

BAYOU HEALTH Shared Plan

Systems Companion Guide

April 2012

Version 3.0

##### BAYOU HEALTH-S Systems Companion Guide

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

Change Control Table

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Author of Change | Sections Changed | Descriptions | Reason | **Date** |
| Darlene White | 2 | Category II CPT Codes | Removal of language | **7/20/2011** |
| Darlene White | Appendix D | Claim Detail | Included PA | **7/27/2011** |
| Darlene White | 1 | Twenty-four (24) Month Claims History | Further clarification added | **7/27/2011** |
| Darlene White | 1 | Batch Submissions | Further clarification added | **7/27/2011** |
| Darlene White | 2 | Transaction Type | Update of Provider and Specialty Type Codes | **7/27/2011** |
| Darlene White | Appendix D | Claims Processing Flowchart | Added to provide further clarification | **7/27/2011** |
| Darlene White | Appendix E | Provider Directory/Network Provider and Subcontractor Registry | Updated Specialty Codes | **7/27/2011** |
| Darlene White | Appendix D  Appendix H  Appendix I | Claims File layout changes and other file layouts (820, PA/Precert, Provider, Diagnosis, CLIA) | Updated claim file layout and added new files layouts to Appendix D.  Added Appendix H (common data elements) and Appendix I (LMMIS Claims Processing Edits) | **9/1/2011 – 9/19/2011** |
| Darlene White | Appendix D | Updated Provider Negotiated Rates File layout  **Added Appendix J – CCN TPL Discovery Web page screens** | Due to an error  **Updates as requested by CCN-S organizations at Q&A meeting** | **9/26/2011** |
| Darlene White | Section 1  Section 2  Section 4  Appendix D  Appendix E  Appendix H  **Appendix K** | Section 1, information on BATCH SUBMISSIONS  Section 2, information on ICN and Claims Adjustments Information  Section 4, Updated Files Table to clarify 834 data  Appendix D: updated Claim Detail file (added claim payment date); updated Prior Authorizations History File (added PA Line Amount Used); updated Provider File (added urban-rural indicator) updated 820 File format to include REF to store procedure code  Appendix E: Included Sample Provider Registry Edit Report  Appendix H: added GSA to Region crosswalk  **Appendix K: added Scopes of Coverage** | Claims submission and adjustments information  Extract File layouts | **10/10/2011 to 10/12/2011** |
| Darlene White | Appendix K | Administrative Fee Payments Crosswalk and Aid Category and Type Cases definitions |  | **10/28/2011** |
| Darlene White | Appendix D  Appendix E  **Appendix I** | Updated 820 File layout to correct RMR segment issue.  Updated Provider Registry Edit Report with additional edit code values  **Updated Edit codes dispositions** |  | **11/29/2011** |
| Darlene White | Appendix E | Changed Provider Registry File format: Provider Name (record position 45-74) is now a structured format. |  | **12/6/2011** |
| Darlene White | Appendix I | Updated Edit codes dispositions. The dispositions for the following edit codes were changed as shown:  010-off,  187-off,  730-off,  784-off,  915-off,  916-off. |  | **12/7/2011** |
| Darlene White | Appendix I | Updated Edit code disposition for 664: Set to E (EOB). |  | **12/14/2011** |
| Darlene White | Appendix D | Updated Claim Detail record layout.  Updated Provider List record layout. | Added diagnosis code 2 and place of service to end of claims detail layout.  Added pay-to address and TIN information to end of Provider List record layout. | **01/06/2012 – 02/13/2012** |
| Darlene White | * + - 1. Section 1 Overview       2. Section 4 Files and Reports   Appendix D  **Appendix I**  **Appendix K** | Section 1: Added note in Batch Submissions paragraph,  **Section 4: Updated frequency of Network Provider and Subcontractor Registry to semi-weekly**  Appendix D: Updated Claim Detail record layout (CCN-O-010, CCN-W-010).  **Appendix D: Updated 820 layout and added description of 820 adjustments process.**  **Appendix D: Updated Provider Registry Edit Report (edit codes definitions) and added Provider Registry edit File layout**  **Appendix D: Added entire section on Provider Registry Site File.**  **Appendix I: turned edits status to O (off) on edit 078.**  **Appendix K: Updated Recipient Type Case values table to add new codes 200 – 205.** | Added note in Batch Submissions paragraph about dedicated dial-up lines for shared plans and BBS (claims submission to Molina). Also added a note about how plans may distribute claim types into submission files.  Added new fields: Rx date, Rx days supply, Rx quantity, prescribing provider NPI and claim/encounter indicator to Claim Detail Record.  **On 820 format, changed definition of 2100B NM108, NM109 and RMR02. Added description (and example) of 820 adjustments records.** | **04/09/2012 – 04/23/2012** |

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# Overview

## Introduction

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

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

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

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

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

## DHH Responsibilities

DHH is responsible for administering the state’s Coordinated Care Network Program. Administration includes data analysis, production of feedback and comparative reports to CCNs, data confidentiality, and the contents of this CCN Systems Companion Guide. Written questions or inquiries about the Guide must be directed to:

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

DHH is responsible for the oversight of the Contract and CCN activities. DHH’s claim responsibilities include production and dissemination of the Systems Companion Guide, the initiation and ongoing discussion of data quality improvement with each CCN, and CCN training. DHH is responsible for reimbursing providers for services rendered to CCN enrollees. DHH will update the Systems Companion Guide on a periodic basis.

## Fiscal Intermediary (FI) Responsibilities

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

## X12 Reporting

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

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

## Proprietary Reports

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

## Enrollment Broker Responsibilities

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

## CCN Responsibilities

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

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

## 

## Claims Preprocessing

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

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

## Claims Submission

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

## Twenty-four (24) Month Claims History

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

## Batch Submissions

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

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

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

Files should be sorted and separated in the following manner:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Transaction | Claim Type | Name | File Extension | Sample file name |
| 837P | 04 | Physician, Pediatric Day Health Care Professional Identify all 837P claims including EPSDT services, and excluding Rehab. | PHY | H4599999.PHY |
| 837P | 05 | Rehabilitation **Provider Type=65, 59** | REH | H4599999.REH |
| 837I | 01 & 03 | Hospital IP/OP Inpatient: Identify by Place of Service:  1st 2 digits of Bill Type =11 or 12.  Outpatient:  Identify by Place of Service:  1st 2 digits of Bill Type = 13, 14 or 72 | UB9 | H4599999.UB9 |
| 837I | 06 | Home Health Bill Type 1st 2 digits of Bill Type=33 | HOM | H4599999.HOM |

## 834 Race/Ethnicity Codes

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

# Transaction Set Supplemental Instructions

## Introduction

The HIPAA transaction and code set regulation requires that covered entities exchanging specified transactions electronically must do so using the appropriate ANSI ASC X12 EDI formats. Further, HIPAA has defined how each of these transactions is to be implemented. Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used.

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

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

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

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

## File Transfer

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

## Prior Authorization

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

## Internal Control Number

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

## Molina Companion Guides and Billing Instructions

Molina, as DHH’s FI, provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 format(s). If the file contains syntactical error(s), the segments and elements where the error(s) occurred are reported in a 997 Functional Acknowledgement. The TA1 report is used to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship. The FI HIPAA Companion Guides can be found at [www.lamedicaid.com](http://www.lamedicaid.com/provweb1) or [www.lmmis.com](http://www.lmmis.com). Select HIPAA Billing Instructions and Companion Guides from the left hand menu.

## Professional Identifiers

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

## Category II CPT Codes

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

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

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

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

## Transaction Type

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

The following provider types use 837I:

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

The following provider types use 837P:

| Provider Type | Description |
| --- | --- |
| 07 | Case Mgmt - Infants & Toddlers |
| 08 | Case Mgmt - Elderly |
| 09 | Hospice Services |
| 12 | Multi-Systemic Therapy |
| 13 | Pre-Vocational Habilitation |
| 19 | Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group |
| 20 | Physician (MD) and Physician (MD) Group |
| 23 | Independent Lab |
| 24 | Personal Care Services (LTC/PCS/PAS) |
| 25 | Mobile X-Ray/Radiation Therapy Center |
| 28 | Optometrist and Optometrist Group |
| 29 | Title V Part C Agency Services (EarlySteps) |
| 30 | Chiropractor and Chiropractor Group |
| 31 | Psychologist |
| 32 | Podiatrist and Podiatrist Group |
| 34 | Audiologist |
| 35 | Physical Therapist |
| 37 | Occupational Therapist |
| 39 | Speech Therapist |
| 40 | DME Provider |
| 41 | Registered Dietician |
| 42 | Non-Emergency Medical Transportation |
| 43 | Case Mgmt - Nurse Home Visit - 1st Time Mother |
| 46 | Case Mgmt – HIV |
| 51 | Ambulance Transportation |
| 61 | Venereal Disease Clinic |
| 62 | Tuberculosis Clinic |
| 66 | KIDMED Screening Clinic |
| 67 | Prenatal Health Care Clinic |
| 68 | Substance Abuse and Alcohol Abuse Center |
| 69 | Hospital - Distinct Part Psychiatric Unit |
| 70 | EPSDT Health Services |
| 71 | Family Planning Clinic |
| 72 | Federally Qualified Health Center |
| 73 | Social Worker |
| 74 | Mental Health Clinic |
| 75 | Optical Supplier |
| 78 | Nurse Practitioner |
| 79 | Rural Health Clinic (Provider Based) |
| 81 | Case Mgmt - Ventilator Assisted Care Program |
| 87 | Rural Health Clinic (Independent) |
| 88 | ICF/DD - Group Home |
| 90 | Nurse-Midwife |
| 91 | CRNA or CRNA Group |
| 93 | Clinical Nurse Specialist |
| 94 | Physician Assistant |
| 95 | American Indian / Native Alaskan "638" Facilities |
| 96 | Psychiatric Residential Treatment Facility |
| 97 | Residential Care |

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

| Specialty | Description | Associated  Provider Types |
| --- | --- | --- |
| 01 | General Practice | 19,20 |
| 02 | General Surgery | 19,20,93 |
| 03 | Allergy | 19,20 |
| 04 | Otology, Laryngology, Rhinology | 19,20 |
| 05 | Anesthesiology | 19,20,91 |
| 06 | Cardiovascular Disease | 19,20 |
| 07 | Dermatology | 19,20 |
| 08 | Family Practice | 19,20,78 |
| 09 | Gynecology (DO only) | 19 |
| 10 | Gastroenterology | 19,20 |
| 12 | Manipulative Therapy (DO only) | 19 |
| 13 | Neurology | 19,20 |
| 14 | Neurological Surgery | 19,20 |
| 15 | Obstetrics (DO only) | 19 |
| 16 | OB/GYN | 19,20,78,90 |
| 17 | Ophthalmology, Otology, Laryngology, Rhinology (DO only) | 19 |
| 18 | Ophthalmology | 20 |
| 19 | Orthodontist | 19,20 |
| 20 | Orthopedic Surgery | 19,20 |
| 21 | Pathologic Anatomy; Clinical Pathology (DO only) | 19 |
| 22 | Pathology | 20 |
| 23 | Peripheral Vascular Disease or Surgery (DO only) | 19 |
| 24 | Plastic Surgery | 19,20 |
| 25 | Physical Medicine Rehabilitation | 19,20 |
| 26 | Psychiatry | 19,20,93 |
| 27 | Psychiatry; Neurology (DO only) | 19 |
| 28 | Proctology | 19,20 |
| 29 | Pulmonary Diseases | 19,20 |
| 30 | Radiology | 19,20 |
| 31 | Roentgenology, Radiology (DO only) | 19 |
| 32 | Radiation Therapy (DO only) | 19 |
| 33 | Thoracic Surgery | 19,20 |
| 34 | Urology | 19,20 |
| 35 | Chiropractor | 30,35 |
| 36 | Pre-Vocational Habilitation | 13 |
| 37 | Pediatrics | 19,20,93 |
| 38 | Geriatrics | 19,20 |
| 39 | Nephrology | 19,20 |
| 40 | Hand Surgery | 19,20 |
| 41 | Internal Medicine | 19,20 |
| 42 | Federally Qualified Health Centers | 72 |
| 44 | Public Health | 66,70 |
| 45 | NEMT - Non-profit | 42 |
| 46 | NEMT - Profit | 42 |
| 47 | NEMT - F+F | 42 |
| 48 | Podiatry - Surgical Chiropody | 20,32 |
| 49 | Miscellaneous (Admin. Medicine) | 20 |
| 51 | Med Supply / Certified Orthotist | 40 |
| 52 | Med Supply / Certified Prosthetist | 40 |
| 53 | Med Supply / Certified Prosthetist Orthotist | 40 |
| 54 | Med Supply / Not Included in 51, 52, 53 | 40 |
| 55 | Indiv Certified Orthotist | 40 |
| 56 | Indiv Certified Protherist | 40 |
| 57 | Indiv Certified Protherist - Orthotist | 40 |
| 58 | Indiv Not Included in 55, 56, 57 | 40 |
| 59 | Ambulance Service Supplier, Private | 51 |
| 60 | Public Health or Welfare Agencies & Clinics | 61,62,66,67 |
| 62 | Psychologist Crossovers only | 29,31 |
| 63 | Portable X-Ray Supplier (Billing Independently) | 25 |
| 64 | Audiologist (Billing Independently) | 29,34 |
| 65 | Indiv Physical Therapist | 29,35 |
| 66 | Dentist, DDS, DMS | 27 |
| 67 | Oral Surgeon - Dental | 27 |
| 68 | Pedodontist | 27 |
| 69 | Independent Laboratory (Billing Independently) | 23 |
| 70 | Clinic or Other Group Practice | 19,20,68,74,76 |
| 71 | Speech Therapy | 29 |
| 72 | Diagnostic Laboratory | 23 |
| 73 | Social Worker Enrollment | 73 |
| 74 | Occupational Therapy | 29,37 |
| 75 | Other Medical Care | 65 |
| 76 | Adult Day Care | 85 |
| 77 | Habilitation | 85 |
| 78 | Mental Health Rehab | 77 |
| 79 | Nurse Practitioner | 78 |
| 81 | Case Management | 07,08,43,46,81 |
| 83 | Respite Care | 83 |
| 85 | Extended Care Hospital | 60 |
| 86 | Hospitals and Nursing Homes | 55,59,60,64,69,80,88 |
| 87 | All Other | 26,40,44 |
| 88 | Optician / Optometrist | 28,75 |
| 93 | Hospice Service for Dual Elig. | 09 |
| 94 | Rural Health Clinic | 79,87 |
| 95 | Psychologist (PBS Program Only) | 31 |
| 96 | Psychologist (PBS Program and X-Overs) | 31 |
| 97 | Family Planning Clinic | 71 |
| 1G | Pediatric Endocrinology | 19,20 |
| 1T | Emergency Medicine | 19,20 |
| 2E | Endocrinology and Metabolism | 19,20 |
| 2H | Hematology | 19,20 |
| 2J | Oncology | 19,20 |
| 2I | Infectious Diseases | 19,20 |
| 2M | Rheumatology | 19,20 |
| 2R | Physician Assistant | 94 |
| 2T | American Indian/Native Alaskan | 95 |
| 4R | Registered Dietician | 41 |
| 5B | PCS-EPSDT | 24 |
| 5C | PAS | 24 |
| 5F | PCS-EPSDT, PAS | 24 |
| 5H | Community Mental Health Center | 18 |
| 5M | Multi-Systemic Therapy | 12 |
| 6A | Psychologist -Clinical | 31 |
| 6B | Psychologist-Counseling | 31 |
| 6C | Psychologist - School | 31 |
| 6D | Psychologist - Developmental | 31 |
| 6E | Psychologist - Non-Declared | 31 |
| 6F | Psychologist - All Other | 31 |
| 6N | Endodontist | 27 |
| 6P | Periodontist | 27 |
| 7A | SBHC - NP - Part Time - less than 20 hrs week | 38 |
| 7B | SBHC - NP - Full Time - 20 or more hrs week | 38 |
| 7C | SBHC - MD - Part Time - less than 20 hrs week | 38 |
| 7D | SBHC - MD - Full Time - 20 or more hrs week | 38 |
| 7E | SBHC - NP + MD - Part Time - combined less than 20 hrs week | 38 |
| 7F | SBHC - NP + MD - Full Time - combined less than 20 hrs week | 38 |
| 9B | Psychiatric Residential Treatment Facility | 96 |
| 9D | Residential Care | 97 |

## Claim Adjustments Information

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

## Line Adjustment Process

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Loop | Segment | Data Element | | Comments |
| 2300 | CLM05-3 | | 1325 | Claim Frequency Type Code  To adjust a previously submitted claim, submit a value of “**7**”. See also 2300/REF02. Louisiana Medicaid MMIS only accepts types ORIGINAL, CORRECTED, VOID. |
| 2300 | REF01 | | 128 | Reference Identification Qualifier  To adjust a previously submitted claim, submit “**F8**” to identify the Original Reference Number. |
| 2300 | REF02 | | 127 | Original Reference Number  To adjust a previously submitted claim, please submit the **13-digit ICN** assigned by the **Molina** adjudication system and printed on theremittance advice or included in the 835 (or included in the claims history file) for the previouslysubmitted claim that is being adjusted by this claim. |

# Repairable Denial Edit Codes and Descriptions

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

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

## Claim Correction Process

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

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

# Files and Reports

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

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

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

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

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

# Transaction Testing and EDI Certification

## Introduction

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

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

## Test Process

The Electronic Data Interchange (EDI) protocols are available at: <http://www.lamedicaid.com/provweb1/billing_information/medicaid_billing_index.htm> or [www.lmmis.com/provweb1/default.htm](http://www.lmmis.com/provweb1/default.htm) and choosing Electronic Claims Submission (EMC). Below are the required steps of the testing process. Please refer to Appendix F for the testing process.

## Electronic Data Interchange (EDI)

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

* + - * 1. Upon request from an approved CCN, the FI will provide application and approval forms for completion by the submitter. When completed, these forms must be submitted to the FI Provider Enrollment Unit.
        2. During the authorization process, the prospective CCN can call the EDI Department to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the potential submitter develops and tests application software to create EDI claims.
        3. Molina requires CCNs to certify with a third-party vendor, EDIFECS, prior to submitting test claims to Molina.
        4. When the submitter is ready to submit a file of test claims, the test claims should be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Management Information System (MMIS) programs that validate the data and formats. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, additional test claims will be submitted until an acceptable test run is completed. **This test submitter number (4509999) should be used for submission of test claims only!**

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

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

* + - * 1. Upon receipt of the submission, the FI’s EDI Department logs the submission and verifies it for completeness. If the submission is not complete, the log is rejected and the submitter is notified about the reject reason(s) via electronic message or telephone call.
        2. If the certification form is complete, the EDI Department enters the submitted claims into a preprocessor production run. The preprocessor generates an claims data file and one report. The Claims Transmittal Summary report, which lists whether a provider's batch of claims has been accepted or rejected, is generated for each submission. If a provider’s claims are rejected, the provider number, dollar amount and number of claims are listed on the report.

