311-311	Breech Presentation	char(1)	R	Was this Breech Presentation at Birth. Y-Yes; N-No.
114	312-312	delimiter	char(1)	R	Constant value of "^".
115	313-313	Other Presentation	char(1)	R	Was Method of Presentation via Other methods. Y-Yes; N-No.
116	314-314	delimiter	char(1)	R	Constant value of "^".
117	315-316	Plurality	num(2)	R	Number of births from this Pregnancy. Numeric (00–99) with 99 being Unknown.
118	317-317	delimiter	char(1)	R	Constant value of "^".
119	318-319	Previous Live Birth – Living (Parity)	num(2)	R	Number of previous Live Births that are now Living (Not including this child). Numeric (00–99) with 99 being Unknown.
120	320-320	delimiter	char(1)	R	Constant value of "^".
121	321-322	Previous Live Birth – Now Dead (Parity)	num(2)	R	Number of previous Live Births that are now Dead (Not including this child). Numeric (00–99) with 99

being

Unknown.

122 323-323 delimiter char(1) R Constant value of “^”.
123 324-325 Previous Other Pregnancy Outcomes (Parity) num(2) R Number of previous Other Pregnancy

Outcomes.
Numeric (00–99) with 99 being

Unknown.
124 326-326 delimiter char(1) R Constant value of “^”.
125 327-327 Previous C-Section char(1) R Did mother have previous C-Section.

Y-Yes; N-No.
126 328-328 delimiter char(1) R Constant value of “^”.
127 329-330 Number of Previous C-Section num(2) R Number of Previous C-Sections.

Numeric (00–99) with 99 being

Unknown.
128 331-331 delimiter char(1) R Constant value of “^”.
129 332-332 Eclampsia char(1) R Was there Eclampsia.
Y-Yes; N-No.
130 333-333 delimiter char(1) R Constant value of “^”.
131 334-334 Pre-Pregnancy Hypertension char(1) R Was there Pre-Pregnancy Hypertension.

Y-Yes; N-No.
132 335-335 delimiter char(1) R Constant value of “^”.
133 336-336 Gestational Hypertension char(1) R Was there Gestational Hypertension.

Y-Yes; N-No.
134 337-337 delimiter char(1) R Constant value of “^”.
135 338-338 Pre-Pregnancy Diabetes char(1) R Was there Pre-Pregnancy Diabetes.

					Y-Yes; N-No.
136	339-339	delimiter	char(1)	R	Constant value of “^”.
137	340-340	Gestational Diabetes	char(1)	R	Was there Gestational Diabetes.
					Y-Yes; N-No.
138	341-341	delimiter	char(1)	R	Constant value of “^”.
139	342-342	Premature Rupture of Membranes	char(1)	R	Was there Premature rupture of membranes during onset of labor.
					Y-Yes; N-No.
140	343-343	delimiter	char(1)	R	Constant value of “^”.
141	344-344	Steriods Used for Fetal Lung	char(1)	R	Was Steroid (Glucocorticoids) used for Fetal Lung Maturation prior to Delivery.
					Y-Yes; N-No.
142	345-345	delimiter	char(1)	R	Constant value of “^”.

END OF RECORD LAYOUT

END OF DOCUMENT