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

## Timing

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



## Definition of Terms

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

|  |  |
| --- | --- |
| **837 Format** | The file format used for electronic billing of professional services, institutional services or dental services.  ANSI 837 is shorthand for the ASC X12N 837 (005010) file format. |
| **997 Functional Acknowledgment** | Transaction set-specific verification is accomplished using a 997 Functional Acknowledgement. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. |
| **Administrative Region** | Louisiana Medicaid is divided into 9 geographically-defined regions according to the following coded values: 1=New Orleans 2=Baton Rouge 3=Houma/Thibodaux 4=Lafayette 5=Lake Charles 6=Alexandria 7=Shreveport 8=Monroe 9=Covington/Bogalusa |
| **Agent** | Any person or entity with delegated authority to obligate or act on behalf of another party. |
| **Atypical providers** | Individuals or businesses that bill Medicaid for services rendered, and do not meet the definition of a health care provider according to the NPI Final Rule 45 CFR 160.103 (e.g., carpenters, transportation providers, etc). |
| **Benefits or Covered Services** | Those health care services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan. |
| **CAS Segment** | Used to report claims or line level adjustments. |
| **Case Management** | Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member’s needs through communication and available resources, to promote high quality, cost-effective outcomes. Case Management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes. |
| **Centers for Medicare and Medicaid Services (CMS)** | The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children’s Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA). |
| **Claim adjustment** | A reason why a claim or service line was paid differently than it was billed. Adjustments are communicated by adjustment reason codes. |
| **Claim denial** | When a claim does not meet the criteria of being complete or does not meet all of the criteria for payment under health plan rules. |
| **Claims adjudication** | In health insurance claims, adjudication refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim. |
| **CommunityCARE 2.0** | Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program, which links Medicaid enrollees to a primary care provider as their medical home. |
| **Contract** | As it pertains to the Louisiana Department of Health and Hospitals (DHH) and the CCNs, the contract signed by or on behalf of the CCN entity and those things established or provided for in R.S. 46:437.11 - 437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the CCN program. It includes the signed Contract, together with any and all future addendums issued thereto by DHH. |
| **Coordinated Care Network (CCN)** | An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles. |
| **Coordinated Care Network – Prepaid (CCN-P)** | The private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid CCN Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22 of the Louisiana Revised Statues, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals. |
| **Coordinated Care Network – Shared Savings (CCN-S)** | An entity that serves as a primary care case manager by providing enhanced primary care case management in addition to contracting with primary care providers (PCPs) for primary care management. |
| **Coordination of Benefits (COB)** | Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. |
| **Co-payment** | Any cost sharing payment for which the Medicaid CCN member is responsible for in accordance with 42 CFR § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members. |
| **Core Benefits and Services** | A schedule of health care benefits and services required to be provided by the CCN to Medicaid CCN members as specified under the terms and conditions of the RFP and Louisiana Medicaid State Plan. |
| **Corrective Action Plan (CAP)** | A plan developed by the CCN that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency. |
| **Corrupt data** | Data corruption refers to errors in electronic data that occur during transmission, retrieval, or processing, introducing unintended changes to the original data. Computer storage and transmission systems use a number of measures to provide data integrity and the lack of errors. In general, when there is a Data Corruption, the file containing that data would be inaccessible, and the system or the related application will give an error. There are various causes of corruption. |
| **Covered Services** | Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan. |
| **Data Certification** | The Balanced Budget Act (BBA) requires that when State payments to a CCN are based on data that is submitted by the CCN, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. |
| **Department (DHH)** | The Louisiana Department of Health and Hospitals, referred to as DHH. |
| **Department of Health and Human Services (DHHS; also HHS)** | The United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families. |
| **Dispute** | An expression of dissatisfaction about any matter other than an action, as action is defined. Examples of a Dispute include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative Disputes are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, or access to care issues. |
| **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** | A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”. |
| **Edit Code Report** | A proprietary report prepared by the Fiscal Intermediary that includes all of the edit codes for each claim line and each claim header. Some edit codes indicate that the claim has denied. Other edit codes are informational only. |
| **EDI Certification** | EDI Certification essentially provides a snapshot that asserts an entity is capable at that point in time of generating or receiving compliant files. It is based solely on the files that have been tested and submitted for certification. Specifically, it is based on the exact capabilities that are reflected within those files. Testing and certification are typically done through a third party vendor prior to claims being submitted to the Fiscal Intermediary. |
| **Eligible** | An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under the Title XIX or Title XXI of the Social Security Act. |
| **Emergency Medical Condition** | A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Emergency care requires immediate face-to-face medical attention. |
| **Enrollee** | Louisiana Medicaid or CHIP recipient who is currently enrolled in a CCN or other managed care program. |
| **Enrollment** | The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a CCN. |
| **Enrollment Broker** | The states contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees and enrollees into a CCN. |
| **Evidence-Based Practice** | Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness. |
| **External Quality Review Organization (EQRO)** | An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, and other related activities as set forth in federal regulations, or both. |
| **Federally Qualified Health Center (FQHC)** | An entity that receives a grant under Section 330 of the Public Health Service Act, as amended, (also see Section 1905(1) (2) (B) of the Social Security Act), to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services. |
| **Fee for Service (FFS)** | A method of provider reimbursement based on payments for specific services rendered to an individual enrolled in Louisiana Medicaid. |
| **File Transfer Protocol (FTP)** | Software protocol for transferring data files from one computer to another with added encryption. |
| **Fiscal Intermediary (FI)** | DHH’s designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support. |
| **Fiscal Year (FY)** | Refers to budget year – A Federal Fiscal Year is October 1 through September 30 (FFY); A State Fiscal Year is July 1 through June 30 (SFY). |
| **Fraud** | As it relates to the Medicaid Program Integrity; means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. |
| **Health Care Professional** | A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician. |
| **Health Care Provider** | A health care professional or entity who provides health care services or goods. |
| **Healthcare Effectiveness Data and Information Set (HEDIS)** | A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (i.e., CCN) performance. |
| **HIPAA – Health Insurance Portability Administration Act** | The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers.  As the industry has implemented these standards, and increased the use of electronic data interchange, the nation's health care system will become increasingly effective and efficient. |
| **Immediate** | In an immediate manner; instant; instantly or without delay, but not more than 24 hours. |
| **Implementation Date** | The date DHH notifies the CCN of on-site Readiness Review completion and approval. It differs from the service start-up or “go live” date (which should be roughly five months from the implementation date). At implementation, a CCN can begin the process of establishing all systems for the subsequent enrollment of Medicaid eligibles and service start-up date, and preparing for DHH’s on-site Readiness Review. Enrollment of members will not begin until the CCN has signed a Contract with DHH and passed the Readiness Review or at the “go live” date. |
| **Information Systems (IS)** | A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction. |
| **Interchange Envelope** | Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B. |
| **Internal Control Number (ICN)** | DHH’s FI assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail. Processing or returning the claim constitutes the FI’s final action on that claim. A resubmission of the same claim is considered a new claim. Each claim sent to the FI is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when the FI actually received the claim. |
| **KIDMED** | Louisiana’s screening component for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). |
| **Louisiana Department of Health and Hospitals (DHH)** | The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana. |
| **Medicaid** | A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals. |
| **Medicaid FFS Provider** | An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, has been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules. |
| **Medicaid Management Information System (MMIS)** | A mechanized claims processing and information retrieval system, which all states Medicaid programs are required to have, and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles. |
| **Medicaid Recipient** | An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made. |
| **Medical Vendor Administration (MVA)** | Refers to the name for the budget unit specified in the Louisiana state budget that contains the Bureau of Health Services Financing (Louisiana’s single state Medicaid Agency). |
| **Medically Necessary Services** | Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the patient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, cosmetic, or intended primarily for the convenience of the recipient or the provider, are specifically excluded from Medicaid coverage and will be deemed “not medically necessary”. The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing such a service in his discretion on a case-by-case basis. |
| **Medicare** | The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs of older American citizens. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65. |
| **Member** | As it relates to the Louisiana Medicaid Program and the Contract, refers to a Medicaid eligible who enrolls in a CCN under the provisions of the Contract and also refers to “enrollee” as defined in 42 CFR 438.10(a). |
| **National Provider Identifier (NPI)** | The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. |
| **Network** | As utilized in the Contract, “network” may be defined as a group of participating providers linked through contractual arrangements to a CCN to supply a range of primary and acute health care services. Also referred to as Provider Network. |
| **Newborn** | A live infant born to a CCN member. |
| **Non-Contracting Provider** | A person or entity that provides hospital or medical care, but does not have a contract, or agreement with the CCN. |
| **Non-Covered Services** | Services not covered under the Title XIX Louisiana State Medicaid Plan. |
| **Non-Emergency** | An encounter by a CCN member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention. |
| **Performance Measures** | Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service. |
| **Policies** | The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and/or federal rules and regulations. |
| **Primary Care Case Management (PCCM)** | A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients. |
| **Primary Care Provider (PCP)** | An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient’s point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital. |
| **Primary Care Services** | Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers. |
| **Prior Authorization** | The process of determining medical necessity for specific services before they are rendered. |
| **Prospective Review** | Utilization review conducted prior to an admission or a course of treatment. |
| **Protected Health Information (PHI)** | Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164. |
| **Provider** | Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services. |
| **Provider Specialty** | A second-level qualification code, specific to Louisiana Medicaid, that designates the specialty classification of a provider according to Louisiana State Plan for Medicaid (for example, for physicians, some specialties are General Practice, Pediatrics, Family Medicine, etc.). |
| **Provider Type** | A high-level identification code, specific to Louisiana Medicaid, that designates the service classification of a provider according to Louisiana State Plan for Medicaid (for example, physician, dentist, pharmacy, hospital, etc.). |
| **Quality** | As it pertains to external quality, review means the degree to which a CCN increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge. |
| **Quality Assessment and Performance Improvement Program (QAPI Program)** | Program that objectively and systematically defines, monitors, evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities. |
| **Quality Assessment and Performance Improvement Plan (QAIP Plan)** | A written plan, required of all CCN-P entities, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees. |
| **Quality Management (QM)** | The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge. |
| **Readiness Review** | Refers to DHH’s assessment of the CCN’s ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of CCN standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the CCN’s ability and readiness to render services. |
| **Recipient** | An individual entitled to benefits under Title XIX of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered. |
| **Reject** | Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported. |
| **Remittance Advice** | An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the CCN, payments for maternity, and adjustments. |
| **Repairable Edit Code** | An encounter that denies for a reason that is repairable (shall be fixed and resubmitted) will have an accompanying “repairable edit code “code” to indicate that the encounter is repairable. |
| **Representative** | Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative. |
| **Risk** | The chance or possibility of loss. The member is at risk only for pharmacy co-payments as allowed in the Medicaid State Plan and the cost of non-covered services. The CCN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population. |
| **Rural Health Clinic (RHC)** | A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on a prospective payment system. |
| **SE Segment** | The 837 transaction set trailer. |
| **Security Rule (45 CFR Parts 160 & 164)** | Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks. |
| **Service Area** | Referred to as geographic service area (GSA) in the Contract. The designated geographical service area(s) within which the CCN is authorized to furnish covered services to enrollees. A service area shall not be less than one GSA. |
| **Service Line** | A single claim line as opposed to the entire claim or the claim header. |
| **Shall** | Denotes a mandatory requirement. |
| **Should** | Denotes a preference but not a mandatory requirement. |
| **Social Security Act** | The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI). |
| **Span of Control** | Information systems and telecommunications capabilities that the CCN itself operates, or for which it is otherwise legally responsible according to the terms and conditions of the Contract with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN. |
| **ST Transaction Set Header** | Indicates the start of a transaction set and to assign a control number. |
| **Start-Up Date** | The date CCN providers begin providing medical care to their Medicaid members. Also referred to as “go-live date”. |
| **State** | The state of Louisiana. |
| **Stratification** | The process of partitioning data into distinct or non-overlapping groups. |
| **Surveillance and Utilization Review Subsystems (SURS) Reporting** | Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention. |
| **Syntactical Error** | Syntax is the term associated with the "enveloping" of EDI messages into interchanges. Items included in Syntax Set maintenance include: "Delimiters" which separate individual elements and segments within the interchange; "Envelope segments" which denote the beginning and ending of messages, functional groups, and interchanges; and "Permitted Characters" which define the values allowed for a particular syntax set. Syntax validation will determine as to whether the data is a valid ANSI ASC X12N. A 997 (Functional Acknowledgement) will be returned to the submitter. The 997 contains ACCEPT or REJECT information. If the file contains syntactical errors, the segment(s) or element(s) where the error(s) occurred will be reported. |
| **System Function Response Time** | Based on the specific sub function being performed:   * Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor. * Record Retrieval Time-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor. * Print Initiation Time- the elapsed time from the command to print a screen or report until it appears in the appropriate queue. * On-line Claims Adjudication Response Time- the elapsed time from the receipt of the transaction by the CCN from the provider and/or switch vendor until the CCN hands-off a response to the provider and/or switch vendor. |
| **System Unavailability** | Measured within the CCN’s information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “enter” or other function key. |
| **TA1** | The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions. Trading partners shall follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgment (TA1), and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendix A and B. |
| **Taxonomy codes** | These are national specialty codes used by providers to indicate their specialty at the claim level. |
| **Trading Partners** | Covered entities who are involved in Electronic Data Interchange involving HIPAA ANSI transactions. |
| **Utilization Management (UM)** | Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.  UM is inclusive of utilization review and service authorization. |
| **Validation** | The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis. |
| **Will** | Denotes a mandatory requirement. |



## Frequently Asked Questions (FAQs)

**What is Molina and what is their role with CCNs?**

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

**Is there more than one 837 format? Which should I use?**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**What is a Trading Partner ID?**

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



## Code Sets

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

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

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

1. 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.

1. 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.
2. National Drug codes (NDC), as maintained and distributed by DHHS, in collaboration with drug manufacturers, for the following:
   * Drugs and
   * Biologics.
3. Current Dental Terminology (CDT) Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA) for dental services.
4. The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by DHHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. Category I CPT codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying G-code number in this category of CPT codes is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Services described by Category I CPT codes include, but are not limited to, the following:
   * Physician services,
   * Physical and occupational therapy services,
   * Radiological procedures,
   * Clinical laboratory tests,
   * Other medical diagnostic procedures,
   * Hearing and vision services, and
   * Transportation services, including ambulance.

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

1. The HCPCS, as maintained and distributed by DHHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:
   * Medical supplies,
   * Orthotic and prosthetic devices, and
   * Durable medical equipment.

Appendix D

## System Generated Reports and Files

## Claims Summary — Molina FILE (FI to CCN)

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

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

| Column(s) | Item | Notes | Length | Format |
| --- | --- | --- | --- | --- |
| **HEADER RECORD** |  | There is only one header record per file. |  |  |
| 1 | Record Type | 0=Header | 1 | Numeric |
| 2 | Delimiter |  | 1 | Uses the ^ character value |
| 3-12 | Report ID | Value is  “**CCN-W-001**” or  “**CCN-O-001**” | 10 | Character |
| 13 | Delimiter |  | 1 | Uses the ^ character value |
| 14-21 | Report Date | Date that the report was created by Molina. | 8 | Numeric, format YYYYMMDD |
| 22 | Delimiter |  | 1 | Uses the ^ character value |
| 23-72 | Report Description | Value is  “**Claims Summary**” | 50 | Character |
| 73 | Delimiter |  | 1 | Uses the ^ character value |
| 74-80 | CCN Provider ID | Medicaid Provider ID associated with the CCN. | 7 | Numeric |
| 81 | Delimiter |  | 1 | Uses the ^ character value |
| **DETAIL RECORD** |  | There may be multiple detail records per file. |  |  |
| 1 | Record Type | 1=Detail | 1 | Numeric |
| 2 | Delimiter |  | 1 | Uses the ^ character value |
| 3-12 | Report ID | Value is  “**CCN-W-001**” or  “**CCN-O-001**” | 10 | Character |
| 13 | Delimiter |  | 1 | Uses the ^ character value |
| 14-21 | Detail Line Number | The line number of the detail record. The detail portion of the file is sorted by this number | 8 | Numeric |
| 22 | Delimiter |  | 1 | Uses the ^ character value |
| 23-24 | Claim Type | Will have one of these values:  01=Inpatient  02=LTC/NH  03=Outpatient  04=Professional  05=Rehab  06=Home Health Outpatient  07=Emergency Medical Transportation  08=Non-emergency Medical Transportation  09=DME  10=Dental  11=Dental  12=Pharmacy  13=EPSDT Services.  14=Medicare Crossover Instit.  15=Medicare Crossover Prof | 2 | Numeric |
| 25 | Delimiter |  | 1 | Uses the ^ character value |
| 26-33 | Number of claim records accepted |  | 8 | Numeric, no commas, decimal points. |
| 34 | Delimiter |  | 1 | Uses the ^ character value |
| 35-42 | Number of claim records denied |  | 8 | Numeric, no commas, decimal points. |
| 43 | Delimiter |  | 1 | Uses the ^ character value |
| 44-51 | Percentage of Denied Claims |  | 8 | Numeric, with decimal point. For example, 00015.99 represents 15.99% |
| 52 | Delimiter |  | 1 | Uses the ^ character value |
| 53-81 | End of Record |  | 29 | Value is spaces. |
| **TRAILER (TOTALS) RECORD** |  | There is only one trailer record per file. |  |  |
| 1 | Record Type | 9=Trailer | 1 | Character |
| 2 | Delimiter |  | 1 | Uses the ^ character value |
| 3-12 | Report ID | Value is  “**CCN-W-001**” or  “**CCN-O-001**” | 10 | Character |
| 13 | Delimiter |  | 1 | Uses the ^ character value |
| 14-21 | Not Used |  | 8 | Character value is spaces. |
| 22 | Delimiter |  | 1 | Uses the ^ character value |
| 23-24 | Totals Line Indicator |  | 2 | Numeric, value is  99. |
| 25 | Delimiter |  | 1 | Uses the ^ character value |
| 26-33 | Total Number of Claim records accepted |  | 8 | Numeric, no commas, decimal points. |
| 34 | Delimiter |  | 1 | Uses the ^ character value |
| 35-42 | Total Number of Claim records denied |  | 8 | Numeric, no commas, decimal points. |
| 43 | Delimiter |  | 1 | Uses the ^ character value |
| 44-51 | Overall Percentage of Denied Claims |  | 8 | Numeric, with decimal point. For example, 00015.99 represents 15.99% |
| 52 | Delimiter |  | 1 | Uses the ^ character value |
| 53-81 | End of Record |  | 29 | Value is spaces. |

## Claim EDIT Disposition Summary — Molina Report (FI to CCN)

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

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

| Column(s) | Item | Notes | Length | Format |
| --- | --- | --- | --- | --- |
| **HEADER RECORD** |  | There is only one header record per file. |  |  |
| 1 | Record Type | 0=Header | 1 | Numeric |
| 2 | Delimiter |  | 1 | Uses the ^ character value |
| 3-12 | Report ID | Value is  “**CCN-W-005**” or  “**CCN-O-005**” | 10 | Character |
| 13 | Delimiter |  | 1 | Uses the ^ character value |
| 14-21 | Report Date | Date that the report was created by Molina. | 8 | Numeric, format YYYYMMDD |
| 22 | Delimiter |  | 1 | Uses the ^ character value |
| 23-72 | Report Description | Value is  “**EDIT Disposition Summary**” | 50 | Character |
| 73 | Delimiter |  | 1 | Uses the ^ character value |
| 74-80 | CCN Provider ID | Medicaid Provider ID associated with the CCN. | 7 | Numeric |
| 81 | Delimiter |  | 1 | Uses the ^ character value |
| **DETAIL RECORD** |  | There may be multiple detail records per file. |  |  |
| 1 | Record Type | 1=Detail | 1 | Numeric |
| 2 | Delimiter |  | 1 | Uses the ^ character value |
| 3-12 | Report ID | Value is  “**CCN-W-005**” or  “**CCN-O-005**” | 10 | Character |
| 13 | Delimiter |  | 1 | Uses the ^ character value |
| 14-21 | Detail Line Number | The line number of the detail record. The detail portion of the file is sorted by this number. | 8 | Numeric |
| 22 | Delimiter |  | 1 | Uses the ^ character value |
| 23-24 | Claim Type | Will have one of these values:  01=Inpatient  02=LTC/NH  03=Outpatient  04=Professional  05=Rehab  06=Home Health Outpatient  07=Emergency Medical Transportation  08=Non-emergency Medical Transportation  09=DME  10=Dental  11=Dental  12=Pharmacy  13=EPSDT Services  14=Medicare Crossover Instit.  15=Medicare Crossover Prof. | 2 | Numeric |
| 25 | Delimiter |  | 1 | Uses the ^ character value |
| 26-29 | Error Code |  | 4 | Numeric |
| 30 | Delimiter |  | 1 | Uses the ^ character value |
| 31-38 | Number of claim records having this error code |  | 8 | Numeric |
| 39 | Delimiter |  | 1 | Uses the ^ character value |
| 40-81 | End of Record |  | 42 | Value is spaces. |
| **TRAILER (TOTALS) RECORD** |  | There is only one trailer record per file. |  |  |
| 1 | Record Type | 9=Trailer | 1 | Numeric |
| 2 | Delimiter |  | 1 | Uses the ^ character value |
| 3-12 | Report ID | Value is  “**CCN-W-005**” or  “**CCN-O-005**” | 10 | Character |
| 13 | Delimiter |  | 1 | Uses the ^ character value |
| 14-21 | Total Detail Lines in the file | This is a number that represents the total detail lines submitted in the file. | 8 | Numeric |
| 22 | Delimiter |  | 1 | Uses the ^ character value |
| 23-24 | Totals Line Indicator |  | 2 | Numeric, value is  99. |
| 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. |

## Claim Detail — Molina file (FI to CCN)

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

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

| Column(s) | Item | | Notes | Length | | | Format |
| --- | --- | --- | --- | --- | --- | --- | --- |
| HEADER RECORD |  | | There is only one header record per file. |  | | |  |
| 1 | Record Type | | 0=Header | 1 | | | Numeric |
| 2 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 3-12 | Report ID | | Value is  “CCN-W-010” or  “CCN-O-010” | 10 | | | Character |
| 13 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 14-21 | Report Date | | Date that the report was created by Molina. | 8 | | | Numeric, format YYYYMMDD |
| 22 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 23-72 | Report Description | | Value is  “Claim Detail” | 50 | | | Character |
| 73 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 74-80 | CCN Provider ID | | Medicaid Provider ID associated with the CCN. | 7 | | | Numeric |
| 81 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 82 | End of Record | |  | 1 | | | Value is spaces. |
| DETAIL RECORD |  | | There may be multiple detail records per file. |  | | |  |
| 1 | Record Type | | 1=Detail | 1 | | | Numeric |
| 2 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 3-12 | Report ID | | Value is  “CCN-W-010” or  “CCN-O-010” | 10 | | | Character |
| 13 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 14-21 | Detail Line Number | | The line number of the detail record. The detail portion of the file is sorted by this number | 8 | | | Numeric |
| 22 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 23-35 | Claim ICN | | Internal Claim Number, assigned by Molina. Unique per claim line. | 13 | | | Numeric |
| 36 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 37-66 | Medical Record Number | | Submitted on the claim by the CCN. | 30 | | | Character |
| 67 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 68-87 | Patient Control Number | | Submitted on the claim by the CCN | 20 | | | Character |
| 88 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 89-118 | Line Control Number | | Submitted on the claim by the CCN | 30 | | | Character |
| 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 CCN on claim | 14 | | | Numeric with decimal point, left zero-fill. |
| 243 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 244-248 | Procedure Code | | As submitted by CCN on claim, for all claim types except inpatient hospital. |  | | | Character |
| 249 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 250-259 | Provider Billed Units | | As submitted by CCN on claim | 10 | | | Numeric with decimal point, left zero-fill. |
| 260 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 261-274 | Medicaid Payment | | Amount Louisiana Medicaid paid on the claim | 14 | | | Numeric with decimal point, left zero-fill. |
| 275 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 276-286 | NDC | | If Rx claim, then this is the NDC on the claim | 11 | | |  |
| 287 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 288-290 | Therapeutic Class | | If Rx claim | 3 | | |  |
| 291 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 292 | Rx refill code | | If Rx claim:  0=1st script,  1-5=refill number | 1 | | |  |
| 293 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 294-298 | Diagnosis Code 1 | | ICD-9-CM diag code, if available (this represents the primary diagnosis) | 5 | | | Character, does not include the decimal. |
| 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 ( 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 0 value | 10 | | | Numeric |
| 1181 | Delimiter | |  | 1 | | | Uses the ^ character value. |
| 1182-1199 | Reserved space at end of record | |  | 18 | | | Reserved for future use. Will have space value. |
| 1200 | End of Record | |  | 1 | | | Character, value is space. |
| TRAILER (TOTALS) RECORD |  | | There is only one trailer record per file. |  | | |  |
| 1 | Record Type | | 9=Trailer | 1 | | | Numeric |
| 2 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 3-12 | Report ID | | Value is  “CCN-W-010” or  “CCN-O-010” | 10 | | | Character |
| 13 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 14-21 | Total Detail Lines in the file | | This is a number that represents the total detail lines submitted in the file. It is equivalent to the total number of claim lines that denied. | 8 | | | Numeric |
| 22 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 23-24 | Totals Line Indicator | |  | 2 | | | Numeric, value is  99. |
| 25 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 26-33 | Total Number of claim records denied. | | This value represents the count of unique claim lines that appear in the detail portion of this file and have been denied. | 8 | | | Numeric |
| 34 | Delimiter | |  | 1 | | | Uses the ^ character value |
| 35 | End of Record | |  | 1 | | | Value is space. |

## Claims Processing Flowchart



## Provider File (FI to CCN)

| Column(s) | Item | Notes | Length | Format |
| --- | --- | --- | --- | --- |
| 1-7 | Provider ID | LA-MMIS assigned ID number. This is the internal Louisiana Medicaid provider ID | 7 | Numeric |
| 8 | Delimiter |  | 1 | Uses the ^ character value |
| 9-15 | Provider Check-Digit ID | LA-MMIS assigned ID number, check-digit. This is the external Louisiana Medicaid provider ID (the one known by providers) | 7 | Numeric |
| 16 | Delimiter |  | 1 | Uses the ^ character value |
| 17-46 | Provider Name (Servicing) |  | 30 | Character |
| 47 | Delimiter |  | 1 | Uses the ^ character value |
| 48-57 | Provider NPI |  | 10 | Character |
| 58 | Delimiter |  | 1 | Uses the ^ character value |
| 59-68 | Tie-Breaker | Taxonomy or Zip Code | 10 | Character |
| 69 | Delimiter |  | 1 | Uses the ^ character value |
| 70-71 | Provider Type |  | 2 | See Provider Type codes in Appendix H |
| 72 | Delimiter |  | 1 | Uses the ^ character value |
| 73-74 | Provider Specialty |  | 2 | See Provider Specialty codes in Appendix H |
| 75 | Delimiter |  | 1 | Uses the ^ character value |
| 76-83 | Enrollment Effective Begin Date |  | 8 | Numeric, date value in the format YYYYMMDD |
| 84 | Delimiter |  | 1 | Uses the ^ character value |
| 85-92 | Enrollment 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 |
| 156-157 | Provider State | USPS abbreviation | 2 |  |
| 158 | Delimiter |  | 1 | Uses the ^ character value |
| 159-168 | Provider Phone |  | 10 | Numeric |
| 169 | Delimiter |  | 1 | Uses the ^ character value |
| 170-171 | Provider Parish |  | 2 | See parish code values in Appendix H |
| 172 | Delimiter |  | 1 | Uses the ^ character value |
| 173-181 | Provider Zip Code |  | 9 | Numeric |
| 182 | Delimiter |  | 1 | Uses the ^ character value |
| 183 | Urban-Rural Indicator (applicable to hospitals only) |  | 1 | Character:  0=not applicable  1=urban  2=rural  3=sole community hospital |
| 184 | Delimiter |  | 1 | Uses the ^ character value |
| 185-214 | Provider Street Address (Pay-To) |  | 30 |  |
| 215 | Delimiter |  | 1 | Uses the ^ character value |
| 216-245 | Provider City (Pay-To) |  | 30 |  |
| 246 | Delimiter |  | 1 | Uses the ^ character value |
| 247-248 | Provider State  (Pay-To) | USPS abbreviation | 2 |  |
| 249 | Delimiter |  | 1 | Uses the ^ character value |
| 250-258 | Provider Zip (Pay-To) | USPS ZIP code+4, if available | 9 | Numeric |
| 259 | Delimiter |  | 1 | Uses the ^ character value |
| 260 | Tax ID number (TIN) or SSN |  | 9 | Numeric, left fill with zeros |
| 269 | End of Record |  | 1 | Value is spaces. |

## Provider Negotiated Rates File (FI to CCN)

| Column(s) | Item | Notes | Length | Format | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1-7 | Provider ID | LA-MMIS assigned ID number | 7 | Numeric | | | | |
| 8 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 9-15 | Provider Check-Digit ID | LA-MMIS assigned ID number, check-digit | 7 | Numeric | | | | |
| 16 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 17-46 | Provider Name (Servicing) |  | 30 | Character | | | | |
| 47 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 48-57 | Provider NPI |  | 10 | Character | | | | |
| 58 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 59-68 | Tie-Breaker | Taxonomy or Zip Code | 10 | Character | | | | |
| 69 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 70-71 | Provider Type |  | 2 | See Provider Type codes in Appendix H | | | | |
| 72 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 73-74 | Provider Specialty |  | 2 | See Provider Specialty codes in Appendix H | | | | |
| 75 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 76-83 | Enrollment Effective Begin Date |  | 8 | Numeric, date value in the format YYYYMMDD | | | | |
| 84 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 85-92 | Enrollment Effective End  Date |  | 8 | Numeric, date value in the format YYYYMMDD | | | | |
| 93 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 94-101 | Rate 1 | Inpatient General LOC Per-diem | 8 | Numeric with decimal and left-fill with zeros | | | | |
| 102 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 103-110 | Effective Date 1 |  | 8 | Numeric, date value in the format YYYYMMDD | | | | |
| 111 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 112-119 | Rate 2 | Other Inpatient (usually not applicable) | 8 | Numeric with decimal and left-fill with zeros | | | | |
| 120 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 121-128 | Effective Date 2 |  | 8 | Numeric, date value in the format YYYYMMDD | | | | |
| 129 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 130-137 | Rate 9 | Outpatient Cost-to-Charge Ratio | 8 | Numeric with decimal and left-fill with zeros | | | | |
| 138 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 139-146 | Effective Date 9 |  | 8 | Numeric, date value in the format YYYYMMDD | | | | |
| 147 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| The next 40 items depict rates associated with specific revenue codes and/or procedure codes. There are 4 parts to each item: code value, Type of Service, Effective Begin Date and Rate. Each item is 27 bytes in length and there are 40 occurrences. Not all 40 items may be populated… some may contain spaces. | | | | |  |  |  |  |
| 148-152 | Procedure or Revenue Code |  | 5 | Character | | | | |
| 153 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 154-155 | Type of Service |  | 2 | Character, see Type of Service values in Appendix H. | | | | |
| 156 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 157-164 | Effective Begin Date |  | 8 | Numeric, date value in the format YYYYMMDD | | | | |
| 165 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 166-173 | Rate |  | 8 | Numeric with decimal and left-fill with zeros | | | | |
| 174 | Delimiter |  | 1 | Uses the ^ character value | | | | |
| 1228 | End of Record |  | 1 | Value is spaces. | | | | |

## 820 File (FI to CCN)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Loop | Segment | Field | Description | | Valuation | Derived Value (D), Column Map (M), Static Value (S) |
| ST=Transaction Set Header | | | | | | |
| Sample: ST\*820\*0001\*005010X218~ | | | | | | |
|  | ST | ST01 | Transaction Set Identifier Code | | ‘820’ | S |
| Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges. | | | | | | |
|  |  | ST02 | Transaction Set Control Number | |  |  |
| Remark: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges. | | | | | | |
|  |  | ST03 | Implementation Convention Reference | | ‘005010X218’ | S |
| Remark: This element must be populated with the guide identifier named in Section 1.2 of the IG. The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X218. This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (STSE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is utilized at translation time. | | | | | | |
|  | | | | | | |
| BPR=Financial Information | | | | | | |
| Sample: BPR\*I\*1234567.89\*C\*ACH\*CCP\*01\*123456789\*DA\*123456\*1123456789\*\*01\*987654321\*DA\*654321\*20120103~ | | | | | | |
|  | BPR | BPR01 | Transaction Handling Code | | I=Remittance Information Only | S |
|  |  | BPR02 | Monetary Amount | | Total Premium Payment Amount | D |
|  |  | BPR03 | Credit/Debit Flag Code | | C=Credit | S |
|  |  | BPR04 | Payment Method Code | | ACH=Automated Clearinghouse | S |
|  |  | BPR05 | Payment Format Code | | CCP=CCD+ Format | S |
|  |  | BPR06 | (DFI) ID Number Qualifier | | Depository Financial Institution (DFI) Identification Number Qualifier 01 – ABA Transit Routing Number Including Check Digits (9 digits) | S |
| Remark: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.  SEMANTIC: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction.  SITUATIONAL RULE: Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do not send. | | | | | | |
|  |  | BPR07 | (DFI) Identification Number | | ID number of originating Depository (DHH) | S |
|  |  | BPR08 | Account Number Qualifier | | Code indicating type of account “DA” - Demand Deposit | S |
|  |  | BPR09 | Account Number | | Premium payer’s bank account | S |
|  |  | BPR10 | Originating Company Identifier | | Federal tax ID number preceded by a 1. | S |
|  |  | BPR11 | Originating Company Supplemental Code | | NOT USED |  |
|  |  | BRP12 | (DFI) ID Number Qualifier | | Depository Financial Institution (DFI) Identification Number Qualifier “01” – ABA Transit Routing Number Including Check Digits | S |
|  |  | BPR13 | (DFI) Identification Number | | This is the identifying number of the Receiving Depository Financial Institution receiving the transaction into the ACH network. (CCN-S) | S |
|  |  | BRP14 | Account Number Qualifier | | Code indicating type of account “DA” - Demand Deposit “SG” - Savings | S |
|  |  | BPR15 | Account Number | | CCN bank account number |  |
|  |  | BPR16 | EFT Effective Date | | Expressed CCYYMMDD |  |
|  | | | | | | |
| TRN=Reassociation Trace Number | | | | | | |
| Sample: TRN\*3\*1123456789\*\*~ | | | | | | |
|  | TRN | TRN01 | Trace Type Code | | “3” – Financial Reassociation Trace Number.  The payment and remittance information have been separated and need to be reassociated by the receiver. | S |
|  |  | TRN02 | Reference Identification | | EFT Trace Number Used to reassociate payment with remittance information. | S |
|  |  | TRN03 | Originating Company Identifier | | Must contain the Federal Tax ID number preceded by a 1 and must be identical to BPR10 | S |
| REF=Premium Receiver’s Identification Key | | | | | | |
| Sample: REF\*18\*123456789\*CCN Fee Payment~ | | | | | | |
|  |  | REF01 | Reference Identification Qualifier | | ‘18’=Plan Number | S |
|  |  | REF02 | Reference Identification | | Premium Receiver Reference Identifier |  |
|  |  | REF03 | Description | | ‘CCN Fee Payment’ | S |
| DTM=Process Date | | | | | | |
| Sample: DTM\*009\*20120103~ | | | | | | |
|  |  | DTM01 | Date/Time Qualifier | | “009” – Process | S |
|  |  | DTM02 | Date | | Payer Process Date CCYYMMDD | S |
| DTM=Delivery Date | | | | | | |
| Sample: DTM\*035\*20120103~ | | | | | | |
|  |  | DTM01 | Date/Time Qualifier | | “035” – Delivered | S |
|  |  | DTM02 | Date | | Payer Process Date CCYYMMDD | S |
| DTM=Report Period | | | | | | |
| Sample: DTM\*582\*\*\*\*RD8\*20120101-20120131~ | | | | | | |
|  |  | DTM01 | Date/Time Qualifier | | “582” – Report Period | S |
|  |  | DTM02 | Not Used | | Not Used |  |
|  |  | DTM03 | Not Used | | Not Used |  |
|  |  | DTM04 | Not Used | | Not Used |  |
|  |  | DTM05 | Date Time Period Qualifier | | ‘RD8’ | S |
|  |  | DTM06 | Date Time Period | | Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD | D |
|  | | | | | | |
| 1000A PREMIUM RECEIVER’S NAME | | | | | | |
| N1=Premium Receiver’s Name | | | | | | |
| Sample: N1\*PE\*CCN-S of Louisiana\*FI\*1123456789~ | | | | | | |
|  | 1000A | N101 | Entity ID Code | | “PE” – Payee |  |
|  | 1000A | N102 | Name | | Information Receiver Last or Organization Name |  |
|  | 1000A | N103 | Identification Code Qualifier | | “FI” – Federal |  |
|  | 1000A | N104 | Identification Code | | Receiver Identifier |  |
|  | | | | | | |
| 1000B PREMIUM PAYER’S NAME | | | | | | |
| N1=Premium Payer’s Name | | | | | | |
| Sample: N1\*PR\*Louisiana Department of Health and Hospitals\*FI\*1123456789~ | | | | | | |
|  | 1000B | N101 | Entity ID Code | | “PR” – Payer |  |
|  | 1000B | N102 | Name | | Premium Payer Name |  |
|  | 1000B | N103 | ID Code Qualifier | | “FI” - Federal Taxpayer ID number |  |
|  | 1000B | N104 | Identification Code | | Premium Payer ID |  |
|  | | | | | | |
| 2000B INDIVIDUAL REMITTANCE | | | | | | |
| ENT=Individual Remittance | | | | | | |
| Sample: ENT\*1\*2J\*34\*123456789~ | | | | | | |
|  | 2000B | ENT01 | Assigned Number | | Sequential Number assigned for differentiation within a transaction set |  |
|  | 2000B | ENT02 | Entity Identifier Code | | “2J” - Individual |  |
|  | 2000B | ENT03 | Identification Code Qualifier | | “34” - Social Security Number |  |
|  | 2000B | ENT04 | Identification Code | | Individual Identifier - SSN |  |
|  | | | | | | |
| 2100B INDIVIDUAL NAME | | | | | | |
| NM1=Policyholder Name | | | | | | |
| Sample: NM1\*QE\*1\*DOE\*JOHN\*Q\*\*\*N\*1234567890123~ | | | | | | |
|  | 2100B | NM101 | Entity Identifier Code | | “QE” - Policyholder (Recipient Name) |  |
|  | 2100B | NM102 | Policyholder | | “1” - Person |  |
|  | 2100B | NM103 | Name Last | | Individual Last Name |  |
|  | 2100B | NM104 | Name First | | Individual First Name |  |
|  | 2100B | NM105 | Name Middle | | Individual Middle Initial |  |
|  | 2100B | NM106 | NOT USED | | NOT USED |  |
|  | 2100B | NM107 | NOT USED | | NOT USED |  |
|  | 2100B | NM108 | Identification Code Qualifier | | “N” – Individual Identifier |  |
|  | 2100B | NM109 | Identification Code | | Individual Identifier – Recipient ID number |  |
|  | | | | | | |
| 2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL | | | | | | |
| RMR=Organization Summary Remittance Detail | | | | | | |
| Sample: RMR\*11\*1234567890123\*\*400.00~ | | | | | | |
|  | 2300B | RMR01 | Reference Identification Qualifier | | “11” - Account Number |  |
|  | 2300B | RMR02 | Reference Identification | | Claim ICN (Molina internal claims number). |  |
|  | 2300B | RMR04 | Monetary Amount | | Detail Premium Payment Amount |  |
|  |  |  |  | |  |  |
|  | | | | | | |
| REF=Reference Information | | | | | | |
| Sample: REF\*ZZ\*0101C~ | | | | | | |
|  | 2300B | REF01 | Reference Identification Qualifier | “ZZ” - Mutually Identified | |  |
|  | 2300B | REF02 | Reference Identification | Administrative Fee Code  (CCNS1 or CCNS2) | |  |
|  | 2300B | REF03 | Not Used |  | |  |
|  | 2300B | REF04 | Not Used |  | |  |
|  | | | | | | |
| DTM=Individual Coverage Period | | | | | | |
| Sample: DTM\*582\*\*\*\*RD8\*20120101-20120131~ | | | | | | |
|  | 2300B | DTM01 | Date/Time Qualifier | | “582” - Report Period |  |
|  | 2300B | DTM02 | NOT USED | | NOT USED |  |
|  | 2300B | DTM03 | NOT USED | | NOT USED |  |
|  | 2300B | DTM04 | NOT USED | | NOT USED |  |
|  | 2300B | DTM05 | Date Time Period Format Qualifier | | “RD8” – Range of Dates |  |
|  | 2300B | DTM06 | Date Time Period | | Coverage Period, expressed as CCYYMMDD-CCYYMMDD |  |
|  | | | | | | |
| Transaction Set Trailer | | | | | | |
| Sample: SE\*39\*0001~ | | | | | | |
|  | SE | SE01 | Transaction Segment Count | |  |  |
|  |  | SE02 | Transaction Set Control Number | |  |  |
| Remark: The transaction set control numbers in ST02 and SE02 must be identical. This number must be unique within a specific group and interchange, but the number can repeat in other groups and interchanges. | | | | | | |

An adjustment of a previous original administrative fee payment will be shown as two 2300B sets: a void of the previous payment and a record  showing the new adjusted amount.

The void record will have RMR and ADX segments, where the RMR will have the original claim ICN in RMR02 and the original payment amount in RMR05.  The ADX will have a negative amount (equal to the original payment) in ADX01 and the value ‘52’ in ADX02.  The record showing the new adjusted amount will behave in the same manner as an original payment (RMR).  Here is an example of an adjustment set:

***Void sequence (reversal of prior payment):***

ENT\*107\*2J\*ZZ\*7787998022222~

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

RMR\*AZ\*1059610021800\*\*\*500~

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

ADX\*-500\*52~

***Adjusted Amount sequence:***

ENT\*107\*2J\*ZZ\*7787998022222~

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

RMR\*AZ\*1067610041100\*\*600~

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

## Prior Authorization File (FI to CCN)

This file is a one-time file that contains a 2-year history of prior authorization and Pre-Admission Certification (Precert) authorization transactions performed by the Louisiana Medicaid MMIS.

| Column(s) | Item | Notes | Length | Format |
| --- | --- | --- | --- | --- |
| 1-7 | Provider ID | LA-MMIS assigned ID number | 7 | Numeric, non-check-digit. |
| 8 | Delimiter |  | 1 | Uses the ^ character value |
| 9-15 | Provider Check-Digit ID | LA-MMIS assigned ID number, check-digit | 7 | Numeric |
| 16 | Delimiter |  | 1 | Uses the ^ character value |
| 17-29 | Recipient ID (Original) |  | 13 | Numeric |
| 30 | Delimiter |  | 1 | Uses the ^ character value |
| 31-43 | Recipient ID  (Current) |  | 13 | Numeric |
| 44 | Delimiter |  | 1 | Uses the ^ character value |
| 45-54 | NPI |  | 10 | Character |
| 55 | Delimiter |  | 1 | Uses the ^ character value |
| 56 | Taxonomy |  | 10 | Character |
| 66 | Delimiter |  | 1 | Uses the ^ character value |
| 67-71 | Procedure Code |  | 5 | Character, CPT or HCPCS value |
| 72 | Delimiter |  | 1 | Uses the ^ character value |
| 73 | Authorized Units/Amount |  | 10 | Numeric, with decimal and left-zero fill |
| 83 | Delimiter |  | 1 | Uses the ^ character value |
| 84-91 | Effective Begin Date |  | 8 | Numeric, date value in the format YYYYMMDD |
| 92 | Delimiter |  | 1 | Uses the ^ character value |
| 93-100 | Effective End Date |  | 8 | Numeric, date value in the format YYYYMMDD |
| 101 | Delimiter |  | 1 | Uses the ^ character value |
| 102-106 | Admitting 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 |
| 112 | Delimiter |  | 1 | Uses the ^ character value |
| 113 | PA or Precert Type | 1=PA  2=Precert | 1 | Character |
| 114 | Delimiter |  | 1 | Uses the ^ character value |
| 115-116 | PA Type  Or  Precert Type | **Precert**:  03=Inpatient Acute  **PA**:  04=Waiver  05=Rehab  06=HH  07=Air EMT  09=DME  10=Dental  11=Dental  14=EPSDT-PCS  16=PDHC  35=ROW  40=RUM  50=LT-PCS  60=Early Steps CM  88=Hospice  99=Misc. | 2 |  |
| 117 | Delimiter |  | 1 | Uses the ^ character value |
| 118-119 | PA or Precert Status | 02=Approved  03=Denied | 2 | Character |
| 120 | Delimiter |  | 1 | Uses the ^ character value |
| 121-125 | Precert Level of Care  (this field should be blank for PA transactions) | GEN  ICU  NICU  REHAB  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 | 10 | Numeric, with decimal and left-zero fill. |
| 137 | Delimiter |  | 1 | Uses the ^ character value |
| 138-147 | PA or Precert Number assigned by Molina |  | 10 | 9- or 10-digit number |
| 148 | Delimiter |  | 1 | Uses the ^ character value |
| 149 | End of Record Indicator |  | 1 | Value is space. |

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

This file shows all diagnosis codes applicable to the Inpatient Pre-Admission Certification (Precert) operation with Louisiana Medicaid MMIS

| Column(s) | Item | Notes | Length | Format |
| --- | --- | --- | --- | --- |
| 1-5 | Diagnosis Code |  | 5 | Character, does not include the period |
| 6 | Delimiter |  | 1 | Uses the ^ character value |
| 7 | Pre-Cert Status | 1=Applicable  2=Not applicable | 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 | End of Record |  | 1 | Value is spaces. |

## Procedure File for Prior Authorization (FI to CCN)

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

| Column(s) | Item | Notes | Length | Format |
| --- | --- | --- | --- | --- |
| 1-5 | Procedure Code |  | 5 | Character |
| 6 | Delimiter |  | 1 | Uses the ^ character value |
| 7 | PA Status | 1=Applicable  2=Not applicable | 1 | Numeric |
| 8 | Delimiter |  | 1 | Uses the ^ character value |
| 9-16 | Effective Begin Date |  | 8 | Numeric in date format YYYYMMDD |
| 17 | Delimiter |  | 1 | Uses the ^ character value |
| 18-25 | Effective End Date |  | 8 | Numeric in date format YYYYMMDD |
| 26 | Delimiter |  | 1 | Uses the ^ character value |
| 27-28 | Type of Service |  | 2 | Character. See Appendix H for code values |
| 29 | Delimiter |  | 1 | Uses the ^ character value |
| 30-39 | Maximum Amount |  | 10 | Numeric, with decimal and left-fill with zeros, will be zero if not applicable |
| 40 | Delimiter |  | 1 | Uses the ^ character value |
| 41-43 | Minimum Age |  | 3 | Numeric, left-fill with zeros. Will be zero if not applicable. |
| 44 | Delimiter |  | 1 | Uses the ^ character value |
| 45-47 | Maximum Age |  | 3 | Numeric, left-fill with zeros. Will be zero if not applicable. |
| 48 | Delimiter |  | 1 | Uses the ^ character value |
| 49 | Sex  Restriction  Indicator | 0=n/a  1=Male only  2=Female only | 1 | Character |
| 50 | Delimiter |  | 1 | Uses the ^ character value |
| 51-53 | Pricing Action Code |  | 3 | Character  See Appendix H for Code values |
| 54 | Delimiter |  | 1 | Uses the ^ character value |
| 55 | End of Record |  | 1 | Value is spaces. |

## CLIA File (FI to CCN)

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

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

## Quality Profiles Submission File (CCN to FI)

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

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

#### **Record Type 1: Performance Standards Record**

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Number** | **Column positions** | **Format and Valuation** | **Length** |
| Q\_RECORD\_TYPE | 1 | Character, value=1 | 1 |
| Delimiter | 2 | Character, value=’^’ | 1 |
| QPS\_CCN\_PROV\_ID | 3-9 | Numeric, this is your assigned CCN Provider ID.  Left-fill with zeros. | 7 |
| Delimiter | 10 | Character, value=’^’ | 1 |
| QPS\_TIMEKEY | 11-15 | Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4. | 5 |
| Delimiter | 16 | Character, value=’^’ | 1 |
| QPS\_PHONE\_ACCESS\_24X7\_PERCENT | 17-22 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 23 | Character, value=’^’ | 1 |
| QPS\_SERVICE\_AUTH\_PERCENT | 24-29 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 30 | Character, value=’^’ | 1 |
| QPS\_PRE\_PROCESS\_CLAIMS\_PERCENT | 31-36 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 37 | Character, value=’^’ | 1 |
| QPS\_REJECTED\_CLAIMS\_TO\_PROV\_PERCENT | 38-43 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 44 | Character, value=’^’ | 1 |
| QPS\_CALL\_CENTER\_CALLS\_PERCENT | 45-50 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 51 | Character, value=’^’ | 1 |
| QPS\_CALL\_CENTER\_AVERAGE\_CALL\_ANSWER\_TIME | 52-57 | Numeric, 6 digits, no comma, no decimal, left fill with zeroes. Expressed in seconds. | 6 |
| Delimiter | 58 | Character, value=’^’ | 1 |
| QPS\_CALL\_CENTER\_ABANDON\_RATE | 59-64 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 65 | Character, value=’^’ | 1 |
| QPS\_GRIEVANCES\_RESOLVED\_RATE | 66-71 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| END-OF-RECORD-INDICATOR | 72 | Character, value=’E’ | 1 |

#### **Record Type 2: Incentive-Based Measures Record**

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Number** | **Column positions** | **Format and Valuation** | **Length** |
| Q\_RECORD\_TYPE | 1 | Character, value=2 | 1 |
| Delimiter | 2 | Character, value=’^’ | 1 |
| QIB \_CCN\_PROV\_ID | 3-9 | Numeric, this is your assigned CCN Provider ID.  Left-fill with zeros. | 7 |
| Delimiter | 10 | Character, value=’^’ | 1 |
| QIB \_TIMEKEY | 11-15 | Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4. | 5 |
| Delimiter | 16 | Character, value=’^’ | 1 |
| QIB\_ADULT\_ACCESS\_TO\_PREV\_AMB\_SERVICES | 17-22 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 23 | Character, value=’^’ | 1 |
| QIB\_COMPREHENSIVE\_DIABETES\_CARE\_HGBA1C | 24-29 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 30 | Character, value=’^’ | 1 |
| QIB\_CHLAMYDIA\_SCREENING | 31-36 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 37 | Character, value=’^’ | 1 |
| QIB\_WELL\_CHILD\_VISITS\_THIRD\_YEAR | 38-43 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 44 | Character, value=’^’ | 1 |
| QIB\_WELL\_CHILD\_VISITS\_FOURTH\_YEAR | 45-50 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 51 | Character, value=’^’ | 1 |
| QIB\_WELL\_CHILD\_VISITS\_FIFTH\_YEAR | 52-57 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 58 | Character, value=’^’ | 1 |
| QIB\_WELL\_CHILD\_VISITS\_SIXTH\_YEAR | 59-64 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 65 | Character, value=’^’ | 1 |
| QIB\_ADOLESCENT\_WELL\_VISITS | 66-71 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| END-OF-RECORD-INDICATOR | 72 | Character, value=’E’ | 1 |

#### **Record Type 3: Level I Measures Record**

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Number** | **Column positions** | **Format and Valuation** | **Length** |
| Q\_RECORD\_TYPE | 1 | Character, value=3 | 1 |
| Delimiter | 2 | Character, value=’^’ | 1 |
| QLI\_CCN\_PROV\_ID | 3-9 | Numeric, this is your assigned CCN Provider ID.  Left-fill with zeros. | 7 |
| Delimiter | 10 | Character, value=’^’ | 1 |
| QLI\_TIMEKEY | 11-15 | Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4. | 5 |
| Delimiter | 16 | Character, value=’^’ | 1 |
| QLI\_CHILD\_AND\_ADOL\_ACCESS\_TO\_PCP | 17-22 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 23 | Character, value=’^’ | 1 |
| QLI\_TIMELINESS\_OF\_PRENATAL\_AND\_POSTPARTUM\_CARE | 24-29 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 30 | Character, value=’^’ | 1 |
| QLI\_CHILDHOOD\_IMMUN\_STATUS | 31-36 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 37 | Character, value=’^’ | 1 |
| QLI\_IMMUNIZATIONS\_FOR\_ADOL | 38-43 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 44 | Character, value=’^’ | 1 |
| QLI\_LEAD\_SCREENING\_CHILDREN | 45-50 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 51 | Character, value=’^’ | 1 |
| QLI\_CERVICAL\_CANCER\_SCREENING | 52-57 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 58 | Character, value=’^’ | 1 |
| QLI\_PERCENT\_LIVE\_BIRTHS\_WEIGHT\_LT\_2500G | 59-64 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 65 | Character, value=’^’ | 1 |
| QLI\_WEIGHT\_ASSESSMENT\_CHILDREN\_ADOL | 66-71 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 72 | Character, value=’^’ | 1 |
| QLI\_MEDICATIONS\_FOR\_PERSONS\_WITH\_ASTHMA | 73-78 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 79 | Character, value=’^’ | 1 |
| QLI\_COMPREHENSIVE\_DIABETES\_CARE | 80-85 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 86 | Character, value=’^’ | 1 |
| QLI\_BREAST\_CANCER\_SCREENING | 87-92 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 93 | Character, value=’^’ | 1 |
| QLI\_EPSDT\_SCREENING\_RATE | 94-99 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 100 | Character, value=’^’ | 1 |
| QLI\_ADULT\_ASTHMA\_ADMISSION\_RATE | 101-106 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 107 | Character, value=’^’ | 1 |
| QLI\_CHF\_ADMISSION\_RATE | 108-113 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 114 | Character, value=’^’ | 1 |
| QLI\_UNCONTROLLED\_DIABETES\_ADMISSION\_RATE | 115-120 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 121 | Character, value=’^’ | 1 |
| QLI\_INPATIENT\_HOSP\_READMISSION\_RATE | 122-127 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 128 | Character, value=’^’ | 1 |
| QLI\_WELL\_CHILD\_VISITS\_IN\_FIRST\_15\_MONTHS | 129-134 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 135 | Character, value=’^’ | 1 |
| QLI\_AMBULATORY\_CARE\_ER\_UTILIZATION | 136-141 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| END-OF-RECORD-INDICATOR | 142 | Character, value=’E’ | 1 |

**Record Type 4: Level II Measures Record**

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Field Number** | **Column positions** | **Format and Valuation** | **Length** |
| Q\_RECORD\_TYPE | 1 | Character, value=4 | 1 |
| Delimiter | 2 | Character, value=’^’ | 1 |
| QLII\_CCN\_PROV\_ID | 3-9 | Numeric, this is your assigned CCN Provider ID.  Left-fill with zeros. | 7 |
| Delimiter | 10 | Character, value=’^’ | 1 |
| QLII\_TIMEKEY | 11-15 | Numeric, format=YYYYQ, where YYYY is the calendar year and Q is the quarter number, from 1 to 4. | 5 |
| Delimiter | 16 | Character, value=’^’ | 1 |
| QLII\_FOLLOWUP\_CARE\_CHILD\_WITH\_ADHD | 17-22 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 23 | Character, value=’^’ | 1 |
| QLII\_OTITIS\_MEDIA\_EFFUSION | 24-29 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 30 | Character, value=’^’ | 1 |
| QLII\_DEVEL\_SCREENING\_IN\_FIRST\_3\_YEARS | 31-36 | Numeric in the format NNN.NN, with the decimal included. | 6 |
| Delimiter | 37 | Character, value=’^’ | 1 |
| QLII\_PED\_CENTRAL\_LINE\_ASSOC\_BLOODSTREAM | 38-43 | Numeric in the format 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 Claim Report (CCN to FI)

DHH is interested in analyzing claims denied for the following reasons:

Lack of documentation to support Medical Necessity

Prior Authorization denied

Member has other insurance that must be billed first

Claim was submitted after the timely filing deadline

Service was not covered

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

CCNs are to submit to DHH (FI) an electronic report monthly on the number and type of denied claims referenced above. The report shall include the:

* Denial reason code
* Claim type
* Missing documentation to support medical necessity
* Missing documentation of prior authorization (PA); e.g., PA denied
* Date of service
* Date of receipt by CCN
* Denied Date
* Primary diagnosis code
* Secondary diagnosis code, if applicable
* Procedure/HCPCs code(s)
* Surgical procedure code(s), if applicable
* Revenue code(s), if applicable
* Primary insurance carrier (TPL), if applicable
* Primary insurance coverage begin date (TPL), if applicable

Appendix E

## Provider Directory/Network Provider and Subcontractor Registry (CCN to FI)

At the onset of the CCN 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 CCN and or its contractor. The CCN 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 CCN with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker.

The CCN-S program requires claims to be paid through the MMIS on a FFS basis. Network providers must be enrolled as a Louisiana Medicaid provider.

CCNs will be required to provide DHH with a list of contracted primary care providers. DHH shall be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any providers no longer taking patients must be clearly identified.

The provider directory must include the following information:

* NPI
* Entity Type Code (1-Individual or 2-Organization)
* Replacement NPI
* Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), or the Legal Business Name for Organizations)
* Provider Other Name (First Name, Middle Name, Last Name, or 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
* Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code[[1]](#footnote-1), and Country Code if outside U.S., Telephone Number, Fax Number)
* Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
* Healthcare Provider Taxonomy Code(s)
* Other Provider Identifier(s)
* Other Provider Identifier Type Code
* Provider Enumeration Date
* Last Update Date
* NPI Deactivation Reason Code
* NPI Deactivation Date
* NPI Reactivation Date
* Provider Gender Code
* Provider License Number
* Provider License Number State Code
* Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)
* Panel Open (Y/N)
* Language
* Age Restriction
* PCP Linkage Maximum
* PCP Linkages with Others
* CCN Enrollment Indicator
* CCN Enrollment Indicator Effective Date
* Family Only Indicator
* Provider Sub-Specialty
* CCN Contract Name or Number
* CCN Contract Begin Date
* CCN Contract Termination Date
* Provider Parish

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

| Provider Type | Description |
| --- | --- |
| 07 | Case Mgmt - Infants & Toddlers |
| 08 | Case Mgmt - Elderly |
| 09 | Hospice Services |
| 12 | Multi-Systemic Therapy |
| 13 | Pre-Vocational Habilitation |
| 19 | Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group |
| 20 | Physician (MD) and Physician (MD) Group |
| 23 | Independent Lab |
| 24 | Personal Care Services (LTC/PCS/PAS) |
| 25 | Mobile X-Ray/Radiation Therapy Center |
| 28 | Optometrist and Optometrist Group |
| 29 | Title V Part C Agency Services(EarlySteps) |
| 30 | Chiropractor and Chiropractor Group |
| 31 | Psychologist |
| 32 | Podiatrist and Podiatrist Group |
| 34 | Audiologist |
| 35 | Physical Therapist |
| 37 | Occupational Therapist |
| 39 | Speech Therapist |
| 40 | DME Provider |
| 41 | Registered Dietician |
| 42 | Non-Emergency Medical Transportation |
| 43 | Case Mgmt - Nurse Home Visit - 1st Time Mother |
| 44 | Home Health Agency |
| 46 | Case Mgmt - HIV |
| 51 | Ambulance Transportation |
| 54 | Ambulatory Surgery Center |
| 55 | Emergency Access Hospital |
| 59 | Neurological Rehabilitation Unit (Hospital) |
| 60 | Hospital |
| 61 | Venereal Disease Clinic |
| 62 | Tuberculosis Clinic |
| 64 | Mental Health Hospital Freestanding |
| 65 | Rehabilitation Center |
| 66 | KIDMED Screening Clinic |
| 67 | Prenatal Health Care Clinic |
| 68 | Substance Abuse and Alcohol Abuse Center |
| 69 | Hospital – Distinct Part Psychiatric |
| 69 | Hospital - Distinct Part Psychiatric Unit |
| 70 | EPSDT Health Services |
| 71 | Family Planning Clinic |
| 72 | Federally Qualified Health Center |
| 73 | Social Worker |
| 74 | Mental Health Clinic |
| 75 | Optical Supplier |
| 76 | Hemodialysis Center |
| 77 | Mental Health Rehabilitation |
| 78 | Nurse Practitioner |
| 79 | Rural Health Clinic (Provider Based) |
| 80 | Nursing Facility |
| 81 | Case Mgmt - Ventilator Assisted Care Program |
| 87 | Rural Health Clinic (Independent) |
| 88 | ICF/DD - Group Home |
| 90 | Nurse-Midwife |
| 91 | CRNA or CRNA Group |
| 93 | Clinical Nurse Specialist |
| 94 | Physician Assistant |
| 95 | American Indian / Native Alaskan "638" Facilities |
| 96 | Psychiatric Residential Treatment Facility |
| 97 | Residential Care |

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

| Specialty | Description | Associated  Provider Types |
| --- | --- | --- |
| 01 | General Practice | 19,20 |
| 02 | General Surgery | 19,20,93 |
| 03 | Allergy | 19,20 |
| 04 | Otology, Laryngology, Rhinology | 19,20 |
| 05 | Anesthesiology | 19,20,91 |
| 06 | Cardiovascular Disease | 19,20 |
| 07 | Dermatology | 19,20 |
| 08 | Family Practice | 19,20,78 |
| 09 | Gynecology (DO only) | 19 |
| 10 | Gastroenterology | 19,20 |
| 12 | Manipulative Therapy (DO only) | 19 |
| 13 | Neurology | 19,20 |
| 14 | Neurological Surgery | 19,20 |
| 15 | Obstetrics (DO only) | 19 |
| 16 | OB/GYN | 19,20,78,90 |
| 17 | Ophthalmology, Otology, Laryngology, Rhinology (DO only) | 19 |
| 18 | Ophthalmology | 20 |
| 19 | Orthodontist | 19,20 |
| 20 | Orthopedic Surgery | 19,20 |
| 21 | Pathologic Anatomy; Clinical Pathology (DO only) | 19 |
| 22 | Pathology | 20 |
| 23 | Peripheral Vascular Disease or Surgery (DO only) | 19 |
| 24 | Plastic Surgery | 19,20 |
| 25 | Physical Medicine Rehabilitation | 19,20 |
| 26 | Psychiatry | 19,20,93 |
| 27 | Psychiatry; Neurology (DO only) | 19 |
| 28 | Proctology | 19,20 |
| 29 | Pulmonary Diseases | 19,20 |
| 30 | Radiology | 19,20 |
| 31 | Roentgenology, Radiology (DO only) | 19 |
| 32 | Radiation Therapy (DO only) | 19 |
| 33 | Thoracic Surgery | 19,20 |
| 34 | Urology | 19,20 |
| 35 | Chiropractor | 30,35 |
| 36 | Pre-Vocational Habilitation | 13 |
| 37 | Pediatrics | 19,20,93 |
| 38 | Geriatrics | 19,20 |
| 39 | Nephrology | 19,20 |
| 40 | Hand Surgery | 19,20 |
| 41 | Internal Medicine | 19,20 |
| 42 | Federally Qualified Health Centers | 72 |
| 44 | Public Health | 66,70 |
| 45 | NEMT - Non-profit | 42 |
| 46 | NEMT - Profit | 42 |
| 47 | NEMT - F+F | 42 |
| 48 | Podiatry - Surgical Chiropody | 20,32 |
| 49 | Miscellaneous (Admin. Medicine) | 20 |
| 51 | Med Supply / Certified Orthotist | 40 |
| 52 | Med Supply / Certified Prosthetist | 40 |
| 53 | Med Supply / Certified Prosthetist Orthotist | 40 |
| 54 | Med Supply / Not Included in 51, 52, 53 | 40 |
| 55 | Indiv Certified Orthotist | 40 |
| 56 | Indiv Certified Protherist | 40 |
| 57 | Indiv Certified Protherist - Orthotist | 40 |
| 58 | Indiv Not Included in 55, 56, 57 | 40 |
| 59 | Ambulance Service Supplier, Private | 51 |
| 60 | Public Health or Welfare Agencies & Clinics | 61,62,66,67 |
| 62 | Psychologist Crossovers only | 29,31 |
| 63 | Portable X-Ray Supplier (Billing Independently) | 25 |
| 64 | Audiologist (Billing Independently) | 29,34 |
| 65 | Indiv Physical Therapist | 29,35 |
| 66 | Dentist, DDS, DMS | 27 |
| 67 | Oral Surgeon - Dental | 27 |
| 68 | Pedodontist | 27 |
| 69 | Independent Laboratory (Billing Independently) | 23 |
| 70 | Clinic or Other Group Practice | 19,20,68,74,76 |
| 71 | Speech Therapy | 29 |
| 72 | Diagnostic Laboratory | 23 |
| 73 | Social Worker Enrollment | 73 |
| 74 | Occupational Therapy | 29,37 |
| 75 | Other Medical Care | 65 |
| 76 | Adult Day Care | 85 |
| 77 | Habilitation | 85 |
| 78 | Mental Health Rehab | 77 |
| 79 | Nurse Practitioner | 78 |
| 81 | Case Management | 07,08,43,46,81 |
| 83 | Respite Care | 83 |
| 85 | Extended Care Hospital | 60 |
| 86 | Hospitals and Nursing Homes | 55,59,60,64,69,80,88 |
| 87 | All Other | 26,40,44 |
| 88 | Optician / Optometrist | 28,75 |
| 93 | Hospice Service for Dual Elig. | 09 |
| 94 | Rural Health Clinic | 79,87 |
| 95 | Psychologist (PBS Program Only) | 31 |
| 96 | Psychologist (PBS Program and X-Overs) | 31 |
| 97 | Family Planning Clinic | 71 |
| 1G | Pediatric Endocrinology | 19,20 |
| 1T | Emergency Medicine | 19,20 |
| 2E | Endocrinology and Metabolism | 19,20 |
| 2H | Hematology | 19,20 |
| 2J | Oncology | 19,20 |
| 2I | Infectious Diseases | 19,20 |
| 2M | Rheumatology | 19,20 |
| 2R | Physician Assistant | 94 |
| 2T | American Indian/Native Alaskan | 95 |
| 4R | Registered Dietician | 41 |
| 5B | PCS-EPSDT | 24 |
| 5C | PAS | 24 |
| 5F | PCS-EPSDT, PAS | 24 |
| 5H | Community Mental Health Center | 18 |
| 5M | Multi-Systemic Therapy | 12 |
| 6A | Psychologist -Clinical | 31 |
| 6B | Psychologist-Counseling | 31 |
| 6C | Psychologist - School | 31 |
| 6D | Psychologist - Developmental | 31 |
| 6E | Psychologist - Non-Declared | 31 |
| 6F | Psychologist - All Other | 31 |
| 6N | Endodontist | 27 |
| 6P | Periodontist | 27 |
| 7A | SBHC - NP - Part Time - less than 20 hrs week | 38 |
| 7B | SBHC - NP - Full Time - 20 or more hrs week | 38 |
| 7C | SBHC - MD - Part Time - less than 20 hrs week | 38 |
| 7D | SBHC - MD - Full Time - 20 or more hrs week | 38 |
| 7E | SBHC - NP + MD - Part Time - combined less than 20 hrs week | 38 |
| 7F | SBHC - NP + MD - Full Time - combined less than 20 hrs week | 38 |
| 9B | Psychiatric Residential Treatment Facility | 96 |
| 9D | Residential Care | 97 |

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

| Column(s) | Item | Notes | Length | Format | R=Required  O=Optional |
| --- | --- | --- | --- | --- | --- |
| NOTE: This record format describes a fixed-format layout. The record size is fixed at 750 bytes. If a field is listed as Optional (O), and the CCN elects not to populate the field, then it should be filled with blanks or zeros as appropriate to the Length and Format definition (character or numeric, respectively). | | | | | |
| 1-20 | NPI | National Provider ID number | 20 | First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to include them. | R |
| 21 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 22 | Entity Type code | **1**=Individual,  **2**=Organization | 1 |  | R |
| 23 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 24-43 | Replacement NPI | DO NOT USE AT THIS TIME. FOR FUTURE USE. | 20 | First 10 characters should represent the NPI. Last 10 characters should be spaces. If the number has leading zeroes, be sure to use them. | O |
| 44 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 45-74 | Provider Name OR the Legal Business Name for Organizations.  If the entity type=1 (individual), please format the name in this manner:  First 13 positions= provider first name,  14th position=middle initial (or space),  15-27th characters=last name,  28-30th positions=suffix.  If names do not fit in these positions, please truncate the end of the item so that it fits in the positions. |  | 30 | Character | R |
| 75 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 76-105 | Provider Business Mailing Address (First line address) |  | 30 | Character | R |
| 106 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 107-136 | Provider Business Mailing Address (Second line address) |  | 30 | Character | O |
| 137 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 138-167 | Provider Business Mailing Address (City,) |  | 30 | Character | R |
| 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 Address (First line address) | No P.O. Box here, please use a physical address. | 30 | Character | R |
| 246 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 247-276 | Provider Business Location Address (Second line address) |  | 30 | Character | O |
| 277 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 278-307 | Provider Business Location Address (City,) |  | 30 | Character | R |
| 308 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 309-310 | Provider Business Location Address (State) |  | 2 | USPS state code abbreviation | R |
| 311 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 312-321 | Provider Business Location Address (Postal Code) |  | 10 | Character, left-justify, right-fill with spaces if necessary | R |
| 322 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 323-332 | Provider Business Location Address (Country Code if outside U.S) | Leave blank if business mailing address is not outside the U.S. | 10 | Character, left-justify, right-fill with spaces if necessary | O |
| 333 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 334-343 | Provider Business Location Address (Telephone Number) | Do not enter dashes or parentheses. | 10 | Numeric | R |
| 344 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 345-354 | Provider Business Location Address (Fax Number) | Do not enter dashes or parentheses. | 10 | Numeric | O |
| 355 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 356-365 | Healthcare Provider Taxonomy Code 1 |  | 10 | Character | R  Note: if a single NPI is used for multiple entities then we require at least 1 taxonomy per NPI.  For example, if a single NPI is used for an acute care hospital as well as a DPPU in the hospital, then we need taxonomy for both units… each sent in a separate record. |
| 366 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 367-376 | Healthcare Provider Taxonomy Code 2 | Use if necessary; otherwise leave blank. | 10 | Character | O |
| 377 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 378-387 | Healthcare Provider Taxonomy Code 3 | Use if necessary; otherwise leave blank. | 10 | Character | O |
| 388 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 389-395 | Other Provider Identifier | If available, enter the provider’s Louisiana Medicaid Provider ID | 7 | Numeric, left-fill with zeroes. | R, if provider is already enrolled with Medicaid; otherwise, optional. |
| 396 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 397-400 | Other Provider Identifier Type Code | Provider Type and Provider Specialty | 4 | 1st 2 characters are provider type; last 2 characters (3-4) are provider specialty.  See CCN Companion Guide for list of applicable provider types and specialties. | R |
| 401 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 402-409 | Provider Enumeration Date | NPPES enumeration date. | 8 | Numeric, format YYYYMMDD | R |
| 410 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 411-418 | Last Update Date | NPPES last update date; leave all zeros if not available. | 8 | Numeric, format YYYYMMDD | O |
| 419 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 420-439 | NPI Deactivation Reason Code | NPPES deactivation reason; leave blank if appropriate. | 20 | Left justify, right-fill with spaces. | O |
| 440 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 441-448 | NPI Deactivation Date | NPPES deactivation date; leave all zeros if not appropriate. | 8 | Numeric, format YYYYMMDD | O |
| 449 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 450-457 | NPI Reactivation Date | NPPES reactivation date; leave all zeros if not appropriate. | 8 | Numeric, format YYYYMMDD | O |
| 458 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 459 | Provider Gender Code | **M**=Male,  **F**=Female,  **N**=Not applicable | 1 | Character  . | R |
| 460 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 461-480 | Provider License Number |  | 20 | Character, left-justified, right-fill with spaces. | R |
| 481 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 482-483 | Provider License Number State Code | 2-character USPS state code value | 2 | Character | R |
| 484 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 485-534 | Authorized Official Contact Information (First Name, Middle Name, Last Name) |  | 50 | Character, left-justified, right-fill with spaces. | R |
| 535 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 536-565 | Authorized Official Contact Information (Title or Position) |  | 30 | Character, left-justified, right-fill with spaces. | O |
| 566 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 567-576 | Authorized Official Contact Information (Telephone Number) | Do not enter dashes or parentheses. | 10 | Numeric | R |
| 577 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 578 | Panel Open Indicator | **Y**=Yes, panel is open.  **N**=No, panel is not open. | 1 | Character | R for PCPs; otherwise optional. |
| 579 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 580 | Language Indicator 1  (this is the primary language indicator) | 1=English-speaking patients only  2=Accepts Spanish-speaking patients  3=Accepts Vietnamese-speaking patients  4=Accepts French-speaking patients  5=Accepts Cambodian-speaking patients | 1 | Character | R for PCPs, specialists and other professionals; otherwise optional. |
| 581 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 582 | Language Indicator 2  (this is a secondary language indicator) | 0=no other language supported  1= Accepts English-speaking patients  2=Accepts Spanish-speaking patients  3=Accepts Vietnamese-speaking patients  4=Accepts French-speaking patients  5=Accepts Cambodian-speaking patients | 1 | Character | O |
| 583 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 584 | Language 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. It should be left all zeroes if the provider is not a PCP/specialist. | R for PCPs; otherwise optional. |
| 597 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 598-602 | PCP Linkages with CCN | Numeric | 5 | Numeric, left fill with zeroes. This number represents the maximum number of CCN enrollees that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist. | R for PCPs; otherwise optional. |
| 603 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 604-608 | PCP Linkages with Others | Numeric | 5 | Numeric, left fill with zeroes. This number represents the maximum number of enrollees in other plans (not CCN) that can be linked to the PCP. It should be left all zeroes if the provider is not a PCP/specialist. | R for PCPs; otherwise optional. |
| 609 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 610 | CCN Enrollment Indicator | **N**=New enrollment  **C**=Change to existing enrollment  **D**=Disenrollment | 1 | Use this field to identify new providers, changes to existing providers, and disenrolled providers | R |
| 611 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 612-619 | CCN Enrollment Indicator Effective Date | Effective date of Enrollment Indicator above. | 8 | Numeric, format YYYYMMDD | R |
| 620 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 621 | Family Only Indicator | **0**=no restrictions  **1**=family members only | 1 |  | R for PCPs; otherwise optional. |
| 622 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 623-624 | Provider Sub-Specialty 1 | Value set is determined by DHH and is available in CCN Companion Guide | 2 |  | R for PCPs; otherwise optional |
| 625 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 626-627 | Provider Sub-Specialty 2 | If necessary, Value set is determined by DHH and is available in CCN Companion Guide | 2 |  | O |
| 628 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 629-630 | Provider Sub-Specialty 3 | If necessary, Value set is determined by DHH and is available in CCN Companion Guide | 2 |  | O |
| 631 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 632-661 | CCN Contract Name or Number | This should represent the contract name/number that is established between the CCN and the Provider | 30 | Character | R |
| 662 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 663-670 | CCN Contract Begin Date | Date that the contract between the CCN and the provider started | 8 | Numeric date value in the form YYYYMMDD | R |
| 671 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 672-679 | CCN Contract Term Date | Date that the contract between the CCN and the provider was terminated. | 8 | Numeric date value in the form YYYYMMDD | R  Contract Term 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 CCN Companion Guide. | R |
| 683 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 684-685 | Provider Parish served – 2nd | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 686 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 687-688 | Provider Parish served – 3rd | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 689 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 690-691 | Provider Parish served – 4th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN 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 CCN Companion Guide. | O |
| 695 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 696-697 | Provider Parish served – 6th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 698 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 699-700 | Provider Parish served – 7th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 701 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 702-703 | Provider Parish served – 8th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 704 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 705-706 | Provider Parish served – 9th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 707 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 708-709 | Provider Parish served – 10th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 710 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 711-712 | Provider Parish served – 11th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 713 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 714-715 | Provider Parish served – 12th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 716 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 717-718 | Provider Parish served – 13th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 719 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 720-721 | Provider Parish served – 14th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 722 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 723-724 | Provider Parish served – 15th | Parish code value that represents a secondary or other parish that the provider serves.  Use only if necessary; otherwise enter 00. | 2 | 2-digit parish code value. See the CCN Companion Guide. | O |
| 725 | Delimiter |  | 1 | Character, use the ^ character value |  |
| 726-749 | Spaces | End of record filler | 24 | Enter all spaces |  |
| 750 | End of record delimiter |  | 1 | Character, use the ^ character value |  |

## 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

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XXXXXXX XXXXXXXXXXXXXXXXXXXX XXXXXXXXXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

XXXXXXX XXXXXXXXXXXXXXXXXXXX XXXXXXXXXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

XXXXXXX XXXXXXXXXXXXXXXXXXXX XXXXXXXXXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

XXXXXXX XXXXXXXXXXXXXXXXXXXX XXXXXXXXXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

XXXXXXX XXXXXXXXXXXXXXXXXXXX XXXXXXXXXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

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

000=(A) No errors found

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

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

003=(R) Provider record must include taxonomy

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

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

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

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

008=(R) Missing/Invalid enrollment effective date

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

010=(R) Invalid Language indicator value (must be 0,1,2,3,4,5. 1st indicator cannot be 0)

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

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

013=(R) Invalid PCP Linkage 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

END OF REPORT

## Provider Registry Edit file layout

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Columns | Field Name | Format | Size | Comments |
| 1-7 | BAYOU HEALTH Plan ID number | Numeric | 7 digits | This is the plan ID. |
| 8 | Delimiter | Character | 1 | Value is ^ character. |
| 9 | Enroll Code | Character | 1 | Submitted by plan:  N=New  C=Change  D=Disenroll |
| 10 | Delimiter | Character | 1 | Value is ^ character. |
| 11-17 | Provider ID | Numeric | 7 digits | This is the provider’s Medicaid ID number |
| 18 | Delimiter | Character | 1 | Value is ^ character. |
| 19-28 | Provider NPI | Character | 10 |  |
| 29 | Delimiter | Character | 1 | Value is ^ character. |
| 30-59 | Provider Name | Character | 30 |  |
| 60 | Delimiter | Character | 1 | Value is ^ character. |
| 61-70 | Provider Taxonomy | Character | 10 |  |
| 71 | Delimiter | Character | 1 | Value is ^ character. |
| 72-78 | Provider ID | Numeric | 7 digits |  |
| 79 | Delimiter | Character | 1 | Value is ^ character. |
| 80 | Molina Accept/Reject Indicator | Character | 1 | A=Accepted  R=Rejected |
| 81 | Delimiter | Character | 1 | Value is ^ character. |
| 82-84 | Edit Code 1 | Character | 3 |  |
| 85 | Delimiter | Character | 1 | Value is ^ character. |
| 86-88 | Edit Code 2 | Character | 3 |  |
| 89 | Delimiter | Character | 1 | Value is ^ character. |
| 90-92 | Edit Code 3 | Character | 3 |  |
| 93 | Delimiter | Character | 1 | Value is ^ character. |
| 94-96 | Edit Code 4 | Character | 3 |  |
| 97 | Delimiter | Character | 1 | Value is ^ character. |
| 98-100 | Edit Code 5 | Character | 3 |  |
| 101 | Delimiter | Character | 1 | Value is ^ character. |
| 102-104 | Edit Code 6 | Character | 3 |  |
| 105 | Delimiter | Character | 1 | Value is ^ character. |
| 106-108 | Edit Code 7 | Character | 3 |  |
| 109 | Delimiter | Character | 1 | Value is ^ character. |
| 110-112 | Edit Code 8 | Character | 3 |  |
| 113 | Delimiter | Character | 1 | Value is ^ character. |
| 114-116 | Edit Code 9 | Character | 3 |  |
| 117 | Delimiter | Character | 1 | Value is ^ character. |
| 118-120 | Edit Code 10 | Character | 3 |  |
| 121 | Delimiter | Character | 1 | Value is ^ character. |

## Provider Registry Site File

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

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

The plans can upload test files until Friday 4/13/12 COB. We will run the test site provider registry files and return the results on Monday 4/16/12. Go-live is Friday 4/20/12. The plans have until 8:00PM on that day to upload their production site changes.

Site File Format

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Column**  **ID** | **Field Position in record** | **Field** | **Type** | **Length** | **Required or Optional** | **Valid values** | **Other notes** | **Applicable Error Code(s) (see table below).** |
| 1 | 1-7 | Plan ID | Numeric | 7 | Required | Must be your assigned Plan ID | Use your Plan ID formatted 2162nnn, where nnn is your specific assigned number. | 016 |
| 2 | 8 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 3 | 9-18 | Provider NPI | Numeric | 10 | Required | Must be the provider’s NPI |  | 001, 004, 013, 015 017.  (015 is not a rejection error for Pre-Paid plans), |
| 4 | 19 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 5 | 20-29 | Provider Taxonomy | Character | 10 | Required | Must be a valid Taxonomy |  | 002, 020 |
| 6 | 30 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 7 | 31-37 | LMMIS Medicaid Provider ID | Numeric | 7 | Optional | If not available then place all zeros in this field. | This is the assigned Louisiana Medicaid Provider ID. It is the check-digit number. Check-digit provider numbers begin with 1 or 2, not with 00 or 01. | 014 .  (014 is not a rejection error for Pre-Paid plans). |
| 8 | 38 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 9 | 39-41 | Site Number | Numeric | 3 | Required | **Must be a number between 001 and 998. May not be 000 or 999.**  Be sure to left-fill with zeros, if appropriate.  **Plan’s MUST maintain consistency with this number by NPI and Taxonomy.** | Site Number should be a unique number for each practice site/location by Provider (NPI and Taxonomy). For a specific provider, it should start with 001 for the first site, then 002, etc. | 003, 022 |
| 10 | 42 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 11 | 43-92 | Practice/Site Street Address 1 | Character | 50 | Required |  | Do not use a PO Box.  **Do not send multiple site records that share the exact same address, based on columns 11, 13, 15, and 17.** | 003, 013, 021 |
| 12 | 93 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 13 | 94-143 | Practice/Site Street Address 2 | Character | 50 | Optional | If not used, then place spaces in this field. | Do not use a PO Box. | 003, 013, 021 |
| 14 | 144 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 15 | 145-194 | City | Character | 50 | Required | Must not be all spaces. |  | 003 |
| 16 | 195 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 17 | 196-197 | State Abbreviation | Character | 2 | Required | Must use the appropriate USPS State or Territory abbreviation. |  | 003 |
| 18 | 198 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 19 | 199-207 | Zip Code | Numeric | 9 | Required | Must use the USPS ZIP+4 format. If the last 4 digits are not available, then code them with 0000. |  | 003 |
| 20 | 208 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 21 | 209-210 | Parish Code | Numeric | 2 | Required | Must use a valid Louisiana Medicaid parish code value between ‘01’ and ‘64’ if in-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 fpr 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 | For changes and disenrollments, this record (identified by **Plan ID, NPI, Taxonomy and Site Number**) must already exist on the site registry. For new records, the record must not already exist on the site registry. | 005, 018, 019 |
| 38 | 372 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 39 | 373-380 | Submission Date | Numeric | 8 | Required | Must be a numeric date value in the format YYYYMMDD. | This is the date that you are submitting the record. | 006 |
| 40 | 381 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 41 | 382-389 | Site Enrollment Effective Begin Date | Numeric | 8 | Required | Must be a numeric date value in the format YYYYMMDD. | This is the effective begin date of the practice/site enrollment. You may not use zeros, and it must represent a valid date. | 009 |
| 42 | 390 | Delimiter | Character | 1 | Required | ^ |  | 023 |
| 43 | 391-398 | Site Enrollment Effective End Date | Numeric | 8 | Required | Must be a numeric date value in the format YYYYMMDD. | This is the effective end date of the practice/site enrollment. You may not use zeros, and it must represent a valid date.  Do not use zeros to indicate open-end; instead, use 20991231 to indicate open-end. The enrollment end date must be greater than or equal to the enrollment begin date. | 010 |
| 44 | 399 | END OF RECORD INDICATOR | Character | 1 | Required | ^ | If not present, the record will be rejected. | 023 |
|  |  |  |  |  |  |  |  |  |

**Error Messages**

       '000'='No errors found'

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

'002'='Provider record must include taxonomy'

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

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

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

'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 disenrolled'

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

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

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

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

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

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

**Error File Format**

Column Name Size Type

**1** BAYOU HEALTH Plan ID 7 numeric

**8** Delimiter 1 ^

**9** SUBMISSION TYPE 1 alphanumeric

**10** Delimiter 1 ^

**11** PROVIDER NPI 10 numeric

**21** Delimiter 1 ^

**22** PROVIDER NAME 30 alphanumeric

**52** Delimiter 1 ^

**53** PROVIDER TAXONOMY 10 alphanumeric

**63** Delimiter 1 ^

**64** SITE NUMBER 3 numeric

**67** Delimiter 1 ^

**68** ERROR INDICATOR 1 alphanumeric

**69** Delimiter 1 ^

**70** ERROR 1 3 numeric

**73** Delimiter 1 ^

**74** ERROR 2 3 numeric

**77** Delimiter 1 ^

**78** ERROR 3 3 numeric

**81** Delimiter 1 ^

**82** error 4 3 numeric

**85** Delimiter 1 ^

**86** ERROR 5 3 numeric

**89** Delimiter 1 ^

**90** ERROR 6 3 numeric

**93** Delimiter 1 ^

**94** ERROR 7 3 numeric

**97** Delimiter 1 ^

**98** ERROR 8 3 numeric

**101** Delimiter 1 ^

**102** ERROR 9 3 numeric

**105** Delimiter 1 ^

**106** ERROR 10 3 numeric

**109** Delimiter 1 ^

Appendix F

## Test Plan

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

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

## Testing Tier I

The first step in submitter testing is enrollment performed via Molina Electronic Data Interchange (EDI) Services, Inc. Each CCN must enroll with EDI to receive a Trading Partner ID in order to submit electronic claim data. In most cases, the CCNs will already have an ID, but are only permitted to receive electronic transactions; e.g. 834, 820, not to submit them. In this step, permission is granted for the CCNs to be able to both transmit and receive.

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

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

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

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

## Testing Tier II

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

## Testing Tier III

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

Appendix G

## Websites

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

| Website Address | Website Contents |
| --- | --- |
| <http://aspe.hhs.gov/admnsimp/> | This links to the **Department of Health and Human Services website regarding the Administrative Simplification provisions of HIPAA**. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA. |
| <http://www.lamedicaid.com>  or  <http://www.lmmis.com> | DHH FI Provider Web site  You need a valid Louisiana Medicaid Provider ID or CCN ID in order to register on the web site. Provider Applications (such as those used to upload and download files) are available on this web site to authorized, registered providers or CCN organizations.  Links available to CCN-S entities on the FI Provider Web site are:   * 820 File Download * Claims File Download * Provider Enrollment File Download * Provider Registry Upload * Provider Registry Error Report Download * Third-Party Liability Data Entry * Provider Negotiated Rates File Download * PA and Precert Requests History File * MMIS Claims Processing Information: * Procedure Codes Requiring PA * Diagnosis Codes Requiring Precert * CLIA File |
| <http://www.cms.gov> | This is the **CMS home page**. |
| <http://www.wedi.org/snip/> | This is the **Workgroup for Electronic Data Interchange website**. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions. |
| <http://www.ansi.org> | This is the **American National Standards Institute website** that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process. |
| <http://www.x12.org> | This is the **Data Interchange Standards Association website**. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level. |
| <http://www.nubc.org> | This is the **National Uniform Billing Committee website**. This site contains NUBC meeting minutes, activities, materials, and deliberations. |
| <http://www.nucc.org> | This is the **National Uniform Claims Committee website**. This site includes a data set identified by the NUCC for submitting non-institutional claims, claims, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations. |
| <http://HL7.org> | This site contains information on Logical Observation Identifier Names and Codes (LOINC) - **Health Level Seven (HL7)**. HL7 is being considered for requests for attachment information. |
| http://www.cms.hhs.gov/home/medicare.asp | This is the **Medicare EDI website**. At this site, you will find information regarding Medicare EDI, advantages to using Medicare EDI, Medicare EDI formats and instructions, news and events, frequently asked questions about Medicare EDI, and information regarding Medicare paper forms and instructions. |

Appendix H

## Common Data Element Values

The following common data element values are provided as references for useful information for CCN entities.

Type of Service (TOS)

|  |  |
| --- | --- |
| **TOS Code** | **Description** |
| **00** | Not applicable |
| **01** | Anesthesia |
| **02** | Assistant Surgeon |
| **03** | Full-Service Physician, Labs, NEMT, Lab 60%, PACE capitation |
| **04** | Adult Dental, 62% Lab |
| **05** | Professional Component |
| **06** | Pharmacy, Crossover Immuno Drugs |
| **07** | RHC, FQHC, CommunityCARE Enhanced, 0 – 15 y/o Enhanced |
| **08** | DEFRA, Lab 62%, Ambulatory Surgery, Outpatient Hospital Rehab |
| **09** | DME, Emergency Ambulance Services (EMT), Prenatal Care Clinic Services, EPSDT Case Management, VACP, Nurse Home Visits, Infants & Toddlers, HIV, High-Risk Pregnant Women, Vision Eyeglass Program, Personal Care Services(EPSDT), Rehabilitation Centers |
| **10** | Family Planning Clinics |
| **11** | Mental Health |
| **12** | School Boards and Early Intervention Centers |
| **13** | Office of Public Health (OPH) |
| **14** | Psychological and Behavioral Services (PBS) |
| **15** | Outpatient Ambulatory Surgical Services |
| **16** | Personal Attendant Services (PAS) -- Ticket to Work Program |
| **17** | Home Health |
| **18** | Expanded Dental Services for Pregnant Women (EDSPW) |
| **19** | Personal Care Services (LTC) |
| **20** | Enhanced Outpatient Rehab Services |
| **21** | EPSDT, EPSDT Dental |
| **22** | Childnet (Early Steps) |
| **23** | Waiver - Children's Choice |
| **24** | Waiver - ADHC |
| **25** | Waiver - EDA |
| **26** | Waiver - PCA |
| **27** | Special Purpose Facility |
| **28** | Center Based Special Purpose Facility |
| **29** | American Indian |
| **30** | Acute Care Outpatient Services |
| **31** | Family Planning Waiver |
| **32** | Supports Waiver |
| **33** | New Opportunity Waiver (NOW) |
| **34** | DME Special Rates |
| **35** | Residential Options Waiver (ROW) |
| **36** | Community Mental Health Center |
| **37** | Small Rural Hospital Outpatient |
| **38** | Adult Residential Care (ARC) |
| **39** | State Hospital Outpatient Services |
| **40** | Sole Community Hospital |
| **41** | Psychiatric Residential Treatment Facility |
| **42** | Mental Health Rehabilitation |
| **43** | LaPOP, Louisiana Personal Options Program |
| **44** | Pediatric Day Health Care Facility (PDHC) |
| **45** | Coordinated Care Network - Pre-paid (CCN-P) |
| **46** | Coordinated Care Network - Shared Services (CCN-S) |

Category of Service (COS)

|  |  |
| --- | --- |
| **State COS** | **Description** |
| **00** | Inpatient Service in TB Hospital |
| **01** | Inpatient Service in General Hospital |
| **02** | Inpatient Service in Mental Hospital |
| **03** | SNF Service |
| **04** | ICF-DD |
| **05** | ICF-I Service |
| **06** | ICF-II Service |
| **07** | Physician Services |
| **08** | Outpatient Hospital Services |
| **09** | Clinic - Hemodialysis |
| **10** | Clinic - Alcohol & Substance Abuse |
| **11** | Clinic - Mental Health |
| **12** | Clinic - Ambulatory Surgical |
| **13** | Rehab Services |
| **14** | Adult Day Care |
| **15** | Independent Lab |
| **16** | Chiropractic Services |
| **17** | Home Health |
| **18** | Prescribed Drugs and Immunizations by Pharmacists |
| **19** | Habilitation |
| **20** | DME (Appliances) |
| **21** | Rural Health Clinics |
| **22** | Family Planning Service |
| **23** | Non-Emergency Medical Transportation |
| **24** | Medical Transportation |
| **25** | Adult Dental Services |
| **26** | EPSDT - Screening Services |
| **27** | EPSDT - Dental |
| **28** | EPSDT - Other |
| **29** | Homemaker Services |
| **30** | Other Medical Services |
| **31** | Default |
| **32** | Administrative Error State Funds Only |
| **33** | Recovery Unidentified Services |
| **34** | EPSDT Health Services Non-School Board |
| **35** | Medical TPL |
| **36** | Title XIX Health Insurance Payment |
| **37** | Case Management |
| **38** | FQHC |
| **39** | PCA |
| **40** | Personal Health Care Clinic Services |
| **41** | HMO Over 65 |
| **42** | Rehab for Chronically Mentally Ill |
| **43** | Childrens' Choice Waiver |
| **44** | EPSDT - Personal Care Services |
| **45** | Dental Services for Pregnant Women |
| **46** | EPSDT Health Services |
| **47** | VD Clinic |
| **48** | TB Clinic |
| **49** | Title XIX Part-A Premium |
| **50** | Psychology |
| **51** | Audiology |
| **52** | Physical Therapy |
| **53** | Multi-Specialty Clinic Services |
| **54** | Certified Registered Nurse (CRNA) |
| **55** | Private Duty Nurse |
| **56** | Occupational Therapy |
| **57** | CM - HIV |
| **58** | CM - CMI |
| **59** | CM - PW |
| **60** | Rehab - ICF/DD |
| **61** | CM - DD |
| **62** | DD Waiver |
| **63** | CM - Infants & Toddlers |
| **64** | Home Care Elderly Waiver |
| **65** | Head Injury Maintenance Waiver |
| **66** | Hospice / NF |
| **67** | Social Worker Services |
| **68** | Contractors / CM |
| **69** | Nurse Home Visits - First Time Mothers Program |
| **70** | NOW Waiver |
| **71** | LTC - Personal Care Services |
| **72** | PAS - Personal Care Services |
| **73** | Early Steps |
| **74** | Behavior Management Services |
| **75** | PACE |
| **76** | American Indian/Native Alaskans |
| **77** | Family Planning Waiver |
| **78** | Support Waiver |
| **79** | Community Mental Health Center |
| **80** | Residential Options Waiver (ROW) |
| **81** | Coordinated Care Network |
| **91** | Coded for internal purposes only |
| **99** | LTC Administrative Cost |

Provider Type

|  |  |
| --- | --- |
| **Provider Type Code** | **Description** |
| **01** | Fiscal Agent - Waiver |
| **02** | Transitional Support - Waiver |
| **03** | Children's Choice - Waiver |
| **04** | Pediatric Day Health Care (PDHC) facility |
| **05** | CCN-P Organization (Coordinated Care Network, Pre-Paid) |
| **06** | NOW Professional (RN LPN PHD SW) |
| **07** | Case Mgmt - Infants & Toddlers |
| **08** | Case Mgmt - Elderly |
| **09** | Hospice Services |
| **10** | Comprehensive Community Support Services |
| **11** | Shared Living |
| **12** | Multi-Systemic Therapy |
| **13** | Pre-Vocational Habilitation |
| **14** | Adult Day Habilitation - Waiver |
| **15** | Environmental Modifications - Waiver |
| **16** | Personal Emergency Response Systems - Waiver |
| **17** | Assistive Devices - Waiver |
| **18** | Community Mental Health Center |
| **19** | Doctor of Osteopathy (DO) and Doctors of Osteopathy(DO) Group |
| **20** | Physician (MD) and Physician (MD) Group |
| **21** | EDI Billing Agent |
| **22** | Waiver Personal Care Attendant |
| **23** | Independent Lab |
| **24** | Personal Care Services (LTC/PCS/PAS) |
| **25** | Mobile X-Ray/Radiation Therapy Center |
| **26** | Pharmacy |
| **27** | Dentist and Dental Group |
| **28** | Optometrist and Optometrist Group |
| **29** | Title V Part C Agency Services(EarlySteps) |
| **30** | Chiropractor and Chiropractor Group |
| **31** | Psychologist |
| **32** | Podiatrist and Podiatrist Group |
| **33** | Prescribing Only Provider |
| **34** | Audiologist |
| **35** | Physical Therapist |
| **36** | Not in Use |
| **37** | Occupational Therapist |
| **38** | School-Based Health Center |
| **39** | Speech Therapist |
| **40** | DME Provider |
| **41** | Registered Dietician |
| **42** | Non-Emergency Medical Transportation |
| **43** | Case Mgmt - Nurse Home Visit - 1st Time Mother |
| **44** | Home Health Agency |
| **45** | Case Mgmt - Contractor |
| **46** | Case Mgmt - HIV |
| **47** | Case Mgmt - CMI |
| **48** | Case Mgmt - Pregnant Woman |
| **49** | Case Mgmt - DD |
| **50** | PACE Provider |
| **51** | Ambulance Transportation |
| **52** | CCN-S Organization (Coordinated Care Network, Shared Savings) |
| **53** | Not in Use |
| **54** | Ambulatory Surgical Center |
| **55** | Emergency Access Hospital |
| **56** | Not in Use: to-be used for Licensed Professional Counselor |
| **57** | Not in Use: to-be used for RN |
| **58** | Not in Use: to-be used for LPN |
| **59** | Neurological Rehabilitation Unit (Hosp) |
| **60** | Hospital |
| **61** | Venereal Disease Clinic |
| **62** | Tuberculosis Clinic |
| **63** | Tuberculosis Inpatient Hospital |
| **64** | Mental Health Hospital (Free-Standing) |
| **65** | Rehabilitation Center |
| **66** | KIDMED Screening Clinic |
| **67** | Prenatal Health Care Clinic |
| **68** | Substance Abuse and Alcohol Abuse Center |
| **69** | Hospital - Distinct Part Psychiatric Unit |
| **70** | EPSDT Health Services |
| **71** | Family Planning Clinic |
| **72** | Federally Qualified Health Center |
| **73** | Social Worker |
| **74** | Mental Health Clinic |
| **75** | Optical Supplier |
| **76** | Hemodialysis Center |
| **77** | Mental Health Rehabilitation |
| **78** | Nurse Practitioner |
| **79** | Rural Health Clinic (Provider Based) |
| **80** | Nursing Facility |
| **81** | Case Mgmt - Ventilator Assisted Care Program |
| **82** | Personal Care Attendant - Waiver |
| **83** | Respite Care (Center Based)- Waiver |
| **84** | Substitute Family Care - Waiver |
| **85** | ADHC Home and Community Based Services |
| **86** | ICF/DD Rehabilitation |
| **87** | Rural Health Clinic (Independent) |
| **88** | ICF/DD - Group Home |
| **89** | Supervised Independent Living - Waiver |
| **90** | Nurse-Midwife |
| **91** | CRNA or CRNA Group |
| **92** | Private Duty Nurse |
| **93** | Clinical Nurse Specialist |
| **94** | Physician Assistant |
| **95** | American Indian / Native Alaskan "638" Facilities |
| **96** | Psychiatric Residential Treatment Facility |
| **97** | Adult Residential Care |
| **98** | Supported Employment - Waiver |
| **99** | Not in Use |

Provider Specialty, Sub-specialty

|  |  |  |
| --- | --- | --- |
| **Specialty Code** | **Description** | **Type: 1=Specialty, 2=Subspecialty** |
| **00** | All Specialties | 1 |
| **01** | General Practice | 1 |
| **02** | General Surgery | 1 |
| **03** | Allergy | 1 |
| **04** | Otology, Laryngology, Rhinology | 1 |
| **05** | Anesthesiology | 1 |
| **06** | Cardiovascular Disease | 1 |
| **07** | Dermatology | 1 |
| **08** | Family Practice | 1 |
| **09** | Gynecology (DO only) | 1 |
| **10** | Gastroenterology | 1 |
| **11** | Not in Use | n/a |
| **12** | Manipulative Therapy (DO only) | 1 |
| **13** | Neurology | 1 |
| **14** | Neurological Surgery | 1 |
| **15** | Obstetrics (DO only) | 1 |
| **16** | OB/GYN | 1 |
| **17** | Ophthalmology, Otology, Laryngology, Rhinology (DO only) | 1 |
| **18** | Ophthalmology | 1 |
| **19** | Orthodontist | 1 |
| **20** | Orthopedic Surgery | 1 |
| **21** | Pathologic Anatomy; Clinical Pathology (DO only) | 1 |
| **22** | Pathology | 1 |
| **23** | Peripheral Vascular Disease or Surgery (DO only) | 1 |
| **24** | Plastic Surgery | 1 |
| **25** | Physical Medicine Rehabilitation | 1 |
| **26** | Psychiatry | 1 |
| **27** | Psychiatry; Neurology (DO only) | 1 |
| **28** | Proctology | 1 |
| **29** | Pulmonary Diseases | 1 |
| **30** | Radiology | 1 |
| **31** | Roentgenology, Radiology (DO only) | 1 |
| **32** | Radiation Therapy (DO only) | 1 |
| **33** | Thoracic Surgery | 1 |
| **34** | Urology | 1 |
| **35** | Chiropractor | 1 |
| **36** | Pre-Vocational Habilitation | 1 |
| **37** | Pediatrics | 1 |
| **38** | Geriatrics | 1 |
| **39** | Nephrology | 1 |
| **40** | Hand Surgery | 1 |
| **41** | Internal Medicine | 1 |
| **42** | Federally Qualified Health Centers | 1 |
| **43** | Not in Use | n/a |
| **44** | Public Health | 1 |
| **45** | NEMT - Non-profit | 1 |
| **46** | NEMT - Profit | 1 |
| **47** | NEMT - F+F | 1 |
| **48** | Podiatry - Surgical Chiropody | 1 |
| **49** | Miscellaneous (Admin. Medicine) | 1 |
| **50** | Day Habilitation | 1 |
| **51** | Med Supply / Certified Orthotist | 1 |
| **52** | Med Supply / Certified Prosthetist | 1 |
| **53** | Med Supply / Certified Prosthetist Orthotist | 1 |
| **54** | Med Supply / Not Included in 51, 52, 53 | 1 |
| **55** | Indiv Certified Orthotist | 1 |
| **56** | Indiv Certified Protherist | 1 |
| **57** | Indiv Certified Protherist - Orthotist | 1 |
| **58** | Indiv Not Included in 55, 56, 57 | 1 |
| **59** | Ambulance Service Supplier, Private | 1 |
| **60** | Public Health or Welfare Agencies & Clinics | 1 |
| **61** | Voluntary Health or Charitable Agencies | 1 |
| **62** | Psychologist Crossovers only | 1 |
| **63** | Portable X-Ray Supplier (Billing Independently) | 1 |
| **64** | Audiologist (Billing Independently) | 1 |
| **65** | Indiv Physical Therapist | 1 |
| **66** | Dentist, DDS, DMS | 1 |
| **67** | Oral Surgeon - Dental | 1 |
| **68** | Pedodontist | 1 |
| **69** | Independent Laboratory (Billing Independently) | 1 |
| **70** | Clinic or Other Group Practice | 1 |
| **71** | Speech Therapy | 1 |
| **72** | Diagnostic Laboratory | 1 |
| **73** | Social Worker Enrollment | 1 |
| **74** | Occupational Therapy | 1 |
| **75** | Other Medical Care | 1 |
| **76** | Adult Day Care | 1 |
| **77** | Habilitation | 1 |
| **78** | Mental Health Rehab | 1 |
| **79** | Nurse Practitioner | 1 |
| **80** | Environmental Modifications | 1 |
| **81** | Case Management | 1 |
| **82** | Personal Care Attendant | 1 |
| **83** | Respite Care | 1 |
| **84** | Substitute Family Care | 1 |
| **85** | Extended Care Hospital | 1 |
| **86** | Hospitals and Nursing Homes | 1 |
| **87** | All Other | 1 |
| **88** | Optician / Optometrist | 1 |
| **89** | Supervised Independent Living | 1 |
| **90** | Personal Emergency Response Sys (Waiver) | 1 |
| **91** | Assistive Devices | 1 |
| **92** | Prescribing Only Providers | 1 |
| **93** | Hospice Service for Dual Elig. | 1 |
| **94** | Rural Health Clinic | 1 |
| **95** | Psychologist (PBS Program Only) | 1 |
| **96** | Psychologist (PBS Program and X-Overs) | 1 |
| **97** | Family Planning Clinic | 1 |
| **98** | Supported Employment | 1 |
| **99** | Provider Pending Enrollment | 1 |
| **1A** | Adolescent Medicine | 2 |
| **1B** | Diagnostic Lab Immunology | 2 |
| **1C** | Neonatal Perinatal Medicine | 2 |
| **1D** | Pediatric Cardiology | 2 |
| **1E** | Pediatric Critical Care Medicine | 2 |
| **1F** | Pediatric Emergency Medicine | 2 |
| **1G** | Pediatric Endocrinology | 2 |
| **1H** | Pediatric Gastroenterology | 2 |
| **1I** | Pediatric Hematology - Oncology | 2 |
| **1J** | Pediatric Infectious Disease | 2 |
| **1K** | Pediatric Nephrology | 2 |
| **1L** | Pediatric Pulmonology | 2 |
| **1M** | Pediatric Rheumatology | 2 |
| **1N** | Pediatric Sports Medicine | 2 |
| **1P** | Pediatric Surgery | 2 |
| **1S** | BRG - Med School | 2 |
| **1T** | Emergency Medicine | 1 |
| **1Z** | Pediatric Day Health Care | 1 |
| **2A** | Cardiac Electrophysiology | 2 |
| **2B** | Cardiovascular Disease | 2 |
| **2C** | Critical Care Medicine | 2 |
| **2D** | Diagnostic Laboratory Immunology | 2 |
| **2E** | Endocrinology & Metabolism | 2 |
| **2F** | Gastroenterology | 2 |
| **2G** | Geriatric Medicine | 2 |
| **2H** | Hematology | 2 |
| **2I** | Infectious Disease | 2 |
| **2J** | Medical Oncology | 2 |
| **2K** | Nephrology | 2 |
| **2L** | Pulmonary Disease | 2 |
| **2M** | Rheumatology | 2 |
| **2N** | Surgery - Critical Care | 2 |
| **2P** | Surgery - General Vascular | 2 |
| **2R** | Physician Assistant | 1 |
| **2S** | LSU Medical Center New Orleans | 2 |
| **2T** | American Indian / Native Alaskan | 2 |
| **2Y** | OPH Genetic Disease Program | 1 |
| **3A** | Critical Care Medicine | 2 |
| **3B** | Gynecologic oncology | 2 |
| **3C** | Maternal & Fetal Medicine | 2 |
| **3S** | LSU Medical Center Shreveport | 2 |
| **4A** | Developmental Disability | 1 |
| **4B** | NOW RN | 1 |
| **4C** | NOW LPN | 1 |
| **4D** | NOW Psychologist | 1 |
| **4E** | NOW Social Worker | 1 |
| **4R** | Registered Dietician | 1 |
| **4S** | Ochsner Med School | 2 |
| **4X** | Waiver-Only Transportation | 1 |
| **4W** | Waiver Services | 1 |
| **5A** | PCS-LTC | 1 |
| **5B** | PCS-EPSDT | 1 |
| **5C** | PAS | 1 |
| **5D** | PCS-LTC, PCS-EPSDT | 1 |
| **5E** | PCS-LTC, PAS | 1 |
| **5F** | PCS-EPSDT, PAS | 1 |
| **5G** | OCS-LTC, PCS-EPSDT, PAS | 1 |
| **5H** | Community Mental Health Center |  |
| **5M** | Multi-Systemic Therapy |  |
| **5P** | PACE | 1 |
| **5Q** | CCN-P (Coordinated Care Network, Pre-paid) |  |
| **5R** | CCN-S (Coordinated Care Network, Shared Savings) | 1 |
| **5S** | Tulane Med School | 2 |
| **6A** | Psychologist -Clinical | 1 |
| **6B** | Psychologist-Counseling | 1 |
| **6C** | Psychologist - School | 1 |
| **6D** | Psychologist - Developmental | 1 |
| **6E** | Psychologist - Non-Declared | 1 |
| **6F** | Psychologist - All Other | 1 |
| **6H** | LaPOP | 1 |
| **6N** | Endodontist | 1 |
| **6P** | Periodontist | 1 |
| **6S** | E Jefferson Fam Practice Ctr - Residency Program | 2 |
| **7A** | SBHC - NP - Part Time - less than 20 hrs week | 1 |
| **7B** | SBHC - NP - Full Time - 20 or more hrs week | 1 |
| **7C** | SBHC - MD - Part Time - less than 20 hrs week | 1 |
| **7D** | SBHC - MD - Full Time - 20 or more hrs week | 1 |
| **7E** | SBHC - NP + MD - Part Time - combined less than 20 hrs week | 1 |
| **7F** | SBHC - NP + MD - Full Time - combined less than 20 hrs week | 1 |
| **7M** | Retail Convenience Clinics | 2 |
| **7N** | Urgent Care Clinics | 2 |
| **7S** | Leonard J Chabert Medical Center - Houma | 2 |
| **8A** | EDA & DD services | 2 |
| **8B** | EDA services | 2 |
| **8C** | DD services | 2 |
| **9B** | Psychiatric Residential Treatment Facility | 1 |
| **9D** | Residential Care | 1 |
| **9E** | Children's Choice Waiver | 1 |
| **9L** | RHC/FQHC OPH Certified SBHC | 1 |
| **9Q** | PT 21 - EDI Independent Billing Company | 2 |
| **9U** | Medicare Advantage Plans | 1 |
| **9V** | OCDD - Point of Entry | 1 |
| **9W** | OASS - Point of Entry | 1 |
| **9X** | OAD | 1 |
| **9Z** | Other Contract with a State Agency | 1 |

Region

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

GSA

GSA - A is comprised of Regions 1 and 9

GSA - B is comprised of Regions 2, 3, and 4

GSA - C is comprised of Regions 5, 6, 7 and 8.

Parish

|  |  |  |
| --- | --- | --- |
| **Parish Code** | **Recipient Parish Description** | **Recipient Medicaid Region** |
| **01** | ACADIA | 4 |
| **02** | ALLEN | 5 |
| **03** | ASCENSION | 2 |
| **04** | ASSUMPTION | 3 |
| **05** | AVOYELLES | 6 |
| **06** | BEAUREGARD | 5 |
| **07** | BIENVILLE | 7 |
| **08** | BOSSIER | 7 |
| **09** | CADDO | 7 |
| **10** | CALCASIEU | 5 |
| **11** | CALDWELL | 8 |
| **12** | CAMERON | 5 |
| **13** | CATAHOULA | 6 |
| **14** | CLAIBORNE | 7 |
| **15** | CONCORDIA | 6 |
| **16** | DESOTO | 7 |
| **17** | EAST BATON ROUGE | 2 |
| **18** | EAST CARROLL | 8 |
| **19** | EAST FELICIANA | 2 |
| **20** | EVANGELINE | 4 |
| **21** | FRANKLIN | 8 |
| **22** | GRANT | 6 |
| **23** | IBERIA | 4 |
| **24** | IBERVILLE | 2 |
| **25** | JACKSON | 8 |
| **26** | JEFFERSON | 1 |
| **27** | JEFFERSON DAVIS | 5 |
| **28** | LAFAYETTE | 4 |
| **29** | LAFOURCHE | 3 |
| **30** | LASALLE | 6 |
| **31** | LINCOLN | 8 |
| **32** | LIVINGSTON | 9 |
| **33** | MADISON | 8 |
| **34** | MOREHOUSE | 8 |
| **35** | NATCHITOCHES | 7 |
| **36** | ORLEANS | 1 |
| **37** | OUACHITA | 8 |
| **38** | PLAQUEMINES | 1 |
| **39** | POINTE COUPEE | 2 |
| **40** | RAPIDES | 6 |
| **41** | RED RIVER | 7 |
| **42** | RICHLAND | 8 |
| **43** | SABINE | 7 |
| **44** | ST BERNARD | 1 |
| **45** | ST CHARLES | 3 |
| **46** | ST HELENA | 9 |
| **47** | ST JAMES | 3 |
| **48** | ST JOHN | 3 |
| **49** | ST LANDRY | 4 |
| **50** | ST MARTIN | 4 |
| **51** | ST MARY | 3 |
| **52** | ST TAMMANY | 9 |
| **53** | TANGIPAHOA | 9 |
| **54** | TENSAS | 8 |
| **55** | TERREBONNE | 3 |
| **56** | UNION | 8 |
| **57** | VERMILION | 4 |
| **58** | VERNON | 6 |
| **59** | WASHINGTON | 9 |
| **60** | WEBSTER | 7 |
| **61** | WEST BATON ROUGE | 2 |
| **62** | WEST CARROLL | 8 |
| **63** | WEST FELICIANA | 2 |
| **64** | WINN | 6 |
| **87** | Texas | 10 |
| **88** | Mississippi | 11 |
| **89** | Arkansas | 12 |
| **90** | Texas Border County | 10 |
| **91** | Mississippi Border County | 11 |

|  |  |  |
| --- | --- | --- |
| **92** | Arkansas Border County | 12 |
| **99** | Other Out-of-State | 13 |

**Pricing Action Code (PAC)**

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

Appendix I

## Louisiana MMIS Claims Processing Edits

This list of edits is not complete, but demonstrates the edit dispositions as researched by DHH, Mercer and Molina.

Standard edits, such as recipient eligibility on DOS and provider enrollment on DOS still apply.

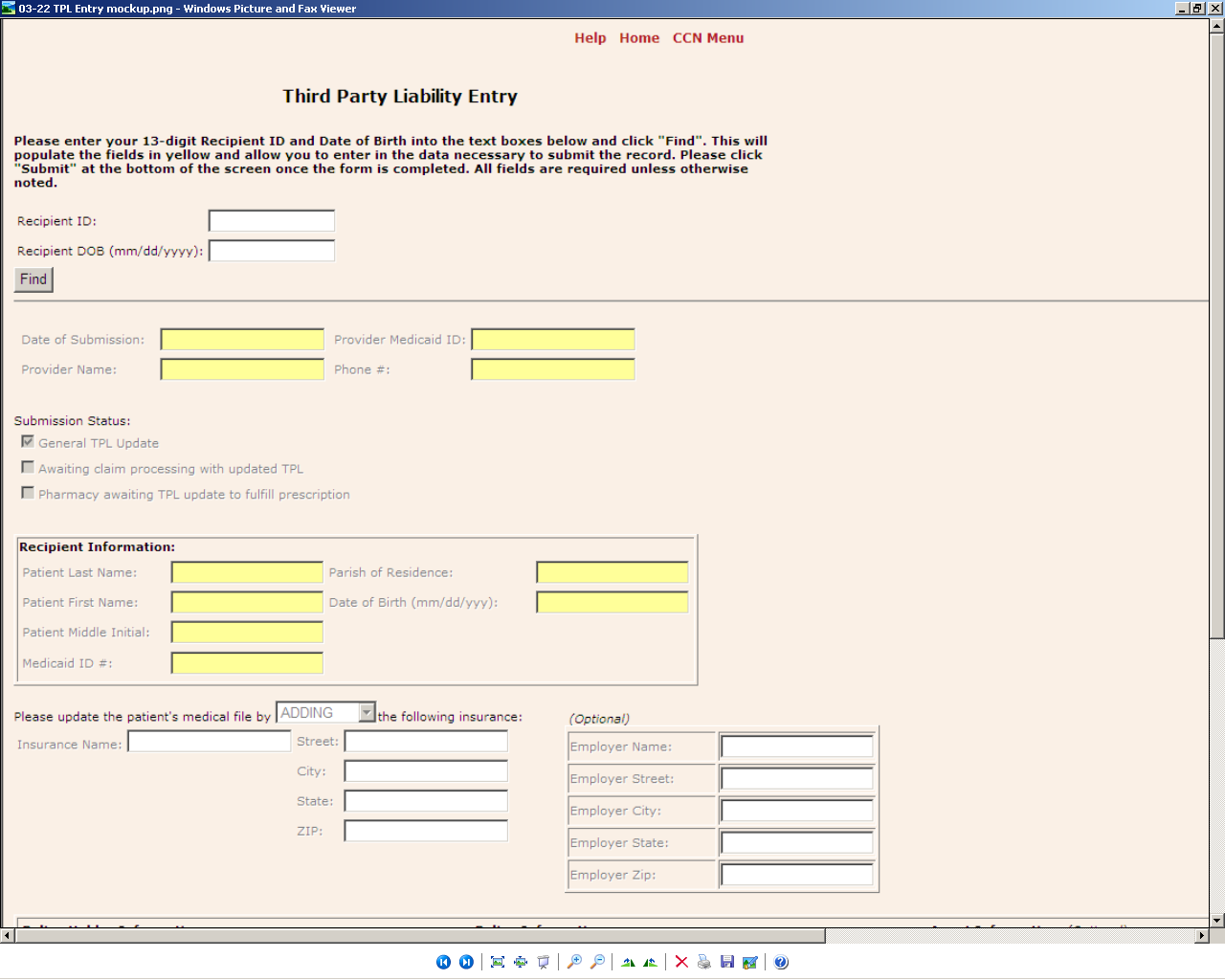
The following list of edits was updated on 11/29/2011 as a result of a meeting with DHH and Molina SMEs that occurred on 11/18/2011. This list is subject to change.

|  |  |  |  |
| --- | --- | --- | --- |
| **CCN Status values:**  **P=Pend, D=Deny, E=Educational, O=Off, T=Test (error is not set).** | | |  |
|  |  |  |  |
| **Edit Code** | **Short Description** | **Long Description** | **CCNS Status** |
| **010** | **INV PRIOR AUTH DATE** | **PRIOR AUTHORIZATION DATE NOT NUMERIC** | **O** |
| 076 | INVALID-DME-PA-AMOUNT | INVALID DME PA AMOUNT (PRIOR AUTHORIZATION AMOUNT NOT NUMERIC) | P |
| 078 | RESUB W/ DOCUMENTS | RESUB W/ DOCUMNTS CALL 800-473-2783 (Transplants) | O |
| 106 | BILL PRV NOT PCP | BILLING PROVIDER NOT PCP OR SERVICE NOT AUTHOR BY PCP | D |
| 110 | REBILL OB/ABORT D&C | REBILL OB OR ABORTION D & C CPT CODE WITH REPORTS | O |
| 147 | REF/PCP NPI NO MATCH | REFERRING/PCP NPI MISMATCH | E |
| 160 | PRECERT-NOT-ON-FILE | PRECERT NUMBER NOT ON FILE | O |
| 161 | HOSP-STAY-REQUIRES-PRECERT | HOSPITAL STAY REQUIRES PRECERTIFICATION | D |
| 162 | PRECERT-NOT-APPROVED | PRECERT NOT APPROVED | O |
| 163 | CLAIM-DOS-NOT-PRECERT-COVERED | CLAIM DATE OF SERVICE NOT PRECERT COVERED | O |
| 164 | CLAIM > PRECERT LOS | CLAIM EXCEEDS PRECERT AUTHORIZED DAYS | O |
| 165 | SURG-REQUIRES-PRECERT | SURGERY REQUIRES PRECERT | O |
| 166 | PRECERT-RECIP-NOT-MATCHED | CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRECERT FILE | O |
| 167 | PRECERT-PROV-NOT-MATCHED | CLAIM PROVIDER ID DOES NOT MATCH ID ON PRECERT FILE | O |
| 168 | PRECRT SURG DATE ERR | CLAIM SURGERY DATE DOES NOT MATCH DATE ON PRECERT FILE | O |
| 169 | CUTBACK-TO-PRECERT-DAYS | DAYS CUTBACK TO PRECERT APPROVED DAYS | O |
| 170 | PRECERT-PEND-REVIEW | PRECERT PEND REVIEW | O |
| 171 | PRECERT-NOF-RESUBMIT | NO HOSPITAL PRECERT ON FILE; RESUBIT WITH DOCUMENTATION | O |
| 172 | CLM/PA DTE MUST MTCH | CLAIM DATES MUST MATCH PRIOR AUTHORIZATION DATES | O |
| **187** | **PA-THRU-CLAIM-THRU-NOT-SAME** | **CLAIM THRU DOS MUST = PA 30 DAY THRU PERIOD** | **O** |
| **189** | **PUT PA# IN BLOCK 23** | **CORRECT PA# MUST BE IN BLOCK 23 ON CLAIM** | O |
| 190 | PA-NOT-ON-FILE | PA NUMBER NOT ON FILE | O |
| 191 | PROC-REQUIRES-PRIOR-AUTH | PROCEDURE REQUIRES PRIOR AUTHORIZATION | D |
| 192 | PA-NOT-APPROVED | PA HAS NOT BEEN APPROVED | O |
| 193 | CLAIM-DATE-NOT-PA-COVERED | DATE ON CLAIM NOT COVERED BY PA | O |
| 194 | PA-ALREADY-CONSUMED | CLAIM EXCEEDS PRIOR AUTHORIZED LIMITS | O |
| 195 | PA-TOTAL-NOT-SPANNED | MUST HAVE SPANNING DOS IF BILLING FOR TOTAL AUTHORIZATION AMOUNT | D |
| 196 | PA-RECIP-ID-NOT-MATCHED | CLAIM RECIPIENT ID DOES NOT MATCH ID ON PRIOR AUTHORIZATION FILE | O |
| 197 | PA-PROV-NOT-MATCHED | PA PROVIDER ID NOT SAME AS CLAIM PROVIDER ID | O |
| 198 | PA-PROC-NOT-MATCHED | PA PROCEDURE NOT SAME AS CLAIM PROCEDURE | O |
| 203 | PROVIDER ON REVIEW | PROVIDER ON REVIEW | P |
| 214 | PROV-ALLOW-ONE-PROC | PROVIDER ALLOWED 1 SERVICE PER RECIPIENT PER DAY | D |
| 227 | POSSIBLE-707 | POSSIBLE 707 PEND (CLAIM IN PROCESS) | O |
| 228 | POSSIBLE-713 | POSSIBLE 713 PEND (CLAIM IN PROCESS) | O |
| 229 | POSSIBLE-714 | POSSIBLE 714 PEND (CLAIM IN PROCESS) | O |
| 237 | P/F PROV SPEC RESTRT | P/F PROVIDER SPECIALTY RESTRICTION | P |
| 246 | STAND-BY-CHGS | PROLONGED ATTENDANCE BILLED; PENDED FOR REVIEW | O |
| 249 | SURG-REQ-REVIEW | SURGERY REQUIRES REVIEW FOR ATTACHMENTS | E |
| 250 | DIAG-REQ-REVIEW | DIAGNOSIS/PROCEDURE REQUIRES REVIEW | E |
| 251 | DENIED-DUE-TO-DIAG | PROCEDURE DENIED; NOT JUSTIFIED BY DIAGNOSIS | D |
| 259 | ANESTH-UNITS-REQ-REVIEW | ANESTHESIA UNITS/MINUTES REQUIRE MEDICAL REVIEW | O |
| 260 | ANESTHESIA-UNITS-NOF | ANESTHESIA BASE UNITS ARE NOT ON FILE | P |
| 263 | PROCEDURE-AGE-RESTRT | PROCEDURE ALLOWED FOR RECIP 0-30 DAYS OLD | O |
| 264 | PA-01 REQUIRES REVIE | PA-01 FORM REQUIRES REVIEW FOR VALIDITY | O |
| 265 | SURG REQUIRES PA-0 | SURGERY DONE AS IP REQUIRES VALID PA-01 FORM | D |
| 280 | MANUAL-PRICE-PEND | MANUAL PRICING REQUIRED/HARD COPY BILL | P |
| 284 | MANUAL-PRICE-GR-BILLED | MANUAL PRICE EXCEEDS BILLED CHARGES | P |
| 285 | PAYMENT-GR-BILL-CHARGE | PAYMENT EXCEEDS BILLED CHARGES/REQUIRES REVIEW | P |
| 320 | REF-ASSIST-MISS-REF1 | REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 1 | O |
| 323 | REF-ASSIST-MISS-REF2 | REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 2 | O |
| 324 | REF-ASSIST-MISS-REF3 | REFERRAL ASSISTANCE MISSING AND REQUIRED FOR REFERRAL 3 | O |
| 331 | ABORTION JUST | DOES NOT MEET PROGRAM CRITERIA FOR ABORTION | E |
| 332 | STERILIZATION < 21 | STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21 | D |
| 333 | AUTH MINOR UNM MO | FOUND NO DOCUMENT/OVERRIDE CODE MINOR UNM MOTHER/UNBORN | O |
| 334 | CONSENT 30/180 DAYS | CONSENT MUST BE AT LEAST 30 DAYS BUT NO MORE THAN 180 DAYS | O |
| 335 | SERVICE LIMIT REVIEW | ATTACHMENT REVIEW SERVICE LIMITS | O |
| 336 | ABORTION-REQUIRES-REVIEW | ABORTION REQUIRES REVIEW | O |
| 337 | STERILIZATION-REQUIRES-REVIEW | STERILIZATION OFS FORM 96 REQUIRES REVIEW | O |
| 338 | HYSTERECTOMY-REQUIRES-REVIEW | HYSTERECTOMY REQUIRES REVIEW | O |
| 347 | EXCEEDS MAX 23 DAYS | EXCEEDS MAXIMUM MONTHLY DAYS | D |
| 368 | REASON-REF-MISS-REF1 | REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 1 | O |
| 390 | SERV MAX 1 PER MO | SERVICE EXCEEDS MAXIMUM ALLOWABLE OF 1 PER MONTH | D |
| 399 | REASON-REF-MISS-REF2 | REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 2 | O |
| 400 | REFER-PHYS-REQD | REFERRING/ATTENDING PHYSICIAN REQUIRED | O |
| 402 | NO-SERV-EXCEEDS-MAX | NUMBER OF SERVICES EXCEEDS STATE MAX/ CUTBACK APPLIED | E/D |
| 403 | MULTIPLE SURGERY | MULTIPLE SURGERY - PENDED FOR MANUAL PRICING | O |
| 406 | EXCEEDS TREATMENTS | EXCEEDS 3 CHIRO TREATMENTS SAME DAY | D |
| 410 | REASON-REF-MISS-REF3 | REASON FOR REFERRAL MISSING AND REQUIRED FOR REFERRAL 3 | O |
| 411 | REF-NAME-MISS-REF1 | REFERRED TO NAME IS MISSING AND REQUIRED FOR REFERRAL 1 | O |
| 412 | REF-NAME-MISS-REF2 | REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #2 | O |
| 413 | DME-REQUIRES-PRIOR-AUTH | DME REQUIRES PRIOR AUTHORIZATION | O |
| 414 | REF-NAME-MISS-REF3 | REFERRED TO NAME MISSING AND REQUIRED FOR REFERRAL #3 | O |
| 415 | PA AMOUNT GR LEVEL3 | PRIOR AUTHORIZED AMOUNT GREATER THAN LEVEL 3 CHARGE | O |
| 416 | REF-PHONE-MISS-REF1 | REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #1 | O |
| 417 | REF-PHONE-MISS-REF2 | REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #2 | O |
| 418 | REF-PHONE-MISS-REF3 | REFERRED TO PHONE IS MISSING/REQUIRED FOR REFERRAL #3 | O |
| 419 | OFS REV PA DT GT DOS | OFS TO REVIEW-PA DATE GREATER THAN SERVICE DATE | O |
| 422 | ONE H.HLTH NURSE/DAY | ONLY ONE HOME HEALTH NURSE VISIT ALLOWED PER DAY | O |
| 423 | ONE H.HLTH AIDE/DAY | ONLY ONE HOME HEALTH AIDE VISIT ALLOWED PER DAY | O |
| 468 | JUSTIFY EYEGLASSES | SEND DOCUMENTATION FOR MORE THAN 3 EYEGLASSES PER YEAR | O |
| 469 | EYEWEAR DENIED | LIMITATION MET - SUBMIT JUSTIFICATION FOR ADD'L EYEWEAR | E |
| 470 | SUBMIT-ANESTH-DOC | ATTACH ANESTHESIA RECORD AND DOCUMENT MEDICAL NECESSITY | O |
| 477 | JUSTIFY OVER 1/A/YR | SEND DOC TO JUSTIFY OVER ONE PROCEDURE PER YEAR | O |
| 478 | SONOGRAM-AND REPORTS | SEND WRITTEN SONOGRAM RESULTS WITH OP PATH AND HISTORY | E |
| 488 | ONLY-1ST DIAG,VS PD | KELOID TREATMENT-ONLY FIRST DIAGNOSTIC VISIT IS PAID | E |
| 496 | DOC MEDICA NECESSITY | SUBMIT DOCUMENTATION TO WARRANT MEDICAL NECESSITY | O |
| 510 | ALLOW 1 PER 7 YEARS | ONLY 1 OF THESE PROCS IN 7 YEARS PER RECIP/PROVIDER | D |
| 512 | VNS REPROGRAMMING | SUBMIT MEDICAL DOCUMENTATION TO JUSTIFY REPROGRAMMING | O |
| 533 | EXCEEDS MAX ER REVS | EXCEEDS MAXIMUM ER REVENUE CODES PER VISIT | O |
| 534 | PA-APRVD-PROC-DELETED | PRIOR AUTHORIZATION APPROVED PRIOR TO DELETION OF PROCEDURE CODE | O |
| 538 | REVIEW-DIAG-MED | REVIEW DIAGNOSIS AND/OR ATTACHMENT FOR MEDICAL NECESSITY | D |
| 542 | UNITS EXCEED DAILY MAX | UNITS EXCEED MAXIMUM ALLOWED DAILY LIMIT | D |
| 564 | MAX EXCEEDS LIFETIME | MAXIMUM SERVICES EXCEEDED-LIFETIME/CLAIMCHECK | D |
| 565 | MAX SERVICE SAME DAY | MAXIMUM SERVICES EXCEEDED SAME DAY/CLAIMCHECK | D |
| 597 | PA/CLM MOD NOT SAME | PA MODIFIER DOES NOT MATCH CLAIM MODIFIER | D |
| 599 | SONOS NOT JUST | DOCUMENTATION DOES NOT JUSTIFY ADDITIONAL SONOGRAMS | O |
| 616 | ONE PANEL/PREGNANCY | ONLY ONE PRENATAL LAB PANEL PER PREGNANCY | D |
| 620 | PAN & IND CODE/ PANE | ONE URINALYSIS PER PREGNANCY PAYABLE | D |
| 621 | RESUBMIT-WITH-REPORTS | RESUBMIT WITH OPERATIVE AND PATHOLOGY REPORTS AND HISTORY | O |
| 623 | EXCEEDS ONE PER YEAR | SEND DOCUMENTAION TO JUSTIFY MORE THAN ONE PER YEAR | O |
| 625 | MED NEC INSUFFICIENT | DOCUMENTATION OF MEDICAL NECESSITY INSUFFICIENT | D |
| 627 | SEND MED NECESSITY | SEND PROOF OF MEDICAL NECESSITY AND EPSDT REFERRAL | O |
| 628 | NEED EPSDT & MED NEC | NEED EPSDT REFERRAL AND PROOF OF MEDICAL NECESSITY | O |
| 640 | EXCEEDS MAX,PHYS,YRS | EXCEEDS MAXIMUM ALLOWED BY SAME PHYSICIAN W/I 3 YEARS | E |
| 641 | EXCEEDS MAX/HOSPITAL | EXCEEDS MAXIMUM ALLOWED PER HOSPITALIZATION | E |
| 642 | 1 CONSLT/PHYS/HOSP | ONLY 1 INITIAL CONSULT-SAME PHYS.PER HOSPITALIZATION | E |
| 643 | EXCEEDS DAY MAX VISI | EXCEEDS DAILY MAXIMUM ALLOWED VISITS | E |
| 646 | EXCEEDS DAY MAX VISI | EXCEEDS DAILY MAXIMUM VISITS PER PROVIDER/SPECIALTY | E |
| 664 | 1 PAYABLE/180 DAYS | ONLY ONE (1) PAYABLE PER 180 DAYS | E |
| 696 | PROBLEM CODE PD 2YRS | PROBLEM ORIENTED CODE PAID WITHIN 2 YEARS | O |
| 709 | STERILIZATION-REVIEW | STERILIZATION CONSENT FORM INCORRECT/ILLEGIBLE | O |
| 712 | INITIAL HOSP INPT PD | ONE INITIAL HOSPITAL INPATIENT SERVICE PAID PER ADMISS | D |
| 715 | 2ND. VISIT SAME DAY | FOUND DUPLICATE VISIT SAME DAY | O |
| 726 | MULTIPLE SURGERY | MULTIPLE SURGERY-PENDED FOR REVIEW | O |
| 727 | EXCEEDS DAILY MAX | EXCEEDS DAILY SERVICE MAXIMUM | E |
| **730** | **1 INP HSP VST PER DA** | **ONE INP HOSP INITIAL/SUBSEQ CARE VISIT ALLOWED PER DAY** | **O** |
| 734 | EXCEEDS-MAX-UNITS-AL | RECIPIENT HAS EXCEEDED MAXIMUM ALLOWED SERVICES PER 6MO | E |
| 739 | EXCEEDS-MAX-UNITS-AL | RECIPIENT HAS EXCEEDED MAXIMUM ALLOWED SERVICES PER YR | E |
| 742 | ALLOW 1 PER 5 YEARS | ONLY 1 OF THESE PROCS ALLOWED IN 5 YEARS PER RECIP/PROV | D |
| 743 | PREG EXCEEDED | MAX PER PREGNANCY EXCEEDED | O |
| 745 | 1/PREG-158A NEEDED | ONE ALLOWED/PREG.;158-A NEEDED FOR UNUSUAL SITUATIONS | O |
| 748 | 1 DEL.ALLOW. 6MTH.SP | ONLY 1 DELIVERY ALLOWED IN 6 MONTH SPAN | D |
| 751 | HYSTERECTOMY-REVIEW | HYSTERECTOMY REQUIRED ACKNOWLEDGEMENT OR PROOF PREVIOUSLY STERILE | O |
| 752 | TL NEEDS OFS 96 | STERILIZATION REQUIRES OFS FORM 96. | O |
| 754 | RVW READMIT/DSCHG DX | PEND FOR REVIEW OF READMIT/DISCHARGE DIAGNOSIS | E |
| 756 | DOC/READMIT SAME DAY | RESUBMIT WITH DOCUMENTATION OF DISC/READMIT SAME DATE | E |
| 761 | SEND DATED OP REPORT | SEND DATED OPERATIVE REPORT FOR DATE BILLED | O |
| 762 | SEND DATED NOTES | SEND SPECIFIC DATED NOTES FOR EACH DATE BILLED | O |
| 769 | REFERRED TO P.A. | TO BE REVIEWED BY PRIOR AUTHORIZATION;DO NOT RESUBMIT | O |
| 770 | PERTINENT HIST/REQ | RESUBMIT WITH PERTINENT HISTORY | O |
| 771 | SEND L & D RECORDS | RESUBMIT WITH LABOR AND DELIVERY RECORDS | O |
| 778 | CIRCLE UNLISTED DESC | CIRCLE UNLISTED CODE DESCRIPTION IN-OPERATIVE REPORT | O |
| 782 | SEND DATED NOTES | EXCEEDS SONOGRAMS/PREGNANCY IN 270 DAYS | O |
| 783 | EXCEEDS SONOS/270DAY | JUSTIFY ADDITIONAL SONOGRAMS W PERTINENT DATED NOTES | E |
| **784** | **EXCEEDS MO LIMIT** | **EXCEEDS MONTHLY LIMIT** | **O** |
| 785 | SERV REV/CHIRO CNSLT | SERVICE LIMIT REVIEW BY CHIROPRACTIC CONSULTANT | O |
| 786 | UNKNOWN ABBREVATION | RESUBMIT WITH ABBREVATION LEGEND | O |
| 900 | LIFETIME LIMITS-ONE | ONLY 1 NEWBORN HOSPITAL CARE PER RECIPIENT ALLOWED | O |
| 901 | UNITS WERE CUTBACK | SERVICE LIMITS EXCEEDED - PARTIAL/FULL CUTBACK APPLIED | E |
| 904 | SVC BEYOND TIME LIM | SERVICE PERFORMED BEYOND REQUIRED TIME SPECIFICATIONS | O |
| 906 | EXCEEDS MAX ALLOWED | EXCEEDS MAMIMUM ALLOWED | E |
| 907 | PHY/CLINIC OVER MAX | PHYSICIAN/CLINIC VISITS EXCEEDS ANNUAL MAXIMUM | E |
| 908 | HH VISITS OVER 50 | HOME HEALTH VISITS EXCEEDS ANNUAL MAXIMUM ALLOWED (50) | D |
| 911 | HOSP DAYS OVER MAX | HOSPITAL DAYS EXCEED ANNUAL MAXIMUM ALLOWED | O |
| 913 | PHY/HOSP VIS OVER MX | PHYSICIAN HOSPITAL VISITS EXCEED ANNUAL MAXIMUM | O |
| **915** | **EMERG OP OVER 3** | **EMERGENCY OUTPATIENT VISITS EXCEED ANNUAL MAXIMUM (3)** | **O** |
| **916** | **NON-EMER OP OVER 12** | **NON-EMERGENCY OUTPATIENT VISITS EXCEED MAXIMUM (12)** | **O** |
| 917 | OVER LIFETIME LIMIT | LIFETIME LIMITS FOR THIS SERVICE HAVE BEEN EXCEEDED | D |
| 923 | CHIROP E&M VISIT MAX | CHIROPRACTIC E & M VISIT MAX REACHED | D |
| 950 | OPERATIVE-REQUESTED | ATTACH BOTH OPERATIVE AND HISTORY REPORT | O |
| 957 | PROC/DIAG NO MED NEC | PROCEDURE/DIAGNOSIS NOT MEDICALLY NECESSARY | E |
| 960 | NEED-AUTH-AND-REPORT | ATTACH BHSF AUTHORIZATION LETTER AND OPERATIVE REPORT | E |

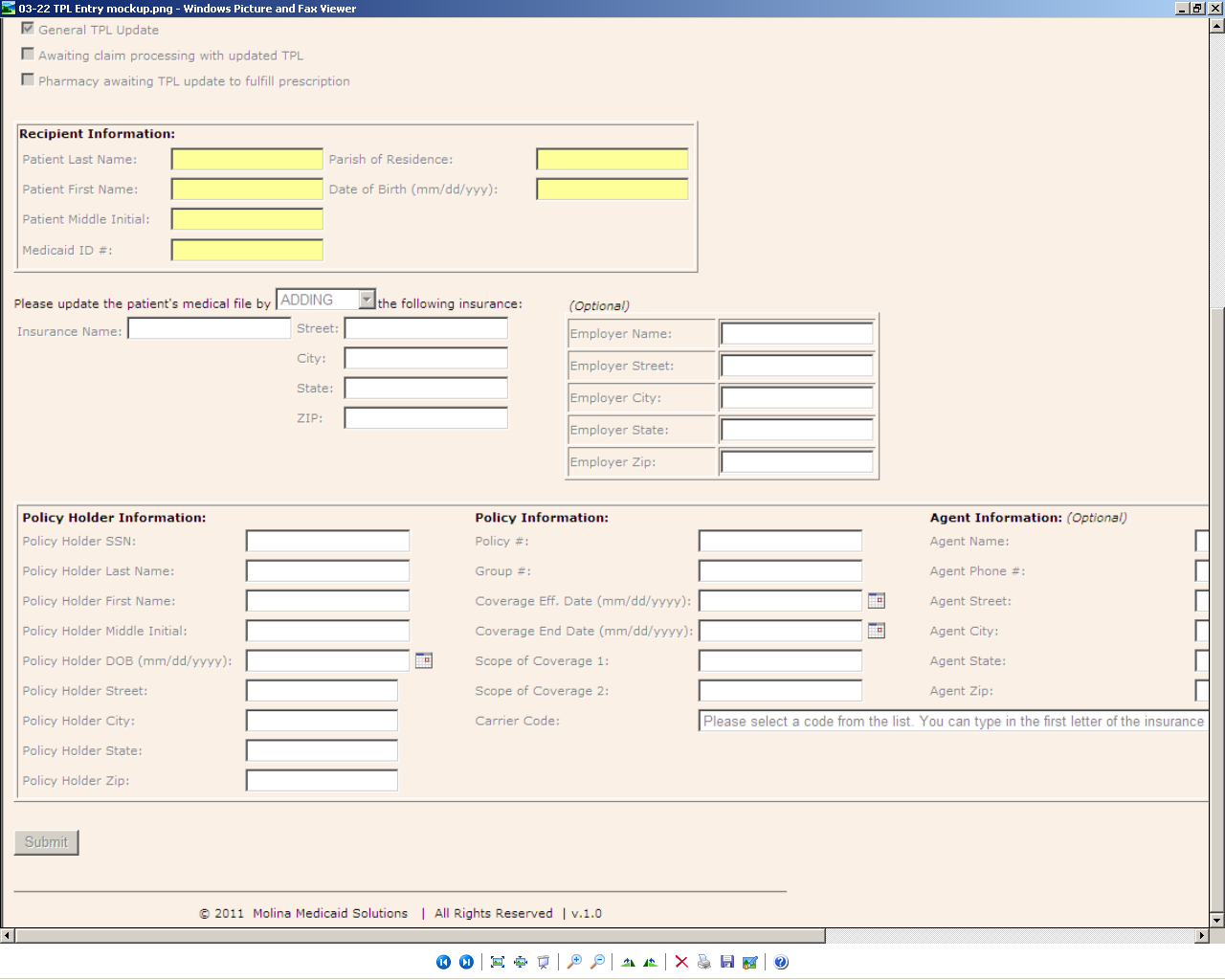
Appendix J

## CCN TPL Discovery Web Application

The following web page screens depict the web application that is made available to CCN organizations to identify and report to DHH the TPL information for Medicaid recipients who are linked.



**TPL Entry Screen, Page 1**



**TPL Entry Screen, Page 2**

Scopes of Coverage

Below is the list from the MDW DED:

|  |  |
| --- | --- |
| **Scope of Coverage** | **Description** |
| 00 | Not Available |
| 01 | Major Medical |
| 02 | Medicare Supplement |
| 03 | Hospital, Physician, Dental and Drugs |
| 04 | Hospital, Physician, Dental |
| 05 | Hospital, Physician, Drugs |
| 06 | Hospital, Physician |
| 07 | Hospital, Dental and Drugs |
| 08 | Hospital, Dental |
| 09 | Hospital, Drugs |
| 10 | Hospital Only |
| 11 | Inpatient Hospital Only |
| 12 | Outpatient Hospital Only |
| 13 | Physician, Dental and Drugs |
| 14 | Physician and Dental |
| 15 | Physician and Drugs |
| 16 | Physician Only |
| 17 | Dental and Drugs Only |
| 18 | Dental Only |
| 19 | Drugs Only |
| 20 | Nursing Home Only |
| 21 | Cancer Only |
| 22 | CHAMPUS/CHAMPVA |
| 23 | Veterans Administration |
| 24 | Transportation |
| 25 | HMO |
| 26 | Carrier declared Bankruptcy |
| 27 | Major Medical without maternity benefits |
| 28 | HMO/Insurance Premium Paid by Medicaid GHIPP Program |
| 29 | Skilled Nursing Care |
| 30 | Medicare HMO (Part C) |
| 31 | Physician Only HMO |
| 32 | Pharmacy (PBM) |
| 33 | HMO No Maternity |

Appendix K

## Administrative Fee Payments Crosswalk

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***CCN-S (Shared) Administrative Fee Payment Codes*** | | | | |  |  |
| Publication Date: 10/20/2011 | | |  |  |  |  |
| **SUBJECT TO CHANGE** | | |  |  |  |  |
|  |  |  |  |  |  |  |
| **CCNS1** | Family and Children | |  |  |  |  |
| **CCNS2** | SSI/Foster Care | |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Aid Category** | **Type Case** | **Age Type (M=months, Y=years)** | **Start Age** | **End Age (inclusive)** | **Sex (1=M, 2=F)** | **CCNS Code** |
| 01 | 001 | M | 000 | 002 | 1 | CCNS2 |
| 01 | 001 | M | 000 | 002 | 2 | CCNS2 |
| 01 | 001 | M | 003 | 011 | 1 | CCNS2 |
| 01 | 001 | M | 003 | 011 | 2 | CCNS2 |
| 01 | 001 | Y | 001 | 005 | 1 | CCNS2 |
| 01 | 001 | Y | 001 | 005 | 2 | CCNS2 |
| 01 | 001 | Y | 006 | 013 | 1 | CCNS2 |
| 01 | 001 | Y | 006 | 013 | 2 | CCNS2 |
| 01 | 001 | Y | 014 | 018 | 1 | CCNS2 |
| 01 | 001 | Y | 014 | 018 | 2 | CCNS2 |
| 01 | 001 | Y | 019 | 044 | 1 | CCNS2 |
| 01 | 001 | Y | 019 | 044 | 2 | CCNS2 |
| 01 | 001 | Y | 045 | 150 | 1 | CCNS2 |
| 01 | 001 | Y | 045 | 150 | 2 | CCNS2 |
| 01 | 003 | M | 000 | 002 | 1 | CCNS2 |
| 01 | 003 | M | 000 | 002 | 2 | CCNS2 |
| 01 | 003 | M | 003 | 011 | 1 | CCNS2 |
| 01 | 003 | M | 003 | 011 | 2 | CCNS2 |
| 01 | 003 | Y | 001 | 005 | 1 | CCNS2 |
| 01 | 003 | Y | 001 | 005 | 2 | CCNS2 |
| 01 | 003 | Y | 006 | 013 | 1 | CCNS2 |
| 01 | 003 | Y | 006 | 013 | 2 | CCNS2 |
| 01 | 003 | Y | 014 | 018 | 1 | CCNS2 |
| 01 | 003 | Y | 014 | 018 | 2 | CCNS2 |
| 01 | 003 | Y | 019 | 044 | 1 | CCNS2 |
| 01 | 003 | Y | 019 | 044 | 2 | CCNS2 |
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| 01 | 003 | Y | 045 | 150 | 2 | CCNS2 |
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| 01 | 050 | M | 000 | 002 | 2 | CCNS2 |
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| 01 | 050 | M | 003 | 011 | 2 | CCNS2 |
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| 01 | 050 | Y | 001 | 005 | 2 | CCNS2 |
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| 01 | 056 | M | 003 | 011 | 2 | CCNS2 |
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| 01 | 056 | Y | 001 | 005 | 2 | CCNS2 |
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| 01 | 125 | Y | 045 | 150 | 2 | CCNS2 |
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| 02 | 059 | Y | 019 | 044 | 2 | CCNS2 |
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| 02 | 059 | Y | 045 | 150 | 2 | CCNS2 |
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| 02 | 060 | M | 000 | 002 | 2 | CCNS2 |
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| 02 | 060 | M | 003 | 011 | 2 | CCNS2 |
| 02 | 060 | Y | 001 | 005 | 1 | CCNS2 |
| 02 | 060 | Y | 001 | 005 | 2 | CCNS2 |
| 02 | 060 | Y | 006 | 013 | 1 | CCNS2 |
| 02 | 060 | Y | 006 | 013 | 2 | CCNS2 |
| 02 | 060 | Y | 014 | 018 | 1 | CCNS2 |
| 02 | 060 | Y | 014 | 018 | 2 | CCNS2 |
| 02 | 060 | Y | 019 | 044 | 1 | CCNS2 |
| 02 | 060 | Y | 019 | 044 | 2 | CCNS2 |
| 02 | 060 | Y | 045 | 150 | 1 | CCNS2 |
| 02 | 060 | Y | 045 | 150 | 2 | CCNS2 |
| 02 | 061 | M | 000 | 002 | 1 | CCNS2 |
| 02 | 061 | M | 000 | 002 | 2 | CCNS2 |
| 02 | 061 | M | 003 | 011 | 1 | CCNS2 |
| 02 | 061 | M | 003 | 011 | 2 | CCNS2 |
| 02 | 061 | Y | 001 | 005 | 1 | CCNS2 |
| 02 | 061 | Y | 001 | 005 | 2 | CCNS2 |
| 02 | 061 | Y | 006 | 013 | 1 | CCNS2 |
| 02 | 061 | Y | 006 | 013 | 2 | CCNS2 |
| 02 | 061 | Y | 014 | 018 | 1 | CCNS2 |
| 02 | 061 | Y | 014 | 018 | 2 | CCNS2 |
| 02 | 061 | Y | 019 | 044 | 1 | CCNS2 |
| 02 | 061 | Y | 019 | 044 | 2 | CCNS2 |
| 02 | 061 | Y | 045 | 150 | 1 | CCNS2 |
| 02 | 061 | Y | 045 | 150 | 2 | CCNS2 |
| 02 | 078 | M | 000 | 002 | 1 | CCNS2 |
| 02 | 078 | M | 000 | 002 | 2 | CCNS2 |
| 02 | 078 | M | 003 | 011 | 1 | CCNS2 |
| 02 | 078 | M | 003 | 011 | 2 | CCNS2 |
| 02 | 078 | Y | 001 | 005 | 1 | CCNS2 |
| 02 | 078 | Y | 001 | 005 | 2 | CCNS2 |
| 02 | 078 | Y | 006 | 013 | 1 | CCNS2 |
| 02 | 078 | Y | 006 | 013 | 2 | CCNS2 |
| 02 | 078 | Y | 014 | 018 | 1 | CCNS2 |
| 02 | 078 | Y | 014 | 018 | 2 | CCNS2 |
| 02 | 078 | Y | 019 | 044 | 1 | CCNS2 |
| 02 | 078 | Y | 019 | 044 | 2 | CCNS2 |
| 02 | 078 | Y | 045 | 150 | 1 | CCNS2 |
| 02 | 078 | Y | 045 | 150 | 2 | CCNS2 |
| 02 | 081 | M | 000 | 002 | 1 | CCNS2 |
| 02 | 081 | M | 000 | 002 | 2 | CCNS2 |
| 02 | 081 | M | 003 | 011 | 1 | CCNS2 |
| 02 | 081 | M | 003 | 011 | 2 | CCNS2 |
| 02 | 081 | Y | 001 | 005 | 1 | CCNS2 |
| 02 | 081 | Y | 001 | 005 | 2 | CCNS2 |
| 02 | 081 | Y | 006 | 013 | 1 | CCNS2 |
| 02 | 081 | Y | 006 | 013 | 2 | CCNS2 |
| 02 | 081 | Y | 014 | 018 | 1 | CCNS2 |
| 02 | 081 | Y | 014 | 018 | 2 | CCNS2 |
| 02 | 081 | Y | 019 | 044 | 1 | CCNS2 |
| 02 | 081 | Y | 019 | 044 | 2 | CCNS2 |
| 02 | 081 | Y | 045 | 150 | 1 | CCNS2 |
| 02 | 081 | Y | 045 | 150 | 2 | CCNS2 |
| 02 | 088 | M | 000 | 002 | 1 | CCNS2 |
| 02 | 088 | M | 000 | 002 | 2 | CCNS2 |
| 02 | 088 | M | 003 | 011 | 1 | CCNS2 |
| 02 | 088 | M | 003 | 011 | 2 | CCNS2 |
| 02 | 088 | Y | 001 | 005 | 1 | CCNS2 |
| 02 | 088 | Y | 001 | 005 | 2 | CCNS2 |
| 02 | 088 | Y | 006 | 013 | 1 | CCNS2 |
| 02 | 088 | Y | 006 | 013 | 2 | CCNS2 |
| 02 | 088 | Y | 014 | 018 | 1 | CCNS2 |
| 02 | 088 | Y | 014 | 018 | 2 | CCNS2 |
| 02 | 088 | Y | 019 | 044 | 1 | CCNS2 |
| 02 | 088 | Y | 019 | 044 | 2 | CCNS2 |
| 02 | 088 | Y | 045 | 150 | 1 | CCNS2 |
| 02 | 088 | Y | 045 | 150 | 2 | CCNS2 |
| 03 | 001 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 001 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 001 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 001 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 001 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 001 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 001 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 001 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 001 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 001 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 001 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 001 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 001 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 001 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 002 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 002 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 002 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 002 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 002 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 002 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 002 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 002 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 002 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 002 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 002 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 002 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 002 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 002 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 007 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 007 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 007 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 007 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 007 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 007 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 007 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 007 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 007 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 007 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 007 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 007 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 007 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 007 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 008 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 008 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 008 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 008 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 008 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 008 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 008 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 008 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 008 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 008 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 008 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 008 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 008 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 008 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 013 | M | 000 | 002 | 1 | CCNS2 |
| 03 | 013 | M | 000 | 002 | 2 | CCNS2 |
| 03 | 013 | M | 003 | 011 | 1 | CCNS2 |
| 03 | 013 | M | 003 | 011 | 2 | CCNS2 |
| 03 | 013 | Y | 001 | 005 | 1 | CCNS2 |
| 03 | 013 | Y | 001 | 005 | 2 | CCNS2 |
| 03 | 013 | Y | 006 | 013 | 1 | CCNS2 |
| 03 | 013 | Y | 006 | 013 | 2 | CCNS2 |
| 03 | 013 | Y | 014 | 018 | 1 | CCNS2 |
| 03 | 013 | Y | 014 | 018 | 2 | CCNS2 |
| 03 | 013 | Y | 019 | 044 | 1 | CCNS2 |
| 03 | 013 | Y | 019 | 044 | 2 | CCNS2 |
| 03 | 013 | Y | 045 | 150 | 1 | CCNS2 |
| 03 | 013 | Y | 045 | 150 | 2 | CCNS2 |
| 03 | 014 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 014 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 014 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 014 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 014 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 014 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 014 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 014 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 014 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 014 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 014 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 014 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 014 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 014 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 015 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 015 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 015 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 015 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 015 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 015 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 015 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 015 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 015 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 015 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 015 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 015 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 015 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 015 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 020 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 020 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 020 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 020 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 020 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 020 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 020 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 020 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 020 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 020 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 020 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 020 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 020 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 020 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 052 | Y | 000 | 150 | 2 | CCNS2 |
| 03 | 053 | M | 000 | 002 | 1 | CCNS2 |
| 03 | 053 | M | 000 | 002 | 2 | CCNS2 |
| 03 | 053 | M | 003 | 011 | 1 | CCNS2 |
| 03 | 053 | M | 003 | 011 | 2 | CCNS2 |
| 03 | 053 | Y | 001 | 005 | 1 | CCNS2 |
| 03 | 053 | Y | 001 | 005 | 2 | CCNS2 |
| 03 | 053 | Y | 006 | 013 | 1 | CCNS2 |
| 03 | 053 | Y | 006 | 013 | 2 | CCNS2 |
| 03 | 053 | Y | 014 | 018 | 1 | CCNS2 |
| 03 | 053 | Y | 014 | 018 | 2 | CCNS2 |
| 03 | 053 | Y | 019 | 044 | 1 | CCNS2 |
| 03 | 053 | Y | 019 | 044 | 2 | CCNS2 |
| 03 | 053 | Y | 045 | 150 | 1 | CCNS2 |
| 03 | 053 | Y | 045 | 150 | 2 | CCNS2 |
| 03 | 055 | M | 000 | 002 | 1 | CCNS2 |
| 03 | 055 | M | 000 | 002 | 2 | CCNS2 |
| 03 | 055 | M | 003 | 011 | 1 | CCNS2 |
| 03 | 055 | M | 003 | 011 | 2 | CCNS2 |
| 03 | 055 | Y | 001 | 005 | 1 | CCNS2 |
| 03 | 055 | Y | 001 | 005 | 2 | CCNS2 |
| 03 | 055 | Y | 006 | 013 | 1 | CCNS2 |
| 03 | 055 | Y | 006 | 013 | 2 | CCNS2 |
| 03 | 055 | Y | 014 | 018 | 1 | CCNS2 |
| 03 | 055 | Y | 014 | 018 | 2 | CCNS2 |
| 03 | 055 | Y | 019 | 044 | 1 | CCNS2 |
| 03 | 055 | Y | 019 | 044 | 2 | CCNS2 |
| 03 | 055 | Y | 045 | 150 | 1 | CCNS2 |
| 03 | 055 | Y | 045 | 150 | 2 | CCNS2 |
| 03 | 071 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 071 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 071 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 071 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 071 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 071 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 071 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 071 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 071 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 071 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 071 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 071 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 071 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 071 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 085 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 085 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 085 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 085 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 085 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 085 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 085 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 085 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 085 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 085 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 085 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 085 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 085 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 085 | Y | 045 | 150 | 2 | CCNS1 |
| 03 | 104 | M | 000 | 002 | 1 | CCNS2 |
| 03 | 104 | M | 000 | 002 | 2 | CCNS2 |
| 03 | 104 | M | 003 | 011 | 1 | CCNS2 |
| 03 | 104 | M | 003 | 011 | 2 | CCNS2 |
| 03 | 104 | Y | 001 | 005 | 1 | CCNS2 |
| 03 | 104 | Y | 001 | 005 | 2 | CCNS2 |
| 03 | 104 | Y | 006 | 013 | 1 | CCNS2 |
| 03 | 104 | Y | 006 | 013 | 2 | CCNS2 |
| 03 | 104 | Y | 014 | 018 | 1 | CCNS2 |
| 03 | 104 | Y | 014 | 018 | 2 | CCNS2 |
| 03 | 104 | Y | 019 | 044 | 1 | CCNS2 |
| 03 | 104 | Y | 019 | 044 | 2 | CCNS2 |
| 03 | 104 | Y | 045 | 150 | 1 | CCNS2 |
| 03 | 104 | Y | 045 | 150 | 2 | CCNS2 |
| 03 | 127 | M | 000 | 002 | 1 | CCNS2 |
| 03 | 127 | M | 000 | 002 | 2 | CCNS2 |
| 03 | 127 | M | 003 | 011 | 1 | CCNS2 |
| 03 | 127 | M | 003 | 011 | 2 | CCNS2 |
| 03 | 127 | Y | 001 | 005 | 1 | CCNS2 |
| 03 | 127 | Y | 001 | 005 | 2 | CCNS2 |
| 03 | 127 | Y | 006 | 013 | 1 | CCNS2 |
| 03 | 127 | Y | 006 | 013 | 2 | CCNS2 |
| 03 | 127 | Y | 014 | 018 | 1 | CCNS2 |
| 03 | 127 | Y | 014 | 018 | 2 | CCNS2 |
| 03 | 127 | Y | 019 | 044 | 1 | CCNS2 |
| 03 | 127 | Y | 019 | 044 | 2 | CCNS2 |
| 03 | 127 | Y | 045 | 150 | 1 | CCNS2 |
| 03 | 127 | Y | 045 | 150 | 2 | CCNS2 |
| 03 | 148 | Y | 000 | 150 | 1 | CCNS2 |
| 03 | 148 | Y | 000 | 150 | 2 | CCNS2 |
| 03 | 151 | M | 000 | 002 | 1 | CCNS1 |
| 03 | 151 | M | 000 | 002 | 2 | CCNS1 |
| 03 | 151 | M | 003 | 011 | 1 | CCNS1 |
| 03 | 151 | M | 003 | 011 | 2 | CCNS1 |
| 03 | 151 | Y | 001 | 005 | 1 | CCNS1 |
| 03 | 151 | Y | 001 | 005 | 2 | CCNS1 |
| 03 | 151 | Y | 006 | 013 | 1 | CCNS1 |
| 03 | 151 | Y | 006 | 013 | 2 | CCNS1 |
| 03 | 151 | Y | 014 | 018 | 1 | CCNS1 |
| 03 | 151 | Y | 014 | 018 | 2 | CCNS1 |
| 03 | 151 | Y | 019 | 044 | 1 | CCNS1 |
| 03 | 151 | Y | 019 | 044 | 2 | CCNS1 |
| 03 | 151 | Y | 045 | 150 | 1 | CCNS1 |
| 03 | 151 | Y | 045 | 150 | 2 | CCNS1 |
| 04 | 001 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 001 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 001 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 001 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 001 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 001 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 001 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 001 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 001 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 001 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 001 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 001 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 001 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 001 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 003 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 003 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 003 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 003 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 003 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 003 | Y | 001 | 005 | 2 | CCNS2 |
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| 04 | 003 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 003 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 003 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 003 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 003 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 003 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 003 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 050 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 050 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 050 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 050 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 050 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 050 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 050 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 050 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 050 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 050 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 050 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 050 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 050 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 050 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 056 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 056 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 056 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 056 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 056 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 056 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 056 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 056 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 056 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 056 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 056 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 056 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 056 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 056 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 057 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 057 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 057 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 057 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 057 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 057 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 057 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 057 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 057 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 057 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 057 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 057 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 057 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 057 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 058 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 058 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 058 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 058 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 058 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 058 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 058 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 058 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 058 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 058 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 058 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 058 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 058 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 058 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 059 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 059 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 059 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 059 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 059 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 059 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 059 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 059 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 059 | Y | 014 | 018 | 1 | CCNS2 |
| 04 | 059 | Y | 014 | 018 | 2 | CCNS2 |
| 04 | 059 | Y | 019 | 044 | 1 | CCNS2 |
| 04 | 059 | Y | 019 | 044 | 2 | CCNS2 |
| 04 | 059 | Y | 045 | 150 | 1 | CCNS2 |
| 04 | 059 | Y | 045 | 150 | 2 | CCNS2 |
| 04 | 060 | M | 000 | 002 | 1 | CCNS2 |
| 04 | 060 | M | 000 | 002 | 2 | CCNS2 |
| 04 | 060 | M | 003 | 011 | 1 | CCNS2 |
| 04 | 060 | M | 003 | 011 | 2 | CCNS2 |
| 04 | 060 | Y | 001 | 005 | 1 | CCNS2 |
| 04 | 060 | Y | 001 | 005 | 2 | CCNS2 |
| 04 | 060 | Y | 006 | 013 | 1 | CCNS2 |
| 04 | 060 | Y | 006 | 013 | 2 | CCNS2 |
| 04 | 060 | Y | 014 | 018 | 1 | CCNS2 |
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| 04 | 081 | Y | 019 | 044 | 2 | CCNS2 |
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| 04 | 081 | Y | 045 | 150 | 2 | CCNS2 |
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| 04 | 083 | M | 000 | 002 | 2 | CCNS2 |
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| 04 | 088 | Y | 014 | 018 | 2 | CCNS2 |
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| 04 | 133 | Y | 014 | 018 | 1 | CCNS2 |
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| 06 | 007 | Y | 000 | 150 | 2 | CCNS2 |
| 06 | 013 | Y | 000 | 150 | 1 | CCNS2 |
| 06 | 013 | Y | 000 | 150 | 2 | CCNS2 |
| 06 | 014 | Y | 000 | 150 | 1 | CCNS2 |
| 06 | 014 | Y | 000 | 150 | 2 | CCNS2 |
| 06 | 030 | Y | 000 | 150 | 1 | CCNS2 |
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| 06 | 078 | Y | 014 | 018 | 1 | CCNS2 |
| 06 | 078 | Y | 014 | 018 | 2 | CCNS2 |
| 06 | 078 | Y | 019 | 044 | 1 | CCNS2 |
| 06 | 078 | Y | 019 | 044 | 2 | CCNS2 |
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| 06 | 078 | Y | 045 | 150 | 2 | CCNS2 |
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| 08 | 029 | M | 000 | 002 | 2 | CCNS2 |
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| 08 | 029 | Y | 001 | 005 | 1 | CCNS2 |
| 08 | 029 | Y | 001 | 005 | 2 | CCNS2 |
| 08 | 029 | Y | 006 | 013 | 1 | CCNS2 |
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| 08 | 029 | Y | 014 | 018 | 1 | CCNS2 |
| 08 | 029 | Y | 014 | 018 | 2 | CCNS2 |
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| 08 | 078 | M | 003 | 011 | 2 | CCNS2 |
| 08 | 078 | Y | 001 | 005 | 1 | CCNS2 |
| 08 | 078 | Y | 001 | 005 | 2 | CCNS2 |
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| 08 | 078 | Y | 006 | 013 | 2 | CCNS2 |
| 08 | 078 | Y | 014 | 018 | 1 | CCNS2 |
| 08 | 078 | Y | 014 | 018 | 2 | CCNS2 |
| 08 | 078 | Y | 019 | 044 | 1 | CCNS2 |
| 08 | 078 | Y | 019 | 044 | 2 | CCNS2 |
| 08 | 078 | Y | 045 | 150 | 1 | CCNS2 |
| 08 | 078 | Y | 045 | 150 | 2 | CCNS2 |
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| 13 | 001 | M | 000 | 002 | 2 | CCNS1 |
| 13 | 001 | M | 003 | 011 | 1 | CCNS1 |
| 13 | 001 | M | 003 | 011 | 2 | CCNS1 |
| 13 | 001 | Y | 001 | 005 | 1 | CCNS1 |
| 13 | 001 | Y | 001 | 005 | 2 | CCNS1 |
| 13 | 001 | Y | 006 | 013 | 1 | CCNS1 |
| 13 | 001 | Y | 006 | 013 | 2 | CCNS1 |
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| 13 | 001 | Y | 019 | 044 | 1 | CCNS1 |
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| 13 | 001 | Y | 045 | 150 | 1 | CCNS1 |
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| 13 | 009 | Y | 001 | 005 | 1 | CCNS1 |
| 13 | 009 | Y | 001 | 005 | 2 | CCNS1 |
| 13 | 009 | Y | 006 | 013 | 1 | CCNS1 |
| 13 | 009 | Y | 006 | 013 | 2 | CCNS1 |
| 13 | 009 | Y | 014 | 018 | 1 | CCNS1 |
| 13 | 009 | Y | 014 | 018 | 2 | CCNS1 |
| 13 | 009 | Y | 019 | 044 | 1 | CCNS1 |
| 13 | 009 | Y | 019 | 044 | 2 | CCNS1 |
| 13 | 009 | Y | 045 | 150 | 1 | CCNS1 |
| 13 | 009 | Y | 045 | 150 | 2 | CCNS1 |
| 13 | 071 | M | 000 | 002 | 1 | CCNS1 |
| 13 | 071 | M | 000 | 002 | 2 | CCNS1 |
| 13 | 071 | M | 003 | 011 | 1 | CCNS1 |
| 13 | 071 | M | 003 | 011 | 2 | CCNS1 |
| 13 | 071 | Y | 001 | 005 | 1 | CCNS1 |
| 13 | 071 | Y | 001 | 005 | 2 | CCNS1 |
| 13 | 071 | Y | 006 | 013 | 1 | CCNS1 |
| 13 | 071 | Y | 006 | 013 | 2 | CCNS1 |
| 13 | 071 | Y | 014 | 018 | 1 | CCNS1 |
| 13 | 071 | Y | 014 | 018 | 2 | CCNS1 |
| 13 | 071 | Y | 019 | 044 | 1 | CCNS1 |
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| 13 | 085 | M | 000 | 002 | 1 | CCNS1 |
| 13 | 085 | M | 000 | 002 | 2 | CCNS1 |
| 13 | 085 | M | 003 | 011 | 1 | CCNS1 |
| 13 | 085 | M | 003 | 011 | 2 | CCNS1 |
| 13 | 085 | Y | 001 | 005 | 1 | CCNS1 |
| 13 | 085 | Y | 001 | 005 | 2 | CCNS1 |
| 13 | 085 | Y | 006 | 013 | 1 | CCNS1 |
| 13 | 085 | Y | 006 | 013 | 2 | CCNS1 |
| 13 | 085 | Y | 014 | 018 | 1 | CCNS1 |
| 13 | 085 | Y | 014 | 018 | 2 | CCNS1 |
| 13 | 085 | Y | 019 | 044 | 1 | CCNS1 |
| 13 | 085 | Y | 019 | 044 | 2 | CCNS1 |
| 13 | 085 | Y | 045 | 150 | 1 | CCNS1 |
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| 22 | 007 | Y | 000 | 150 | 2 | CCNS2 |
| 22 | 013 | Y | 000 | 150 | 1 | CCNS2 |
| 22 | 013 | Y | 000 | 150 | 2 | CCNS2 |
| 22 | 014 | Y | 000 | 150 | 1 | CCNS2 |
| 22 | 014 | Y | 000 | 150 | 2 | CCNS2 |
| 22 | 032 | Y | 000 | 150 | 1 | CCNS2 |
| 22 | 032 | Y | 000 | 150 | 2 | CCNS2 |
| 22 | 033 | Y | 000 | 150 | 1 | CCNS2 |
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| 22 | 035 | Y | 000 | 150 | 1 | CCNS2 |
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| 22 | 078 | M | 000 | 002 | 1 | CCNS2 |
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| 22 | 078 | Y | 006 | 013 | 2 | CCNS2 |
| 22 | 078 | Y | 014 | 018 | 1 | CCNS2 |
| 22 | 078 | Y | 014 | 018 | 2 | CCNS2 |
| 22 | 078 | Y | 019 | 044 | 1 | CCNS2 |
| 22 | 078 | Y | 019 | 044 | 2 | CCNS2 |
| 22 | 078 | Y | 045 | 150 | 1 | CCNS2 |
| 22 | 078 | Y | 045 | 150 | 2 | CCNS2 |

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| ***Louisiana Medicaid Recipient Aid Category Codes*** | | |
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| **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 |

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| ***Louisiana Medicaid Recipient Type Case Codes*** | |  |
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| **LAMMIS Type Case** | **Description (see the worksheet TYPE CASE MEANINGS for detailed descriptions)** | **SSI Status** (1=SSI, 0=Non-SSI) |
| **001** | SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic | 0 |
| **002** | Deemed Eligible | 0 |
| **003** | SSI Conversion | 0 |
| **004** | SSI SNF | 1 |
| **005** | SSI/LTC | 1 |
| **006** | 12 Months Continuous Eligibility | 0 |
| **007** | LACHIP Phase 1 | 0 |
| **008** | PAP - Prohibited AFDC Provisions | 0 |
| **009** | LIFC - Unemployed Parent / CHAMP | 0 |
| **010** | SSI in ICF (II)- Medical | 1 |
| **011** | SSI Villa SNF | 1 |
| **012** | Presumptive Eligibility, Pregnant Woman | 0 |
| **013** | CHAMP Pregnant Woman (to 133% of FPIG) | 0 |
| **014** | CHAMP Child | 0 |
| **015** | LACHIP Phase 2 | 0 |
| **016** | Deceased Recipient - LTC | 0 |
| **017** | Deceased Recipient - LTC (Not Auto) | 0 |
| **018** | ADHC (Adult Day Health Services Waiver) | 0 |
| **019** | SSI/ADHC | 1 |
| **020** | Regular MNP (Medically Needy Program) | 0 |
| **021** | Spend-Down MNP | 0 |
| **022** | LTC Spend-Down MNP (Income > Facility Fee) | 0 |
| **023** | SSI Transfer of Resource(s)/LTC | 1 |
| **024** | Transfer of Resource(s)/LTC | 0 |
| **025** | LTC Spend-Down MNP | 0 |
| **026** | SSI/EDA Waiver | 1 |
| **027** | EDA Waiver | 0 |
| **028** | Tuberculosis (TB) | 0 |
| **029** | Foster Care IV-E - Suspended SSI | 0 |
| **030** | Regular Foster Care Child | 0 |
| **031** | IV-E Foster Care | 0 |
| **032** | YAP (Young Adult Program) | 0 |
| **033** | OYD - V Category Child | 0 |
| **034** | MNP - Regular Foster Care | 0 |
| **035** | YAP/OYD | 0 |
| **036** | YAP (Young Adult Program) | 0 |
| **037** | OYD (Office of Youth Development) | 0 |
| **038** | OCS Child Under Age 18 (State Funded) | 0 |
| **039** | State Retirees | 0 |
| **040** | SLMB (Specified Low-Income Medicare Beneficiary) | 0 |
| **041** | OAA, ANB or DA (GERI HP-ICF(I) SSI-No) | 0 |
| **042** | OAA, ANB or DA (GERI HP-ICF(I) SSI Pay) | 1 |
| **043** | New Opportunities Waiver - SSI | 1 |
| **044** | OAA, ANB or DA (GERI HP-ICF(2) SSI-Pay) | 1 |
| **045** | SSI PCA Waiver | 1 |
| **046** | PCA Waiver | 0 |
| **047** | Illegal/Ineligible Aliens Emergency Services | 0 |
| **048** | QI-1 (Qualified Individual - 1) | 0 |
| **049** | QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002) | 0 |
| **050** | PICKLE | 0 |
| **051** | LTC MNP/Transfer of Resources | 0 |
| **052** | Breast and/or Cervical Cancer | 0 |
| **053** | CHAMP Pregnant Woman Expansion (to 185% FPIG) | 0 |
| **054** | Reinstated Section 4913 Children | 0 |
| **055** | LACHIP Phase 3 | 0 |
| **056** | Disabled Widow/Widower (DW/W) | 0 |
| **057** | BPL (Walker vs. Bayer) | 0 |
| **058** | Section 4913 Children | 0 |
| **059** | Disabled Adult Child | 0 |
| **060** | Early Widow/Widowers | 0 |
| **061** | SGA Disabled W/W/DS | 0 |
| **062** | SSI/Public ICF/DD | 1 |
| **063** | LTC Co-Insurance | 0 |
| **064** | SSI/Private ICF/DD | 1 |
| **065** | Private ICF/DD | 0 |
| **066** | AFDC- Private ICF DD - 3 Month Limit | 0 |
| **067** | AFDC or IV-E(1) Private ICF DD | 0 |
| **068** | SSI-M (Determination of disability for Medicaid Eligibility) | 1 |
| **069** | Roll-Down | 0 |
| **070** | New Opportunities Waiver, non-SSI | 0 |
| **071** | Transitional Medicaid | 0 |
| **072** | LAMI Psuedo Income | 0 |
| **073** | Recipient (65 Plus) Eligible SSI/Ven Pay Hospital | 1 |
| **074** | Description not available | 0 |
| **075** | TEFRA | 0 |
| **076** | SSI Children's Waiver - Louisiana Children's Choice | 1 |
| **077** | Children's Waiver - Louisiana Children's Choice | 0 |
| **078** | SSI (Supplemental Security Income) | 1 |
| **079** | Denied SSI Prior Period | 0 |
| **080** | Terminated SSI Prior Period | 1 |
| **081** | Former SSI | 1 |
| **082** | SSI DD Waiver | 1 |
| **083** | Acute Care Hospitals (LOS > 30 days) | 0 |
| **084** | LaCHIP Pregnant Woman Expansion (185-200%) | 0 |
| **085** | Grant Review | 0 |
| **086** | Forced Benefits | 0 |
| **087** | CHAMP Parents | 0 |
| **088** | Medicaid Buy-In Working Disabled (Medicaid Purchase Plan) | 0 |
| **089** | Recipient Eligible for Pay-Habitation and Other | 0 |
| **090** | LTC (Long Term Care) | 0 |
| **091** | A, B, D Recipient in Geriatric SNF; No SSI Pay | 0 |
| **092** | AFCD, GA, A, B, D in SNF; No AFDC Pay | 0 |
| **093** | DD Waiver | 0 |
| **094** | QDWI (Qualified Disabled/Working Individual) | 0 |
| **095** | QMB (Qualified Medicare Beneficiary) | 0 |
| **097** | Qualified Child Psychiatric | 0 |
| **098** | AFDC, GA, A, B, D ICF(2) No AFDC/Other Pay | 0 |
| **099** | Public ICF/DD | 0 |
| **100** | PACE SSI | 1 |
| **101** | PACE SSI-related | 0 |
| **102** | GNOCHC Adult Parent | 0 |
| **103** | GNOCHC Childless Adult | 0 |
| **104** | Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL | 0 |
| **109** | LaChoice, Childless Adults | 0 |
| **110** | LaChoice, Parents with Children | 0 |
| **111** | LHP, Childless Adults | 0 |
| **112** | LHP, Parents with Children | 0 |
| **113** | LHP, Children | 0 |
| **115** | Family Planning, Previous LAMOMS eligibility | 0 |
| **116** | Family Planning, New eligibility / Non LaMOM | 0 |
| **117** | Supports Waiver SSI | 1 |
| **118** | Supports Waiver | 0 |
| **119** | Residential Options Waiver - SSI | 1 |
| **120** | Residential Options Waiver - NON-SSI | 0 |
| **121** | SSI/LTC Excess Equity | 1 |
| **122** | LTC Excess Equity | 0 |
| **123** | LTC Spend Down MNP Excess Equity | 0 |
| **124** | LTC Spend Down MNP Excess Equity(Income over facility fee) | 0 |
| **125** | Disability Medicaid | 0 |
| **127** | LaChip Phase IV: Non-Citizen Pregnant Women Expansion | 0 |
| **130** | LTC Payment Denial/Late Admission Packet | 0 |
| **131** | SSI Payment Denial/Late Admission | 1 |
| **132** | Spendown Denial of Payment/Late Packet | 0 |
| **133** | Family Opportunity Program | 0 |
| **134** | LaCHIP Affordable Plan | 0 |
| **136** | Private ICF/DD Spendown Medically Needy Program | 0 |
| **137** | Public ICF/DD Spendown Medically Needy Program | 0 |
| **138** | Private ICF/DD Spendown MNP/Income Over Facility Fee | 0 |
| **139** | Public ICF/DD Spendown MNP/Income Over Facility Fee | 0 |
| **140** | SSI Private ICF/DD Transfer of Resources | 1 |
| **141** | Private ICF/DD Transfer of Resources | 0 |
| **142** | SSI Public ICF/DD Transfer of Resources | 1 |
| **143** | Public ICF/DD Transfer of Resources | 0 |
| **144** | Public ICF/DD MNP Transfer of Resources | 0 |
| **145** | Private ICF/DD MNP Transfer of Resources | 0 |
| **146** | Adult Residential Care/SSI | 1 |
| **147** | Adult Residential Care | 0 |
| **148** | Youth Aging Out of Foster Care (Chaffee Option) | 0 |
| **149** | New Opportunities Waiver Fund | 0 |
| **150** | SSI New Opportunities Waiver Fund | 1 |
| **151** | ELE - Food Stamps (Express Lane Eligibility-Food Stamps) | 0 |
| **152** | ELE School Lunch (Express Lane Eligibility -School Lunch) | 0 |
| **153** | SSI - Community Choices Waiver | 1 |
| **154** | Community Choices Waiver | 0 |
| **155** | HCBS MNP Spend down | 0 |
| **178** | Disabled Adults authorized for special hurricane Katrina assistance | 0 |
| **200** | CsoC-SED MEDICAID CHILD -MEDS TC and sgmt TC  CSoC Waiver Children - 1915(c) waiver. Children under age 22, meeting a hospital and nursing facility LOC of CSoC will be eligibile up to 300% of FBR, using institutional eligibility criteria. LOC 60=hospital, 61=NF. | 0 |
| **201** | LBHP1915(i) NON MEDICAID ADULT 19 &OLDER  CSoC Waiver Adults - 1915(i) only; non-Medicaid. Adults over the age of 18, not otherwise eligible for Medicaid, meeting the 1915(i) LON criteria up to 150% of FPL. | 0 |
| **202** | CSoC 1915(i)-LIKE MEDICAID CHILD sgmt  1915(i)-like Children (aka 1915(b)(3) children): temp type case on LTC segment if recipient is in LTC/NH/ICF. Otherwise Medicaid eligible children under age 22, meeting a LON of CSoC and eligible for additional services under 1915(b)(3) savings. | 0 |
| **203** | LBHP1915(i) MEDICAID ADULT 19 &OLDER sgmt  CSoC Waiver Adults - 1915(i): temp type case on LTC segment if recipient is in LTC/NH/ICF. Adults over the age of 21, otherwise eligible for Medicaid, meeting the 1915(i) LON criteria. | 0 |
| **204** | LBHP1115-NON-MEDICAID ADULTS 19 & OLDER  1115 waiver for 1915(i) persons whose income is below 150% of FTPL and meeting the LON criteria. These individuals do not have to meet a category of assistance. The new aid cat/type case combination will be 40/204 and the segment temp type case will be 204. | 0 |
| **205** | LBHP Spenddown (Adult) |  |

1. 9-digit Postal Code [↑](#footnote-ref-1)